AN ANALYSIS OF THE EXPERIENCE OF THE ACUTE PHASE OF TRAUMATIC SPINAL CORD INJURY IN A SOUTH AFRICAN SPINAL UNIT

THESIS

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ABSTRACT

This study aims to explore, and to a certain extent to clarify, what it means psychologically to experience Traumatic spinal cord injury (TSCI) in a South African spinal unit. The target time chosen for analysis is the acute medical period. The study presents a review of the literature on psychological adjustment to TSCI and then proceeds to introduce and extensively articulate the hermeneutic approach and methodology. Subsequently, an interpretive research strategy is presented for the purpose of studying the acute phase of TSCI. The data for the study was obtained by means of three dialogical interviews which were tape recorded, transcribed and analyzed within a cyclical framework consisting of three interdependent levels. The interpretive procedure is modeled upon the 'reading guide' developed by Brown, Tappan, Gilligan, Miller and Argyris (1989). The analysis follows a course from the individual psychological descriptions of the experience to the generation of a general, nomothetic narrative account of the acute phase. The findings are then discussed in relation to the existing literature and evaluated on the basis of the goals of the study. The study highlights the value of some of the 'stage' ways of thinking about SCI adjustment, while simultaneously stressing the need for placing adjustment within a more personalized, and individually meaningful context. Significant differences between the psycho-physical experiences of patients in the categories of complete and incomplete SCI were found, which suggests that a sharper distinction be made in the literature between these two groups, in order to account for the marked variations in their experiences. The study also contains a number of shortcomings, such as a lack of understanding about certain historical and contextual factors which may have mediated the experiences of the trauma for the individuals concerned.

These shortcomings and some suggestions for their resolution are then discussed. The study concludes with an evaluation of the research strategy and methodology and also offers some suggestions for future research.

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CHAPTER ONE

INTRODUCTION

1.1 FORMULATING THE RESEARCH PROBLEM

Traumatic Spinal Cord Injury (TSCI), if complete, causes permanent motor paralysis and loss of sensation below the level of injury (Zejdlik, 1992). It is so physically catastrophic, that until recently few persons managed to survive the trauma of injury. As a result of recent medical advances however, and a subsequent increase in the survival rate of the spinal cord injured, investigations into the psycho-social dimensions of the experience have become salient concerns for the rehabilitation context and community (Roessler, 1978).

The aim of the present study is to explore and to a certain extent to clarify what it means psychologically to experience TSCI in a South African spinal unit. The target time chosen for analysis is the acute medical period, i.e. the initial bed ridden phase immediately following the onset of injury. The investigation was conducted for the following primary reasons: (1) the literature on emotional responses appears to be contradictory (Du Preez, 1985), (2) very little research has been conducted on the acute phase (Buchanan and Nawoczenski, 1987) and (3) much of the existing research has been carried out within a natural scientific framework. I shall now expand upon each reason individually, thereby giving this problem formulation greater clarity.

1) To date, many investigators have been pre-occupied with the task of attempting to prove the existence of sequential stages in the adjustment process, for example shock, denial, depression and acceptance; the result being the propogation of various related stage theories (Du Preez, 1985). Other researchers have attempted to fit emotional reactions into theoretical constructs, for example the psychodynamic model developed by Pepper (1977) and the trauma model described by Hamburg and Adams (1967). Others have advocated a more individualistic approach to understanding TSCI. These theorists have argued that persons who sustain spinal cord injuries tend to adjust idiosyncratically to the trauma, and they have stressed the fact that we currently possess incomplete knowledge about the psychological consequences of SCI (Du Preez, 1985; Somers, 1992; Trieschmann, 1980).

(2) While much has been written about the acute phase of psychological adjustment to SCI, very little empirical research has been conducted (Buchanan and Nawoczenski, 1987). It is known that individuals during the acute phase experience pain, persistent sensory and sleep deprivation, a lack of time cues and social isolation; all of which, when combined with the shock induced by the trauma and the effects brought on by powerful psycho-active medications produce profound and complex changes in cognitive functioning, emotional response and behaviour (Brown and

Hughson, 1987; Somers, 1992).

At present, we also lack an understanding of vital subjective human elements in the SCI experience (Du Preez, 1985). We do not know, for instance, how the intensity of emotional reactions affects and impacts upon the adjustment process (Bracken, Shepard and Webb, 1981), and we also do not know what these various reactive phenomena mean for the people experiencing them (Du Preez, 1985). This is due, in part at least to the fact that much of the existing research has been conducted within a natural scientific framework.

(3) While natural scientific methods, notably the extensive use of questionnaires, standardized interviews, clinical observations and diagnostic processes have provided us with much insight and knowledge into the nature of the SCI experience, they have failed to provide us with a complete, (i.e. complex and meaningful) understanding of the phenomenon. The fact that reactions to and experiences with TSCI tend to be highly idiosyncratic and contingent upon a variety of experimentally uncontrollable physiological, psychological and socio-cultural factors, suggests that quantitative statistical procedures, given their proneness to contextual abstraction and preference for generalizable results are an inadequate means for illuminating the meaning of experiences as profound, complex and specific as TSCI.

1.2 PURPOSE OF THE STUDY

In part, the method chosen depends on the problem being considered and on the goal of the investigation. As the purpose of this study is to generate a meaningful and phenomenologically sensitive account of the acute phase, a qualitative hermeneutic approach has been employed. This approach makes use of an interpretive procedure which offers a way of operationalizing the hermeneutic circle, (i.e. the essential circle of understanding) by building up an interpretation of a whole interview narrative out of its constituent parts. It is a structured interpretive procedure which allows for the exploration of experience both within and across interviews by means of an ordered and systematic 'reading guide'. The hermeneutic stance and the reading guide are discussed in detail in the method section of this paper.

1.3 DEFINING KEY TERMS

At this juncture, the need for conducting the present study has been articulated and motivated. I shall now take this opportunity to define certain key terms and concepts which will provide the reader with a greater understanding of what spinal cord trauma entails. When one speaks of spinal cord trauma one is usually referring to the physiological or anatomical aspects of the injury. While this study is concerned primarily with the psychological dimension, a brief description of the physical side is required as this assists one to understand spinal cord injury in a holistic manner.

1.3.1 The Spinal Cord

The spinal cord extends from the medulla oblongata to the level of the L1 or L2 vertebra. It is comprised of various nerves providing common pathways for controlled movement, sensory input and reflex responses. The cord acts as a bi-directional communication cable, carrying motor messages from the brain to the peripheral nervous system and sensory messages from the peripheral nervous system to the brain. When the cord is injured, messages are unable to pass the level of injury as the brain has no means of connecting with body parts below the point of severance (Somers, 1992; Zejdlik, 1992).

1.3.2 The Vertebral Column

The spine consists of 33 individual and fused vertebrae which share common characteristics and are grouped according to location and function. There are seven Cervical, twelve Thoracic, five Lumbar, five Sacral and four Coccygeal vertebrae. The vertebrae of the sacrum and coccyx are fused in the adult to form the tail bone. Ligaments, together with cartilaginous disks bind the vertebrae together. These disks act as shock absorbers and weight bearing structures; i.e. as cushions protecting us from the jars of everyday life (Du Preez, 1985; Zejdlik, 1992). Spinal cord injuries are divided into a number of categories depending on the nature, extent, and level of injury. While it is rare for cord injured individuals to fit neatly and wholly into a clearly delineated categorical niche, the bulk of cord injuries may be divided into three categories or groupings. These are: (1) Paraplegia, (2) Tetraplegia/Quadriplegia, and (3) Complete or Incomplete SCI.

1.3.3 Paraplegia

Paraplegia entails either a partial or complete loss of sensation and voluntary muscle control of the trunk and lower limbs, bladder and rectum, as well as impairment of sexual functioning in males (Du Preez, 1985).

1.3.4 Tetraplegia/Quadriplegia

Tetraplegia entails either a partial or complete loss of sensation and voluntary muscle movement in the arms, trunk, lower limbs, bladder and rectum, in addition to paralysis of the sympathetic nervous system and loss of sexual function in males (Du Preez, 1985).

1.3.5 Complete Or Incomplete/Partial SCI

When the cord is completely severed, total paralysis ensues beneath the point of injury. When the cord is partially or incompletely severed, the resumption of normal functioning is sometimes possible. The extent of functional return is, however, difficult to ascertain in patients with incomplete SCI, as recovery is contingent upon the physiological peculiarities inherent in each individual case.

As stated previously, the bulk of SCI research to date has been conducted within a natural scientific framework. Researchers have relied heavily upon experimentation, which is a quantitative procedure borrowed from natural science. Within this approach, the researcher creates an experimental situation in which relevant 'factors' are identified, controlled and manipulated in a manner allowing for certain aspects of performance to be measured. While it seems possible to obtain valid and objective data by using this method, numerous researchers, most notably those working within the phenomenological and hermeneutical schools have argued that such procedures tend to distort complex human phenomena by ignoring or covering up essential features of the subject matter. These features include the subjects consciousness; i.e. the meaning of the phenomenon for the person concerned (Du Preez, 1985). As meanings are "inherently and irremediably" context contingent, (Mishler, 1979, p. 3) phenomenologically oriented researchers have warned against the use of procedures which tend to 'press' human actions into systems of ideas in which human elements disappear (Kruger, 1979). In order to generate a contexually sensitive and existentially meaningful account of the acute phase of TSCI, the present study will utilize an interpretive procedure which allows for the meaningful exploration of human action, situated in text and context. Through the use of such a procedure, the researcher is able to explore and illuminate the idiographic/nomothetic tension inherent in this particular type of trauma and also develop a more complex understanding of some of the problems involved in the acute phase.

The purpose of this study then is twofold: (1) to generate a meaningful and phenomenologically sensitive account of the acute phase, and (2) to articulate a qualitative or hermeneutic mode of research, which is of value in research such as this.

CHAPTER TWO

LITERATURE REVIEW

2.1 INTRODUCTION

A review of the literature reveals a relatively large body of work focusing on four primary aspects of TSCI. These are: (1) emotional reactions, (2) sexual adjustment, (3) vocational adjustment and (4) rehabilitation. While the studies on sexual and vocational adjustment are relevant to an understanding of the dynamics of the SCI experience as a whole, they are less pertinent with respect to the present investigation, as most of the sexual and vocational studies deal with issues which only assume existential precedence for the cord injured person during the period immediately subsequent to the acute phase of the trauma, i.e. during the rehabilitation phase which is characterized by intensive occupational-therapy and physiotherapy. As the present study is focused upon exploring patients' experiences with TSCI during the acute phase, the studies on vocational and (later) sexual adjustment will not be discussed further at this juncture. In order to appropriately situate the acute phase psychologically within the context of rehabilitation as a whole, the relevant studies concerning rehabilitation will be incorporated into the discussion section of this paper. For this reason, the literature review will be selective rather than comprehensive.

The review will be divided into two sections. The first section deals with the literature discussing the various psychological or emotional reactions to TSCI. Within this section particular emphasis will be placed on examining the numerous stage theories of SCI adjustment, as these theories have historically moulded our conceptions and thinking about the psychological consequences of SCI. The second section deals specifically with the literature discussing those reactions and phenomena most frequently encountered during the acute phase.

2.2 Emotional Reactions Following TSCI

To begin with, there are some researchers who have attempted to fit emotional reactions into theoretical constructs, for example the trauma model described by Hamburg and Adams (1967). The essential feature of this model is that it is applicable not only to SCI but to traumatic experiences in general, for example: childhood experiences of separation and rejection, illness and injuries of childhood, illness and death of loved ones, pregnancy and retirement, among others (Du Preez, 1985, p.14). According to Hamburg and Adams (1967), an individual who experiences any type of trauma will be confronted with the following primary tasks : (1) keeping distress within controlled limits, (2) retaining a sense of personal worth, (3) rebuilding relationships with significant others, (4) surmounting critical tasks and (5) making effective use of one's opportunities (Du Preez, 1985, p.14). Hamburg and Adams (1967) used clinical observations and systematic studies to obtain their results, i.e. questionnaires and the T.A.T. (Thematic Apperception Test). Stewart (1977-78) is one researcher who utilized this model to study the psychological consequences of TSCI. He describes the achievement of tasks as a series of operations involving three interlacing themes, namely denial, depression and restitution, which may or may not be mutually exclusive (Du Preez, 1985). The aim of this coping behaviour is the maintenance of a cohesive sense of self, i.e. something which may take a substantial period of time to achieve. Stewart (1977-78) obtained his data from previous research and theory and integrated it into the above mentioned model to arrive at his conclusions.

Working on the assumption that the cord injured individual experiences a natural regression as a result of the trauma, Pepper (1977) developed a psychodynamic model for correlating the developmental tasks of the infant, child and adolescent with the emotional adjustments of the cord injured patient (Du Preez, 1985). Based on Erikson's first three psycho-social phases (Erikson, 1968), Pepper's model works on the epigenetic principle. This principle holds that psycho-social progress is contingent upon the surmounting of critical tasks inherent in each developmental phase. Although Erikson proposed eight such stages, each expressed as a crisis or dichotomy, related to an ego-strength, an organ mode and a psycho-pathology, Pepper (1977) limited her discussion to the first three. The three tasks are: (1) Trust vs. Mistrust (2) Autonomy vs. Doubt (3) Initiative vs. Guilt. Each of these stages will now be discussed in turn.

2.2.1 Trust vs. Mistrust

Immediately following the onset of the trauma, the cord injured person finds himself/herself in a position of extreme dependency and helplessness. The individual's situation is therefore analogous to that of the infant. Physical dependency on others results in a psychological weakening of the ego, which is exacerbated by the fact that the patient must repeat the developmental tasks of childhood in a hospital setting. This physical and psychical dependency fosters an emotional regression to an earlier stage of development. This view is consistent with Berger and Garret's (1952) observations which revealed that spinal cord patients frequently exhibit immature, passive, submissive, dependent, impulsive and egocentric behaviours.

2.2.2 Autonomy vs. Doubt

While in the hospital, the cord injured individual is usually placed on a rigid therapy schedule. He/She must contend with the vagaries of catheterization in addition to bowel and bladder retraining. As Erikson's second stage is characterized by an opposition between retentive and eliminative tendencies, progress in bowel and bladder control and in physical mobility represents an advancement in autonomy, thereby triggering improvements in self control, self-esteem and ego-reformation. Also important at this stage is the dichotomy between self control and control by the hospital staff. Excessive staff control may result in an internalization which creates compulsivity and rigidity in the patient. Anger and anxiety may become manifest as the patient doubts his/her ability to cope, and the ability or willingness of others to help him/her (Du Preez, 1985).

2.2.3 Initiative vs. Guilt

Pepper (1977) identified guilt as the primary danger of the third phase. During this period, when the cord injured person has regained some sense of composure and self control, confusion about the ability to perform sexually may complicate interpersonal relations. Catheterization and the lack of privacy makes masturbation or other sexual activity extremely difficult (and potentially painful). The loss of sexual function, or the fear of this loss may therefore reactivate the guilt experienced during the Oedipal phase. Freud (1905) pointed out that the sense of guilt in the neurotic is often attached to the memory of some masturbatory activity during puberty. As masturbation represents the executive agency of infantile sexuality in it's entirety, it is able to take over the sense of guilt attaching to it. Thus the danger here is that the patient may believe that the injury is punishment for some past (sexual) wrongdoing (Pepper, 1977).

Although the assumption that regression is 'normal' or even 'requisite', is far from generally accepted, Pepper (1977) claims that there is much clinical evidence to support it. The necessarily intense medical and nursing care which SCI patients experience, combined with the catastrophic nature of the trauma, places the cord injured individual in a dependent position demanding a radical realignment of self concept and body image. Regression provides the patient with an opportunity to reintegrate his/her ego into the new reality situation and also to form new expectations and set attainable goals. Pepper (1977) has argued that correlating the SCI adjustment process with the tasks of psycho-sexual development may be able to account for much of the behaviour of cord injured patients and thereby contribute to our understanding of what these patients experience as a result of the trauma (Du Preez, 1985).

The next group of researchers to be discussed are those who have suggested that the cord injured individual responds to the disability in a kind of stage sequence. Fink (1964) and Pierce and Nickel (1977) have divided the coping process into four key stages. These are, according to Fink (1964)

(1) shock, in which psychological functioning becomes frozen or is retarded, (2) defensive retreat, in which denial of the disability is paramount, (3) acknowledgement, in which the disability is recognized as permanent, and (4) adaptation, in which the individual accepts the new reality situation and integrates it into his/her personality (Fink, 1964).

During the phase of defensive retreat, Fink postulates that the cord injured individual will be relatively free of anxiety and depression, and that anxiety and depression will become manifest during the acknowledgment phase.

Guttmann (1973) conducted extensive studies on the psychological reactions of cord injured war veterans. His findings were based on individual interviews with patients, written reports, clinical observations and extensive experience with the target population. According to Guttmann (1973) a number of primary factors are important in determining the psychological or emotional reaction pattern of the cord injured person. These are: (1) the pre-traumatic personality, (2) mental ability, (3) education, (4) social status, (5) occupation and (6) age; in addition to the type and extent of the paralysis and the efficacy of the initial treatment phase (Guttmann, 1973, pp. 42 - 44). With respect to reactive phases, Guttmann identified two distinct stages, namely 'stage of shock' and 'stage of realization' (Guttman, 1973, p.

44). Spinal shock is the cord's immediate response to the injury. Approximately 30 to 60 minutes following the injury, edema develops, which causes physiologic transection of cord function (Cardona, 1985). During the shock phase, initial awareness of the consequences of the injury may be dulled due to the overwhelming nature of the trauma. The patient may have difficulty absorbing all the implications of the injury, a condition which some clinicians have attributed to 'denial' (Hammell, 1995). In Guttman's view, the initial shock phase is followed by a period of superficial awareness which gradually increases with a realization of the extent of the injury. Denial, anger and depression are thought to accompany the stage of realization, yet these reactions are not allotted separate status as with most of the other stage theories (Du Preez, 1985; Guttmann, 1973).

Weller and Miller (1977) claim to have identified five distinct satges through which the cord injured individual must pass in order to reach "the ultimate goal of psychological adjustment to the changed physiological state" (Weller and Miller, in Du Preez, 1985, p. 17). These are, according to Weller and Miller (1977): (1) shock (2) denial (3) anger (4) depression and (5) acceptance. Furthermore, Weller and Miller have stated that in the acute care phase, no more than one or two stages may be experienced. Weller and Miller based their findings on observations of thirty-seven SCI patients who were admitted to New York University's spinal ward and on the basis of their past experience with the cord injured population. Bracken, Shepard and Webb (1981) empirically examined affective reactions to spinal cord injury. Their results indicated that emotional reactions correlated positively with severity of motor and sensory disability. Most patients exhibited anger, anxiety and depression, all of which were found to be related to the injury. The results were obtained by conducting interviews with physicians, staff and patients, and by the use of standardized questionnaires and rating scales (Du Preez, 1985). These authors state that their study represents an important first stage in quantifying many of the clinical observations frequently cited in the research literature. They suggest, however, that the study be replicated and expanded to include additional data, particularly information concerning the intensity of emotional reactions and their impact upon the natural course of adjustment to the trauma (Bracken, Shepard and Webb, 1981; Du Preez, 1985).

Up until this point, our discussion of the literature on psychological reactions has been confined primarily to the stage theoretical perspective. These theories have been challanged however, and recent research seems to support the notion that the stage theory of adjustment is inaccurate (Sommers, 1992). Trieschmann (1980) has stated that there appears to be more speculation than evidence regarding the existence of stages, and she has identified numerous methodological flaws, such as the 'investigator paradigm effect', the 'experimentor expectancy bias' and the erroneous assumption of SCI group homogeneity, which cast serious doubt on the validity of the stage theories.

Numerous authors have stressed the fact that each SCI patient is unique (Buchanan and Nawoczenski, 1987; Hohmann, 1975; Trieschmann, 1980). It is probable therefore that adjustment will tend to be multi-faceted and highly idiosyncratic. As outcomes are contingent upon the complex interface between personality, injury related and environmental factors, many authors maintain that it is impossible to speak of a uniform or predictable psychological response pattern to SCI. This means that we need to redirect and focus attention away from predetermined categories and stages and move towards placing adjustment within an individually meaningful context.

With this idea in mind, attention will now be given to a discussion of the literature relating specifically to the dynamics of the acute phase.

2.3 Psychological Reactions During The Acute Phase

2.3.1 Regression

Perhaps one of the clearest and most frequently observed early reactions to SCI is the phenomenon of regression.

Buchanan and Nawoczenski (1987) have stated that regression can be directly observed in "the alert and oriented patient" within the initial 48-72hr period following the injury (p. 190). Regression has alternatively been defined as: (1) becoming more childlike and dependent, (2) losing control, (3) losing reinforcement, (4) becoming egocentric and (5) becoming focused on more basic levels of need (Buchanan and Nawoczenski, 1987). Although regression is commonly considered to be a negative phenomenon, it serves a psychologically useful and important function for the recently cord injured person by providing him or her with the ability to tolerate, at least to a certain extent, the overwhelming loss of control, the unknown environment and personal distress encountered as a result of the trauma (Buchanan and Nawoczenski, 1987, p. 190). In addition to regression, numerous other early reactions to TSCI have been observed. Chief among these are: (1) shock, (2) anxiety, (3) anger, (4) grief/mourning, (5) hypersensitivity to small cues, (6) psychosis, (7) depression and (8) denial. Each of these reactions will now be discussed in turn.

2.3.2 Shock

As stated previously, some researchers have spoken of a shock phase with accompanying reactions. Shock is the initial crisis recognition. According to Du Preez (1985), "it is a state of daze wherein clear thinking is retarded if not completely abolished" (p.20). During this phase, which may last for hours or for days, the individual is incapable of acknowledging, or refuses to recognize the extent of the injury. Pierce and Nickel (1977, p. 44-48) have called this the "pre-shock and shock" phase. When the psychological threat of danger is recognized the patient begins what Rigoni (Pierce and Nickel, 1977) calls the "shock phase" of coping, which he considers to be the first stage of adjustment (Du Preez, 1985, p.20).

2.3.3 Anxiety

Anxiety occurrs on a continuum from mild anxiety to panic (Strange, 1987). It is characterized by a set of emotions and physical disturbances experienced in response to an unidentifiable threat on the part of the patient. Strange (1987) has stated that mild anxiety may be beneficial as it characteristically heightens the patient's awareness, thereby helping him/her to deal effectively with actual physical or emotional threats (Strange, 1987, p.287).
As anxiety approaches panic however, it may render the patient incapable of dealing with the precipitating factor, or the anxiety itself without outside intervention.
According to Siller (1969), anxiety is one of the foremost reactions to physical traumatization and is readily observable in the recently cord injured patient. Anxiety may be related to basic needs for air, food and comfort, or to biological threats, disturbances in self concept,

or non-injury related factors (Strange, 1987, p. 287).

2.3.4 Anger

Anger is another frequently cited early reaction to TSCI. According to Du Preez (1985), anger surfaces when the patient's ability to deny the disability begins to break down. Weller and Miller (1977) have stated that the response of anger may be indicative of a highly motivated individual with a powerful self-image struggling to exercise some control over his or her destiny.

2.3.5 Grief/Mourning

All patients who experience physical trauma, whether it be TSCI, amputation of a limb, or any other disabling condition will tend to mourn their losses and all will probably experience grief. Ham and Cotton (1991) have described mourning, or bereavement, as a normal reaction by which the patient begins to meet the loss which has occurred. Mourning is not a state, but a process, involving time and a number of overlapping 'tasks' or 'phases'. Worden (1983) has identified four main tasks which are involved in the bereavement process. These are: (1) to accept the reality and finality of the loss, (2) to experience and work through the pain of grief, (3) to adjust to an environment in which the loss is absent, and (4) to withdraw emotional energy and invest it in other activities or relationships. While there are important differences concerning the way in which different individuals cope with loss, Worden (1983) has argued that there are three overlapping primary stages in the grieving process. The first stage, which he calls "Numbness" usually occurs 2-3 days following the injury. This is similar to Pierce and Nickel's 'shock phase' in which psychological functioning becomes frozen, or is retarded. "Despair" is stage two in Worden's model. This stage is highly complex, involving intense peaks of anguish and distress. Feelings of sadness, anger and frustration, guilt and self reproach, anxiety, loneliness, fatigue and helplessness, shock, pining, emancipation, relief, and/or numbness are believed to be compounded by disturbing physical sensations, a loss of energy and depersonalized states in which 'nothing feels real'. These reactions may further be accompanied by cognitions or thought patterns of disbelief, confusion and preoccupation or hallucinations and behaviours such as sleep and appetite disturbances, social withdrawal, vivid dreams, crying and/or restlessness. The final stage in Worden's model is "Recovery". During this stage, the individual accommodates the changes neccessary for adaptation and reconstructs the new reality situation in light of the loss experienced. Worden admits however, that it is impossible to predict an average time for completion of the grieving process, as so many factors are unique to each individual case (Ham and Cotton, 1991, p. 148-149). In some cases however, grieving does not end, and the typical grief reaction is replaced by the atypical one. The atypical grief reaction has been described by Ham and Cotton (1991) as either: (1) a prolonged reaction, where after a substantial period of time recovery is not seen, or (2) a delayed reaction, often relating to persistent denial of the reality and finality of the loss, and/or (3) increased and persistent feelings of self blame and guilt, which if left unresolved could contribute to depressive illness (Ham and Cotton, 1991, p. 149).

2.3.6 Hypersensitivity To Small Cues

A further predictable response to SCI is hypersensitivity to small cues. When the terrain is unfamiliar, everything is potentially important. Thus expressions, moods, comments and gestures assume a variety of possible meanings. "Anything could mean anything" depending on how the patient views it (Buchanan and Nawoczenski, 1987, p. 192).

2.3.7 Psychosis

For some patients, the combination of sleep and sensory deprivation, immense pain, shock and psycho-active medications is simply overwhelming. In a 1980 study, Trieschmann found that sixteen percent of recently cord injured patients experienced psychotic episodes within the first two weeks of injury. The majority of these episodes were, however, short lived and did not appear to engender long term adjustment problems (Trieschmann, 1980).

2.3.8 Depression

Depression is often cited as a normal consequence of SCI (Polletts, 1985; Roberts, 1972) and plays a central role in many of the stage theories of adjustment. Depressive states are thought to be characterized by a lowering of self-esteem and feelings of fatalism, helplessness and hopelessness (Du Preez, 1985). According to the stage theories, a certain period of depression is required for a healthy adjustment to SCI. Consequently, anyone who does not display depression is thought to be in denial. While this view is consistent with knowledge gained from experience with psychiatric populations, the SCI group cannot, on the whole, be compared with a psychiatric population, as they are heterogeneous and display very little classic psychopathology (Buchanan and Nawoczenski, 1987). Furthermore, recent research has strongly challenged traditional concepts about the role of depression.

Taylor (1967) conducted a study of young cord injured males using the MMPI (Minnesota Multiphasic Personality Inventory). His results indicated that cord injured males displayed profiles similar to those of uninjured males on any university campus. Little evidence of depression was found.

Bourestom and Howard (1965) compared the personality characteristics of three disability groups, namely TSCI, rheumatoid arthritis, and multiple sclerosis using the MMPI. Their results indicated that persons with spinal cord injuries exhibited the most benign MMPI profiles. Dinardo (1971) found that persons who displayed evidence of depression were independently rated as less well adjusted than their counterparts who tended to suppress or repress their emotions (Trieschmann, in Bloch and Basbaum, 1986). Lawson (1978) investigated the incidence, severity and pattern of depression in ten quadriplegic patients throughtout the hospitalization period. Four measures of depression, i.e. self reports, biochemical, behavioural, and reports by others were obtained from each patient on a daily basis. The results indicated that patients experienced mild depression following admission and prior to discharge. Depression was therefore found to be only a minor factor in the overall behavioural adjustment pattern of these patients. Furthermore, the measure on staff ratings revealed that hospital staff consistently overestimated the amount of emotionality actually present (Trieschmann, in Bloch and Basbaum, 1986).

Howell, Fullerton, Harvey and Klein (1981) evaluated twenty-two patients with recent cord injuries by means of standardized interviews and diagnostic processes. Psychiatrists conducted the interviews, utilizing the schedule for affective disorders and schizophrenia. Their results indicated that no patient experienced a severe

depressive episode following the injury, and that only twenty-two percent (five patients) exhibited mild depressive reactions of a temporary or situational type.
The notion that individuals must experience a certain amount of depression in order to achieve a healthy adjustment to SCI has therefore not been consistently substantiated by rigorous scientific research. Numerous authors have stressed the fact that each SCI patient is unique. It is probable therefore, that the meaning of depression or any other emotional reaction will vary from person to person. In one individual depression may be a means for marshalling strength, while in another it may signal failure. (Buchanan and Nawoczenski, 1987, p. 193). Each case therefore requires a careful understanding of personal idiosyncratic features and the meanings associated with specific experiences.

2.3.9 Denial

Denial is another frequently cited reaction in the literature which has hardly been the subject of any research. Wittkower (1955) has stated that denial is always the first response to SCI. Hohmann (1975) concurs with this view while describing denial as a normal response to an abnormal situation (Zedjlik, 1992, p. 156). Psychologically speaking, denial entails a subconscious repression of reality in either a physical or emotional sense. It is usually considered to be a maladaptive device for protecting the ego from overwhelming anxiety. Yet denial is not necessarily a negative phenomenon. It may also serve a positive function, i.e. it may enable the recently cord injured individual to deal with what is momentarily tolerable, by keeping him or her from being overwhelmed in a manner which impairs overall functioning (Buchanan and Nawoczenski, 1987).

2.4 Explaining The Acute Phase

Meyerson's (1971) work on unknown situations is one of the more creditable approaches to understanding the dynamics of the acute phase. Building on earlier work by Lewin (1938), Meyerson predicts common patient reactions on the basis of known responses to unknown situations. As the cord injured individual is thrown into an alien environment which he/she does not understand and has no basis in experience to comprehend, he/she does not know how to react to gain reinforcement. In learning theory terms, the behavioural sequence required for goal attainment from the environment has not been learned. As the location of environmental rewards is unknown, the means for securing these rewards will tend to be haphazard, tentative, and idiosyncratic (Buchanan and Nawoczenski, 1987). Without an outlet for the frustrations inherent in a situation such as SCI, anger is likely to become internalized and transformed into depression. In Meyerson's view, anxiety and extreme behaviour are a manifestation of the patient's inability to contend with, or psychologically structure the unknown. Because structuring the unknown is psychologically fundamental, the only limits to extreme behaviour are the patients imagination and the staff's tolerance (Buchanan and Nawoczenski, 1987). Thus, an understanding of the patient's goals will usually help to reduce and eliminate extreme behaviour (Buchanan and Nawoczenski, 1987, p. 191).

In the past, most of the psychological literature dealing with adjustment to SCI tended to minimize the importance of the acute phase. The patient was assumed to be in a state of 'shock' or 'denial' which precluded him or her from accomplishing any meaningful emotional change or adaptation. This assumption has been challenged however, and recent clinical evidence seems to support the notion that the process of psychological adjustment begins quite early, with early interventions influencing adjustment in both the short and long term (Buchanan and Nawoczenski, 1987; Kemp, 1971).

Guttmann (1973) identified a number of primary factors which he found to be important in determining the psychological reaction pattern of the cord injured patient. One of these factors was the quality and efficacy of the initial treatment phase. Additional evidence to support the idea that acute phase management is significant comes from a number of individual descriptions of adjustment.

One patient, an individual with high quadriplegia, enjoyed an active and successful life prior to SCI. He described his "fear and terror" after being routinely turned one night by nursing staff who forgot to return his environmental control sip-and-puff straw. Environmental control systems are appliances and devices which enable the severely disabled to exert control over and interact with their environment (Hammell, 1995, p. 21). This patient had a tracheotomy and was afraid that if something happened to him, he would be unable to call for help. His fear turned into panic and then frightening hallucinations and delusions. This individual continued to have anxiety attacks, particularly at night, for the rest of his life (Zejdlik, 1992, p. 154).

Another patient described how she was helped by a nurse who responded to her delusion and hallucination that some flowers on a table were on an altar at a funeral. She could not sleep and requested that her bed be moved and that her mother be called to the hospital. Although it was very late at night, the nurse acceded to her requests and the patient's mother arrived. After a short while, the patient relaxed and was able to drift off to sleep (Zejdlik, 1992, p. 154). Yet another patient described "terrible nights" during the acute phase when the medications and his physical condition resulted in hallucinations and extreme discomfort. He recalls a nurse who showed her concern by taking extra time to talk with him and sit by his bed. These actions decreased his anxieties and enabled him to sleep more easily (Zejdlik, 1992, p. 125). Zejdlik (1992) has argued that sleep should be given priority not only in the critically ill, but also in spinal cord patients. As sleep is a restorative process (Zejdlik, 1992) and dreaming a compensatory mechanism for bringing to light the "unconscious contents which are causal factors" in neuroses (Jung, 1933, p. 3), sleep deprivation should be seen as a major impediment to effective rehabilitation. Further evidence stressing the significance of the acute phase comes from insights stemming from the field of crisis response and stress management. According to this view, all individuals seek to achieve a state of physical, social and psychological equilibrium (Zejdlik, 1992, p. 157). A crisis is a state of disequilibrium or imbalance which occurs when there is an "incongruency between the problem solving or coping skills of the individual, his family system, and the stressful event" (Harmon, 1985, p. 246). A situational crisis develops when a specific external event upsets the individual's psychological and physiological equilibrium. Zedjlik (1992) has described crises as occurences which result in states of emergency and incapacity in spinal cord patients, and she has advanced the argument that successfull management of a crisis will improve the patient's ability to cope.

Conversely, unsuccessful management of a crisis may reinforce maladaptive response patterns. Crises thus have "growth promoting potential" (Zejdlik, 1992, p. 157).

As an individual in crisis searches for a resolution to it in the form of equilibrium, the type of balance achieved may represent either a healthy, growth promoting adaptation, or a maladaptive one (Zejdlik, 1992).

As the acute phase represents the first opportunity for promoting growth oriented coping strategies in the cord injured patient, its significance for the overall course of psychological adjustment should not be underestimated. In view of this fact, and considering the relative paucity of phenomenologically sensitive research on the topic, it seems imperative that research endeavours be initiated in order to enhance our understanding of this controversial and complex phase of the SCI experience.

2.5. Purpose Of The Study

As stated previously, the purpose of this study is to provide the reader with a meaningful and phenomenologically sensitive account of the acute phase of TSCI. This investigation should complement and augment existing research in the area by developing an understanding of some of the problems involved in the acute phase, and by generating ideas about how to resolve them.

The hermeneutic approach will now be discussed at length in order to give the reader a greater understanding of its focus and mode of operation in the field of psychology.

CHAPTER THREE

METHOD

3.1 INTRODUCTION

The purpose of this chapter is to articulate a hermeneutic method of research and to describe a research strategy and form of data analysis appropriate for the study of the acute phase of TSCI. In order to achieve the first objective, I have provided the reader with a fairly in depth methodological juxtaposition between hermeneutics and the twin perspectives of rationalism and empiricism. This has been done in order to articulate, clarify and justify the use of a specifically interpretive methodology which (in many respects) differs radically from the more traditional approaches. An understanding of this debate has bearing on the present study as many of the methodological problems associated with the traditional approaches have been carried over into the field of SCI research. For this reason the chapter will be divided into three parts. The first aims at describing the hermeneutic approach and therefore contains the aforementioned debate. The second aims at clarifying important hermeneutic concepts and takes the form of a description of (five) key characteristics which are cornerstones of this approach. The third aims at examining and defining the criteria for evaluating interpretive accounts and also makes explicit the research strategy and form of data analysis used in the present study.

3.2 Describing The Hermeneutic Approach

Hermeneutics has been defined as the science or the art of interpretation (Mahoney, 1991). Hermeneutic approaches therefore differ radically from traditional (rationalist and empiricist) forms of inquiry by calling into question and subverting the traditional view of method as interpretation free procedure or technique. The hermeneutic approach may be usefully explicated by comparing and contrasting the ways in which interpretation, rationalism and empiricism construe four primary areas, or domains of knowledge. These are (1) the domain of inquiry, (2) the origin or source of knowledge, (3) forms of explanation, and (4) the manner/method of inquiry deemed to be most appropriate for the investigation of human action (Packer and Addison, 1989). Each of these categories will now be discussed and dealt with in turn.

3.2.1 Domain Of Inquiry

Each type of systematic investigation, either explicitly or implicitly contains assumptions about the characteristics of the domain under study. The stance of empiricism, for example, assumes that the world is comprised of basic elements and objects which can be described in a manner involving no interpretation (Packer and Addison, 1989; Terwee 1990). Thus the objects of empiricist inquiry are independent entities with absolute properties existing outside of, and quite apart from, the realm of human interests, practices and concerns. The task of scientific psychology, from this perspective, is to objectify these elements and describe their properties and interactions. Upon closer examination however, we find there to be a hidden context to empiricism, i.e. a conceptual grounding in the tenets and suppositions of seventeenth century mechanistic science. According to this view, physical objects (human beings included) are believed to possess context independent properties such as size, position, mass and velocity, in addition to personality traits, intelligence quotients and attachment strengths which may be categorically or quantitatively assessed using simple psychometric tests and measures. The assumption here is that such measures provide us with an objective means for investigating human action in a manner allowing for the precise prediction of subsequent behaviour, i.e. given the existence of specific requisite conditions which may be brought about through experimental manipulations (Packer and Addison, 1989). While it seems possible to obtain valid and objective data by using this method, hermeneutic theorists have long argued that this type of naive mechanistic realism practices, in effect "a terrible form of violence" (Levin, 1988) when transplanted wholesale into the realm of human scientific inquiry, as it oversimplifies and distorts complex human experience to the point of absurdity. Seen from this angle, empiricism appears more as a crude naivety, than as the only true, objective way of seeing the world and some theorists, as a consequence, have argued against its usefulness and appropriateness in the field of contemporary psychological research.

Where empiricism seeks to uncover lawful relations in an unquestionably objective universe, rationalism seeks to construct or reconstruct portions of human knowledge and experience. Rationalists are concerned with abstracted formal structures, i.e. 'competence' or 'deep' structures which are believed to underlie performance. In structuralist research, (one contemporary form of rationalism) the aim is to provide an orderly reconstruction "which introduces clarity and indubitability" into a realm seemingly "filled with ambiguity and error" (Packer and Addison, 1989, p. 17). Thus speech, for Chomsky (1957) and action, for Piaget (1977), are mere occasions of performance which are distorted by "errors, memory constraints and other cognitive limitations" (Packer and Addison, 1989, p. 17). From the rationalist perspective, competence structures have a formal character and are composed of syntactic rules and elements (Williams, 1978). Piaget (1970), a major proponent of this view, has described these structures as "not observable as such, being located at levels which can only be reached by abstracting forms of forms or systems of the nth degree." Which is another way of saying that the detection of structure calls for "a special effort of reflective abstraction' (Piaget, 1970, p. 136).

The central criticism of rationalism has been that when human action is separated from its context, it becomes distorted as opposed to clarified. In the words of Musil (1930/1979), the cost of abstraction is that the object is "mummified" as everything becomes when it is "torn out of context" (Musil, 1930/1979, in Packer and Addison, 1989, p. 18). From the hermeneutic perspective, action and context are inseparable. Performance and setting cannot therefore be artificially compartmentalized or teased apart without producing consequences which subvert the aims of rationalist inquiry. As practical activity is intrinsically linked to context and has "a complex termporal organization," interpretive inquiry, in contradistinction to the more traditional forms, focuses on "human activity, situated in context and on the offspring of such activity," i.e. "institutions, histories, accounts, records, texts, stories, and lives" (Packer and Addison, 1989, p. 19). Consistent with a hermeneutic approach, the present study will concern itself with an analysis of the acute phase of TSCI as situated in text and context, i.e, as situated in texts of interview narratives in which patients' experiences with the phenomenon are discussed and described.

The texts will first be transcribed and then analyzed within a cyclical framework consisting of three interdependent levels, the aim being the generation of a meaningful and phenomenologically sensitive account of the acute phase of TSCI. For a more detailed exposition of the interpretive procedure used for the present study, see section 3.4.6 of the present chapter.

3.2.2 Origin/Source Of Knowledge

Empiricism claims to have identified an epistemological foundation for scientific inquiry on the basis of unquestionable observables, or brute facts which are immediately given to the senses (Packer and Addison, 1989). Taylor (1979) has described these facts as:

> data whose validity cannot be questioned by offering another interpretation or reading, whose credibility cannot be founded or undermined by further reasoning. If such a difference of interpretation can arise over given data, then it must be possible to structure the argument so as to distinguish the basic, brute data from the inferences made on the basis of them (Taylor, 1979, p. 30).

While data of this kind are often taken as the basis for theory in much contemporary psychological research, the claim that any data are self evident, unambiguously observable and recordable without interpretation is untenable. Even in the natural sciences, i.e. what logical positivists see as the epitome of value free descriptions, apparently objective and interpretation free descriptions are known to be contingent upon contexts of particular kinds (Packer and Addison, 1989). In the words of Hansen (1958), observations are intrinsically "theory loaded," with successive theories being incommensurate "in the sense of requiring radical translation between superficially equivalent terms" (Packer and Addison, 1989, p. 21). With the paradigm shift from Newtonian to Einsteinian physics, basic terms like 'mass' and 'inertia' changed their meaning and are now understood differently as a consequence (Kuhn, 1970). Thus positivist attempts to catalogue and describe observables in an objective manner have run into serious difficulties. This argument has relevance for the field of SCI research, as attempts to catalogue and pigeonhole psychological reactions into neatly defined mood states have failed to provide us with a complex and meaningful understanding of the experience.

Rationalism too makes foundational claims. Yet rationalist assertions rest not upon putatively self evident observables, but rather on the consistent procedures of formal logic. Claims of certainty and indubitability permeate the rationalist enterprise, which has sought to establish a "scaffolding of indubitable formal principles," from which structures that reconstruct human phenomena may be "logically generated" (Packer and Addison, 1989, p. 21). Upon close examination however, the logic of formality turns out to be flawed. Hermeneutic theorists have long argued that formal logic cannot bear the weight which rationalists wish to heap upon it and that formal structures, as a consequence, cannot provide us with a foundation for knowledge, either of the world or of the mind (Packer and Addison, 1989, p. 22). Relativity theory has shown that it was a mistake, i.e. what Rosen (1987, p. 153) calls "the shipwreck of formalism" which led to the erroneous belief that logical propositions somehow correspond to, or match reality. Consequently, we see that the explanatory power of rationalism rests not upon indubitability, but rather on its contingent and convenient choice of axioms (Nagel and Newman, 1958).

Some hermeneutic theorists have argued that scientific inquiry cannot attain and does not require an epistemological foundation. As human affairs are intrinsically ambiguous and discourse inherently metaphorical (being contingent upon linguistic usage), these theorists have argued that interpretation is an intrinsic, unavoidable and essential accompaniment to human understanding (Caputo, 1987). As human phenomena are inextricably embedded in the social practices of the home, workplace and society, hermeneutic researchers see practical understanding as the appropriate starting place for scientific inquiry. Interpretive inquiry therefore begins at a place delineated by our everyday participatory understanding of people and events, rather than from an absolute origin of unquestionable data or totally consistent logic (Packer and Addison, 1989, p. 23).

3.2.3 Explanatory Forms

In empiricist inquiry, an explanation has been provided when observation statements have been linked to form theoretical statements (Packer and Addison, 1989, p. 24). Thus, empiricist explanations assume the form of hypothesized lawful statements concerning relationships of co-occurence. Conceived as statements of regularity in the form of general laws, these explanations exhibit the formal characteristics of predictions, i.e. predictions which have been tested empirically through observation.

In contradistinction to empiricism, rationalism provides explanations in the form of algorithms, or sets of rules whose relationship to the domain of inquiry is that of formal logic to a set of statements deducible from its axioms (Packer and Addison, 1989).

One striking criticism of both rationalist and empiricist explanations is that causal laws and formal reconstructions are only what they purport to be, i.e. interpretation free

or fully explicit descriptions of reality if the objects they take as their elements are uninterpreted ones. From the hermeneutic stance, every human action always embodies an interpretation, albeit an often concealed and misunderstood one (Heidegger, 1927; Packer and Addison, 1989). The possibility of interpretation-free description is therefore incommensurate with a hermeneutic and historiological conception of science, which views understanding as both a projective and reflective process,and objectivity as an untenable fiction. As interpretation deals not with objective elements or formal structures, but with "thick concepts" which tend to "meld fact and value" (Williams, 1985), interpretive explanations are thickly descriptive and narrative in form.
Macintyre (1984) has argued that "it is because we all live out narratives in our lives and because we understand our lives in terms of the narratives that we live out that the form of narrative is appropriate for understanding the actions of others" (Macintyre, 1984, p. 211). Thus, in order to identify and understand what someone else is experiencing, hermeneuticians always move towards placing a particualar episode in the context of a set of narrative histories, i.e. histories both of the individuals concerned and of the environmental settings in which they act and suffer (Packer and Addison, 1989). Consistent with this view, the present study will make use of a method which

builds up an interpretation of an entire interview narrative out of its constituent parts, thereby making it possible to understand each work, indeed each sentence more thoroughly than before. As an understanding of the whole and the part are always interdependent (Terwee, 1990), the interpretive procedure is always fundamentally and essentially circular (Dilthey, 1976, p. 259 - 262).

At this stage, arguments have been examined expressing the view that both rationalism and empiricism systematically exclude and deny context and setting while seeking to attain solid epistemological foundations upon which to construct scientific knowledge, and that both these perspectives use explanatory forms in the guise of elements and rules which seek to avoid interpretation and the supposed taint of human evaluation. The case for a hermeneutic conception of science has also been presented, expressing the argument that both rationalism and empiricism unavoidably require interpretation of the phenomena they aim to explain while consistently denying that they do so. Attention will now be given to an examination of the type of method used in each form of inquiry, and thereby to an illumination of some of the more purely methodological problems.

3.2.4 Manner Of Inquiry Deemed Most Appropriate

Both empiricist and rationalist forms of inquiry consider method to be germane to the attainment of foundational knowledge and to the systematic generation of appropriate kinds of explanations. In empiricist inquiry, procedures are initiated which are designed to experimentally manipulate, analytically disjoin and identify regularities among data which meet strict and objective criteria, i.e. usually levels of statistical significance. Rationalist inquiry, on the other hand defines formal principles which serve as the basis for an "axiomatization of the domain under investigation" (Packer and Addison, 1989, p. 27). The intention of both these methods is however the same, namely to generate objective knowledge, i.e. knowledge which is untainted by the vicissitudes of human judgement and evaluation. At this juncture a consideration of the mode or stance of the researcher within these two orientations would shed some light on the aforementioned problem. In both forms of inquiry, 'detachment' is considered to be an essential prerequisite for generating objective and unbiased descriptions. But is detachment objective and unbiased? - and does it lead us to our goal, i.e. knowledge and understanding?

Hermeneutic theorists have long argued that detachment does not guarantee objectivity and leads to distortion, as opposed to clarity. Nagel (1986) has called detachment "the view from nowhere" as being value neutral, free from prejudice, objective and unbiased, to the small extent that these are possible at all, "involves adopting a special posture of distance from, or denial of one's personal interests and concerns, and being unconcerned or disinterested is as little achieved through procedures and techniques as is being concerned" (Nagel, in Packer and Addison, 1989, p. 27). From the Hermeneutic stance, detachment is willful blindness, i.e. it is a distorting move which removes or covers up the cultural, personal and social involvements which enable us to understand one another in the first place (Packer and Addison, 1989, p. 12). Heidegger (1927/1962) has argued that detachment is an unwitting attempt to establish the kind of engagement known as 'the present at hand,' which is a mode of distance from oneself and the world of practical activity. As engagement in this mode is both derivative and privative, Heidegger argued that it is only able to provide us with a shadow of the kind of understanding which is possible through concerned involvement (Packer and Addison, 1989). This problem of detachment is further compounded by a conundrum implicit in the age old correspondence theory of truth, i.e. a theory to which both rationalism and empiricism tacitly subscribe. According to this theory, the aim of method is to employ techniques and procedures which assess correspondence with a reality which is independent of the researcher. Yet how is this to be done? John Locke (1690/1975), a major proponent of this view, saw the problem himself when he wrote, "It is evident that the mind knows things not immediately, but only by intervention of the ideas it has of them. Our knowledge is therefore real only so far as there is conformity between our ideas and the reality of things" (Locke, 1690/1975, in Packer and Addison, p. 28). But what is the criterion for assessing this reality? As Locke himself put it, "How shall the mind, when it perceives nothing but it's own ideas, know that they agree with the things themselves?" (Locke, in Packer and Addison, 1989, p. 28)

From the hermeneutic perspective this conundrum is insoluble, as factual states of affairs cannot be objectively described by a human evaluator. Explanatory accounts cannot therefore be validated (in the traditional scientific sense of the word) on the basis of establishing degrees of correspondence with a reality independent of the researcher, as the researcher unavoidably proceeds from a point of view/perspective which, existentially speaking, cannot simply be wished away. Even the much vaunted "logic of falsification" (Popper, 1959) cannot overcome this limitation.

In rationalist inquiry, reconstructions are assessed on the basis of their ability to show consistency and completeness. First, the system must demonstrate that if follows its own rules, and secondly, its output must accord with "intuitions of correctness," i.e. with the "intuitive knowledge of competent subjects" (Habermas, 1979, p. 9). Yet intuitions, at best, provide us with no more than a dubious procedure for validating formal explanatory reconstructions. One reason for questioning the validity of intuitions lies in the problematic and indefensible rationalist assumption that accuarate intuitive knowledge of the operation of certain segments of our cognitive apparatus is possible. As this assumption overlooks the likelihood that even competent researchers may have only a partial, incomplete or distorted understanding of themselves, or of what they are doing, hermeneutic theorists have argued that intuitions are an unsatisfactory means for assessing the validity of formal reconstructions (Packer and Addison, 1989). It is also for this reason that mathematicians have long engaged in efforts to replace intuitions of validity with formal proof (Hahn, 1933/1980).

In view of their unsubstantiated claims to have located indubitable epistemological foundations and methods based upon interpretation free procedures and techniques, some theorists have advanced the argument that rationalism and empiricism are fundamentally "ideological stances" (Packer and Addison, 1989, p. 31). As research conducted within these frameworks deals not so much with what is done in systematic inquiry, but rather with what is wished could be done, it follows that method cannot be reduced to pure procedure or technique and must, as a consequence, incorporate a central interpretive component. Viewed in this manner, psychological inquiry inevitably turns out to involve the researcher forming "a relationship with the researched, and assessing, evaluating, communicating and acting upon what has been learned" (Packer and Addison, 1989, p. 32). For this reason, it was decided that the present study would make use of a dialogical interview procedure which utilizes self-disclosure as a mechanism of concerned involvement. This should enhance the quality of the research relationship by helping to facilitate good rapport and also stimulate meaningful discussion.

At this juncture, the hermeneutic approach has been described and contrasted with rationalist and empiricist forms of inquiry. It should be clear from the foregoing discussion that interpretive inquiry dispenses with much of the dogmatism (and methodological rigidity) inherent in the more traditional approaches and is concerned primarily with the analysis of human action, situated in text and context. The next part of this paper will expand upon and give clarity to the outlined orientation by discussing key elements which are cornerstones of the hermeneutic approach.

3.3 Key Elements Of The Hermeneutic Approach

While there is no singular hermeneutic method as such, all interpretive forms of inquiry share a number of key features which serve to identify them as hermeneutical. These are: (1) a consideration and operationalization of the hermeneutic circle, (2) a focus on meaningful internal relations, (3) a concern with individual cases, (4) a fusion of interpretive horizons, and (5) a concern with application (Terwee, 1990).

3.3.1 The Hermeneutic Circle

In interpretive inquiry, the researcher's point of view and the evaluation of explanatory accounts are not seen as being separate, but as being engaged in a constant dialogue. Instead of being on opposite ends of a straight line, they are on the circumference of a circle, i.e, the hermeneutic circle. The forward arc of the circle consists in establishing a perspective, i.e, a point of view from which to proceed, with evaluation forming the reverse arc. Establishing a perspective is a forward motion because of a phenomenon which was identified and analyzed by Heidegger (1927), i.e. the phenomenon of 'projection'. According to Heidegger (1927), all understanding takes place within a horizon or framework which is 'projected' by human being (Dasein). As the possibilities for Dasein, literally 'being in the world' are ordered and organized by 'forestructures of projection,' which are existential structures shaped by our expectations, preconceptions, experiences, cultures and traditions, entities can appear to us "only insofar as a certain horizon of being has already been laid out for them in advance" (Packer and Addison, 1989, p.34). As projection is an existential structure, we are thrown into future ways of acting (and interpreting) by the possibilities inherent in it. This is not to say that our forestructure determines, in any strict sense, what is uncovered in an interpretation, but rather that our understanding is innately limited by, and contingent upon, how we enter into and act within the circle of understanding. As the hermeneutic circle is not a purely epistemological or methodological structure, but primarily an existential one, hermeneutic theorists see it as the key to both scientific and everyday understanding (Packer and Addison, 1989, p. 33-34). Operationalized into a method of study, this circle operates as follows: first, the interpreter views phenomena as being parts which are dependent upon larger structures, i.e, the parts are dependent upon the whole. Second, the interpreter relies on his/her preconception of the whole in order to understand the parts and third, the interpreter feeds his/her understanding of the parts into the global preconception (Terwee, 1990). The procedure is unavoidably cyclical because it is regarded as impossible to begin anywhere on a firm basis. As the circle involves both assimilation and accommodation, it is complete, for "if we are persevering and open, our attention will be drawn to the projective character of our understanding, and - in the backward arc, the movement of return, we gain an increased appreciation of what the forestructure involves, and where it might best be changed" (Packer and Addison, 1989, p. 34; Terwee, 1990, p. 116-117).

3.3.2 Meaningful Internal Relations

Interpretation is directed towards the uncovering of meaningful internal relations between actions and events, not to the uncovering of statistical, i.e. external relations. The interpreter looks for meaning relations between words, actions and expressions as they appear in any given context, i.e. defined by the rules of the language game in question. An example of an internal relation is the relationship between an action and a motive, or an action and a belief. While empirical observations may reveal a contiguous or regular relationship between an action and a motive, we only speak of a 'good motive' if we are able to understand the action as springing from the motive, of course presupposing the existence of a cultural background (Terwee, 1990, p. 117).

3.3.3 Individual Cases

Since hermeneutics does not aim at predicting behaviour or at developing general laws, interpretation is usually directed at understanding individual cases. This idiographic focus does not, however, preclude the possibility of the interpreter generating a nomothetic narrative account, as the present study will demonstrate. Danziger (1985) has drawn attention to the strong belief among psychologists that aggregate data form the only acceptable basis for making general theoretical statements about individuals. As a consequence, individual cases tend to be excluded through sampling and experimentation, i.e. the real individual is sacrificed for the sake of the non-existent 'average' individual. This is of course not the only approach. One could just as well study individual cases first and then put the data concerning individuals together at a later stage, or even sample the actions or situations of a single individual (Terwee, 1990).

3.3.4 Fusion Of Horizons

Both the researcher and the researched are known to have a conception of Truth and of the World. As the author of a text has a claim to the truth of it, interpretation is seen as a dialogical process, i.e. a conversation between interpreter and text, subject and object, the aim being the removal of obstacles to understanding. A shared perspective is therefore the ideal aim.

3.3.5 Application

Interpretation is historical and aimed at transferring insights from the past into the present. Trying to understand a text as meaningful human reality means assuming that the text has something to say, i.e. that it has some claim to truth. The task for the interpreter then is to bring out this truth and apply it to the present situation (Terwee, 1990, p. 24). Interpretive research is therefore related to, but not identical with, other pragmatic and proactive research approaches, such as emancipatory and participatory action research, which seek to transform the research situation into a mechanism of empowerment. For this reason, an auxillary goal of this study is to contribute to the efficacy of the rehabilitation process by developing a more complex understanding of some of the problems involved in the acute phase and by generating ideas about how to resolve them.

3.4 Criteria For Evaluating Interpretive Accounts

Before proceeding directly to an examination of the criteria for evaluating interpretive accounts, it would be prudent at this stage to first explain and clarify the hermeneutic conception of Truth, i.e. what hermeneutic theorists see as the aim of interpretive inquiry. If truth is not simply a matter of correspondence between a theory or account and the way things actually are, then should we dispense with the concept of truth altogether? Or is it possible to achieve a new understanding of truth, i.e. an understanding which surpasses the pitfalls of relativism while stripping away all metaphysical notions? (Packer and Addison, 1989, p. 278). This is precisely what Heidegger (1927) proposed to do in his hermeneutic-phenomenological analysis of being, in Being and Time (1927). In this work, Heiddeger attempted to demonstrate that the truth of any theory, interpretation or practical activity is not immediately apparent, but is rather contingent upon a process of 'uncovering'. The uncovering of an entity is the return arc of the hermeneutic circle, it is our evaluation, our response to inquiry. Because interpretation "is a letting-something-be-seen, it can therefore be true or false" (Heidegger, 1927, p. 56). But here everything depends on our steering clear of any conception of truth which is construed in the sense of agreement. For Heidegger, the entities of inquiry must be taken out of their hiddenness, which is to say that they must be uncovered, unmasked, i.e. **discovered.** As interpretation is the "working out of possibilities projected in understanding, it shows entities explicitly, often for the first time" (Packer and Addison, 1989, p. 278). This is not to say that a good interpretation is one which shows things as they 'truly are', but rather one which shows entities as they are capable of being shown. This view of truth is neither simple realism nor truth as coherence. What is crucial for truth as uncovering is an illumination of the way in which the entity shows itself. As Heidegger himself put it, the goal is "to let that which shows itself be seen from itself in the very way in which it shows itself from itself" (p. 58). Due to the nature and character of projection, entities are capable of showing themselves from themselves in many ways, depending in each case on the kind of access we have to them (Heidegger, 1927, p. 51). Heidegger argued that the quality of our interpretation is contingent upon the type of access we have achieved, i.e on the kind of entry into the circle which we made in the first place. What is uncovered in a true interpretation then is a solution to the problem, the confusion, the question with which we are concerned, the breakdown in understanding which led to the inquiry in the first place (Packer and Addison, 1989, p. 279).

With this conception of truth as uncovering in mind we may now direct attention to an examination of the criteria for evaluating interpretive accounts. Four approaches to and requirements of evaluation will be considered. These are: (1) coherence, (2) relationship to external evidence, (3) consensus, and (4) relationship to future events. Each of these requirements will now be discussed in turn.

3.4.1 Coherence

Coherence has also been called plausibility or intelligibility. It is a characteristic which all good interpretive accounts should demonstrate. While the requirement of coherence seems reasonable, it has nevertheless been criticized on the grounds that it fails to live up to a strenuous validation procedure, i.e. the kind of validation procedure favoured by empirical-analytical science (Packer and Addison, 1989). Hirsch (1967) has argued, that due to the projective character of understanding, the perspective one has of a reading will tend to confirm itself, i.e. it will tend to focus on supporting evidence while ignoring discomfirming evidence. Thus an interpretation will inevitably lean towards coherence. The counter argument, however is that Hirsch appears to exaggerate the problem. Packer and Addison (1989) have argued that, in contrast to other kinds of understanding, like delusions for examaple, which are extremely self confirming, interpretation is only weakly self confirming. Whereas the deluded individual sees counter evidence as so threatening that he represses it, interpretive researchers employ stratagems to critique interpretations, thereby facilitating alterations in understanding. Coherence is therefore not inevitable in interpretive inquiry, as interpretive researchers show the negative side of articulation by searching for disconfirming evidence, i.e. by focusing on breakdowns and misunderstandings in the material (Packer and Addison, 1989, p. 281 - 282).

3.4.2 Relationship To External Evidence

In order to avoid being trapped in the hermeneutic circle, Hirsch (1967) proposed that interpretations be measured against a "genuinely discriminating norm", i.e. one which is able to provide us with an interpretation free standard (Hirsch, 1967, p. 26). Hirsch himself suggested the ideal of attempting to understand what the author 'meant' or 'intended' by any given statement. While seemingly reasonable, this approach leads to a number of difficulties, particularly if we are looking for a traditional type of validation procedure. The main difficulty lies in the question of how meanings can be identified. Ricouer (1976) has argued that "the intention in action no longer exists, for it was present only at the time of acting" (Ricouer, 1976, p. 100). As the intention is lost as a "psychical event", it cannot function as the norm by which interpretations may be evaluated. Even if we go back to the respondent or agent and ask him/her what was meant by a certain statement or action, he/she must recall, i.e. recollect and reconstruct what was meant. Thus the character of the author's intention will always remain open to re-interpretation (Packer and Addison, 1989, p. 283). This is not to say that appeals to the author's intentions are of no interest, but rather that such appeals can only fail to provide us with the type of validation procedure sought by Hirsch and others. While respondents recollections remain open to further interpretation, they nevertheless constitute valuable material for interpretive inquiry (Packer and Addison, 1989).

Some theorists have proposed that the agents current view of the situation provides us with a better norm than the one proposed by Hirsch. In this way it seems possible to avoid the problems of evanescent or quickly fading intentions (Packer and Addison, 1989, p. 283). Yet this view seems suspiciously close to the rationalist notion that a valid interpretation is one which corresponds to the intuitions of a competent person. The argument has already been made that intuitions are not capable of providing us with the certainty required of a validity test and that the meaning of a text, the reality of any given situation, or even the informant's view of the accuracy of an account will always be contingent upon interpretation. If our views and the views of informants are fundamentally disparate, it may well be that our interpretation is incorrect, yet we cannot discount the possibility that the disagreement is a result of the respondents' misunderstanding of their own activities, either because certain aspects of their activities are hidden, or because defense mechanisms such as denial may be at work (Packer and Addison, 1989, p. 284). This argument has relevance for research in the field of TSCI, as the various mechanisms of defense may possibly be 'built into' the adjustment process itself. At least, this is what many of the stage theorists would lead us to believe. It would be dangerous however to unquestionably assume that this is always the case, especially when there is strong evidence to the contrary.

3.4.3 Consensus

A convincing interpretation should be sensible and communicable, in a manner which allows others to interpret the material in a similar light (Packer and Addison, 1989; Terwee, 1990). Yet this kind of consensus should not be viewed as being equivalent to a traditional validation procedure, i.e. the assessment of inter-rater or inter-observer reliability. Agreement in this sense inevitably leads to quantification and statistical abstraction, which in turn opens up the possiblity for "collective delusion" (Packer and Addison, 1989, p. 285).

Agreement, in and of itself is no guarantor of correctness, as evidenced by the large scale acceptance of certain prejudices and outdated theoretical beliefs. From the interpretive stance, a better interpretation is one which provides us with a more insightful analysis than rival interpretations (Taylor, 1979). Consensus, as a consequence, cannot be used as a metaphor or substitute for traditional reliability assessment, as further material may show an interpretation to be false, or rival interpretations may proceed from incommensurable perspectives.

3.4.4. Relationship To Future Events

Taylor (1979) has argued that predictive generalizations are an inadequate and unsatisfactory means for explaining human action, and more strongly that "meaningful prediction is impossible in human affairs" (Taylor, 1979, p. 90). He cites the examples of Glasnost in the former Soviet

Union and the introduction of computers into the world of business and education to emphasize the point that major cultural innovation and transformation is unpredictable. As individual decisions affect social life at numerous levels, i.e. institutionally, culturally and personally, they are indeterminate. Pure contingency is a significant factor which cannot be 'controlled for' or simply wished away. Furthermore, predictions are unsatisfactory forms of explanation for another reason, i.e. they are always qualified by 'ceteris paribus' conditions, meaning that they hold true, 'all other things being equal.' This means that the scope of application of such predictions is extremely limited and ill-defined. In the words of Packer and Addison (1989, p. 26), predictive laws are "secondary phenomena, the results of social practices and institutions whose functioning is symbolic and representational, not causal . . . they work, only because our understanding of the causal regularities of nature constrains social life."

While interpretive inquiry is not concerned with predicting outcomes in the traditional mechanistic sense of the word, interpretive accounts may be evaluated on the basis of a "pragmatism criterion" (Fischer, 1987). As interpretive inquiry is intrinsically linked to practical activity and has an emancipatory (as opposed to instrumental) interest (Habermas, 1971), interpretive accounts may be judged on the basis of their ability to bring about changes in the everyday life-world of participants. Thus Lather (1987) speaks of "catalytic validity" in which accounts are evaluated on the basis of their ability to "re-orient, focus and energize participants towards knowing reality in order to transform it" (Lather, 1987, p. 272).

At this stage the criteria for evaluating interpretive accounts have been discussed and examined, and the notion of truth as 'uncovering' propounded. I have argued that this definition of truth and the evaluative criteria outlined above are both reasonable and applicable because they serve to direct attention and discussion towards considerations we value when evaluating interpretive accounts (Packer and Addison, 1989). As the purpose of the present study is to generate a meaningful and phenomenologically sensitive interpretive account of the acute phase of TSCI, it should be evaluated on the basis of its ability to satisfy the criteria outlined above.

If an answer has been uncovered, then the account should be found to be plausible. If it fits with other material then it should be convincing, and if it is convincing, then it should affect our practices (Packer and Addison, 1989). The final part of this method section will be concerned with describing and making explicit, the research strategy and form of data analysis used in the present study.

3.5 Research Strategy And Data-Analysis

3.5.1 Introduction

This section is divided into three parts. Its aim is to make explicit the research strategy to be followed for this particular study. The strategy consists of the following three steps: (1) selecting subjects for participation in the study, (2) explaining the means by which the data/interview narratives will be obtained, and (3) explaining the interpretive procedure which will be used to analyze the data. These three steps will each be discussed in turn.

3.5.2 Selection Procedure

Participants were located by means of a snowballing technique. Nursing staff at the H. F. Verwoerd Spinal Unit in Pretoria introduced me to a number of patients who were currently undergoing rehabilitation at the unit, of which two were selected on the basis of their abililty and willingness to speak about their experiences. The third participant also underwent rehabilitation at the same unit, although I met him by chance at a social event. Although the only criterion for selecting participants was personal experience with TSCI, certain categories of persons were excluded from the study. These were: (1) patients who suffered severe head injuries as a result of the trauma, and (2) patients who lost significant others in the accident/event. Patients in the aforementioned categories were excluded from the study for two main reasons: (1) because of ethical concerns, and (2) because the nature of their circumstances would prevent their descriptions from being exclusive to the phenomenon of TSCI (Du Preez, 1985). As interpretive research is exploratory in nature and aimed at understanding a diverse range of experiences, one complete paraplegic, one incomplete quadriplegic and one incomplete paraplegic patient participated in the study.

3.5.3 Obtaining the data

Participants were told in everyday language what was required of them, i.e. they were asked to describe and discuss their initial experiences with the trauma and to focus on specific incidences, feelings, thoughts and memories, whenever possible. This method of asking subjects to 'describe' their experience has been illustrated by numerous researchers working within a phenomenological framework, for example De Koning (1979), Wertz (1983), and Colaizzi (1975). Du Preez (1985) is one researcher who used this method to study the general experience of TSCI in the South African context. She has argued that by giving patients the opportunity to describe incidents, one is giving them a concrete course to follow, i.e. one which should aid and assist them in this unusual and possibly difficult task. Participants will therefore be given as much or as little time as each requires to reflect upon and respond to the questions posed. Consistent with a hermeneutic approach, a certain amount of self disclosure on the part of the researcher will be used as an avenue of access. As self disclosure is a mechanism of concerned involvement, it should help to establish good rapport with the participants and also facilitate a deeper level of discussion. Participants will be informed that the researcher is a former SCI patient with both a personal and scholarly interest in the phenomenon. In order to capture the meaning of the experience in all it's richness, the interviews will take the form of open-ended dialogical discussions which will be tape recorded and transribed for the purpose of textual 'fixing'. Paul Ricoeur (1979) has argued that, as disourse (human action) may be recorded in the form of written texts, it leaves 'traces' which can be 'fixed' in various ways. Thus action itself, i.e. "action as meaningful, may become an object of science, without losing its character of meaningfulness, through a kind of objectification similar to the fixation which occurs in writing" (Ricoeur, 1979, p. 81).

3.5.4 Interpretive Procedure

The interpretive procedure is modeled upon the 'reading guide' developed by Brown, Tappan, Gilligan, Miller and Argyris (1989). The reading guide is a procedure which offers a way of operationalizing the hermeneutic circle, i.e. the essential circle of understanding, by building up an interpretation of an entire "interview narrative out of its constituent parts" (Brown, Tappan, Gilligan, Miller and Argyris, 1989, p. 144). It is a structured interpretive procedure which allows for the exploration of experience both within and across interviews by means of an ordered and systematic reading guide. The first level of interpretation involves two interwoven steps: (1) the writing of a summary for each individual interview narrative, and (2) the asking of specific questions of each written protocol; in this instance the question, "what does the interview reveal about the meaning of the experience for the person concerned?" The second level of interpretation entails a reading across interviews, i.e. comparing and contrasting experiences for the purpose of identifying themes, patterns, flows and directions in the material. The third, and deepest level of interpretation involves the writing of a general, nomothetic narrative account of the acute phase of TSCI which reflects both the researcher's and the participants' understandings of the phenomenon, situated in appropriate cultural and social context. Difficulties encountered during the interviewing process, and reflections on the study's shortcomings will be structured into the discussion. The findings will be discussed in relation to the existing literature and made available to the H. F. Verwoerd Spinal Unit for circulation and possible incorporation into their rehabilitation program.

CHAPTER FOUR

INTERVIEW NARRATIVES AND THEIR ANALYSES

4.1 INTRODUCTION

This chapter contains three descriptive summaries of the experience of the acute phase of TSCI and their analyses. For the full texts of the transcribed interviews, the reader is referred to Appendices A, B and C. Due to ethical considerations, namely the need for anonymity, the three individuals who provided the descriptions will be referred to as follows:

Subject A

Subject B and

Subject C

Subject A is a female paraplegic (T11 - complete). She was 15 years old at the time of the interview and had been hospitalized for eight weeks.

Subject B is a male quadriplegic (C3 to C4 - incomplete). He was 36 years old and had been hospitalized for seven weeks when I interviewed him at his bedside.

Subject C is a male paraplegic (T12 to L2 - incomplete). He was 34 years old when the injury occurred. I spoke to him at his home two and one-half years after the event.

4.2 Systematic Interpretive Analyses

4.2.1 Summary. Subject A.

A was at the community hall and there was a fight outside. She heard gunshots and ran. Then she felt herself "being hit." As A fell down, she felt an "electric" shock in her back and a loss of feeling in her legs. Only after A saw blood, however, did she realize that she had been shot. A tried to move her legs but could not. She realised that she was "all alone" and she felt "scared." Someone called an ambulance which took A to the hospital. At the hospital, they stuck pipes into her and she felt "terrible pain" in her back. At that point, A was "afraid" for her "life." She worried that she would not "be able to wake up again." Then A was operated upon. After the operation, A was told that she would never walk again. A was devastated by this news and she says that she couldn't believe it. At the same time, A stated that she wanted to walk. A says that she was "very depressed" and that she cries when she thinks of what has happened to her. Also, A stated that it helped her to be among the other spinal patients. Being with them made A realise that she was "not the only one." A teacher comes to see A every day and she does schoolwork. A says that she thinks a lot about what has happened to her and doesn't know whether her visitors help her. For instance, when they ask A what happened, she thinks about the shooting and starts to cry.

A also stated that sometimes, when "somebody slams the door" she thinks "that it's a shot and then it happens again" and that sometimes, when she is "outside" and sees "somebody fighting" she experiences the same reaction all over again.

4.2.1.1 What does the interview reveal about the meaning of the experience for Subject A?.

When A lost feeling and movement in her legs she stated that she felt "alone" and "scared." This 'fear' and 'aloneness' may therefore be of an existential type, meaning that A became aware that she was fundamentally alone in the world, or alternatively, it may mean that A felt literally/situationally alone, in the usual sense of not being in the presence of concerned others. This feeling of aloneness was followed by, or accompanied with worry, i.e. fear/anxiety. The existential interpretation of A's feeling fundamentally "alone" is reinforced by her next reaction, which is the specific fear of death. A worries that she will not "wake up again." A also experienced "terrible pain" in her back. Following the operation, A was told that she would never walk again. To this she reacted with disbelief and denial. Disbelief because she stated explicitly that she couldn't believe it and denial because she expresses a desire to walk without having the physiological capacity to do so. Depression ensued following A's realization that the disability may be permanent, and it is clearly still present. What is clear from A's description is that she appears to be suffering from Post Traumatic Stress Syndrome. This interpretation is reinforced by the fact that the traumatic event is triggered and the anxiety/fear invoked by it,'reexperienced' each time A hears a door slam or sees a fight going on outside.

4.2.2 Summary. Subject B

Just after the accident, B was lying in the veld and he couldn't "feel" or move anything from the neck downwards. He asked someone where his left arm was and she replied, "it's right next to you." B repeated that he couldn't "feel anything" at that point, and expressed his disbelief, by saying "I couldn't believe it." He tried to move his legs but couldn't. After being taken to the hospital, B was X-Rayed and given an injection, which made him feel like he was "far away." B does not recall much of that stage however. B recalls waking up at night and being in traction with a halo device on his head. At this point the Doctor informed B and his wife that he would never be able to use his hands or legs again. B couldn't believe it, but also "couldn't do anything" about it. That night B talked to himself and told himself again that he "couldn't believe it." He also closed his eyes and prayed. The next morning B was lying in bed and he felt something, but he didn't know where the feeling was. It felt like his legs were someone "elses", but also that "the life was coming back." First B regained an altered sort of feeling and movement in his right side, right arm and right leg. It felt like "pins and needles" and only after three or four weeks did B start feeling his left side "come back." Then, suddenly, one day, B tried to move his wrist and succeeded. He felt himself getting stronger as he regained new movement and feeling. Up until the time B's left leg "came back", he stated that he struggled with the idea of walking. He couldn't see himself walking with only one arm and one leg, but he also couldn't see himself sitting in a chair all day. B prayed and tried to stay "positive". Initially, after the accident, B felt pain in his neck and upper arms. B describes the pain as an altered sensation, i.e. "if you press your finger on my arm it's like you're pinching me." He also described how, when he was turned, it felt like "a wild animal tearing him apart" or people "trying to pull off" his arms. B also experienced immense pain when they took off his first halo and put on his second. B is positive that he will walk again. Perhaps in light of this possibility, B states that his experience with the trauma has been 90% positive and 10% negative. Initially, B thought that he was getting a lot of attention because he was a "special person." Later on however, he didn't like it. All the intrusive questions people would ask and the impossible and "stupid" things they would try to get B to do, like "pick up his leg" or touch his "left ear with his right hand over his head" upset him, as he felt like he was being treated as a "joke", or a guinea pig. He didn't know the reason why people were doing this to him as he was just "lying on his back spending time" for "no reason." It made B feel as if there was something "wrong" with him, or his visitors, "like they can't believe what they see." B stated that during the first week, a lot of family came to see him and couldn't believe what they saw. When they cried it made B feel "negative" and "down." B placed things in perspective for them however, i.e. he told them that it happened, that nothing can be done about it and that they shouldn't cry because it hurts him inside. On the positive side, B began to "believe" and "trust" in himself as a result of his return. He felt himself "getting stronger" i.e. regaining more feeling and movement each day. This made him feel like he was "winning." The "only thing" B "couldn't do" at that stage was move his wrist. B described how he felt "stupid" one day because his physio asked him to do something which he couldn't do. Yet B succeeded in doing the very same thing the following day. B described the sensation in his left leg as "normal" and the sensation in his right leg as "stupid." B also describes his boredom, particularly after lunch when he has nothing to do. He can't "pick up a book properly and read," so he lies in bed counting the holes in the roof and working on his weak points. B says that he still can't believe that he's getting stronger each day, but he feels it and "knows" it as a consequence. This feeling B described as "winning." Because B keeps winning, he keeps telling people that he will "stand on his own two feet and walk." B also described the early stages, i.e. his first three weeks of having the catheter in and not being able to urinate on his own as "very difficult." He couldn't move or feel his hands properly and therefore struggled with bladder control and "everything" in the genital area. B referred to his hands as "stupid" at that stage. After three weeks, B succeeded in urinating without help. This made him feel "beautiful," i.e. like he was "winning," like he could "do it" because he had "control of everything." B stated that his visitors "cannot understand" what he's experiencing, but that those of us who have been through it, and the doctors and nurses do. B thinks about a lot of things while he lies in bed. Things like building pens for his animals on the plot, memories of when he was seven years old, when he lost his playing gun and couldn't find it for three weeks. He also stated that he often thinks of what he would have done, if he had known at age seven that he would break his neck at age thirty three. B also thinks of his wife and children, and of his father who had a spinal injury in exactly the same place as B.

B also thinks of the heavy work he used to do and about the accident itself, which he "sees when he closes his eyes." B stated that he still "can't believe" that it happened, i.e. that it was "a stupid thing," which could have been avoided. B describes feeling "confused and stupid" immediately following the accident, and of the early stages he doesn't recall much. He also stated that he has been forgetful lately, i.e. that he listens to his wife, but that he cannot remember some of the things she says. This bothers B because his wife is "part" of him. B says that maybe he got a bump on the head, because sometimes he feels "stupid," but that he thinks it will "go away." B says that he wouldn't wish what happened to him on his "worst enemy." He doesn't know why it happened to him, "but it happened." B also discussed his life before SCI, and described working and being in dangerous situations where he "could have broken" his "neck," but never even got hurt. B says his accident shows that it can happen to anyone, that the "biggest thing he's gotten out of the" experience is that a lot of these accidents are "avoidable," but that people just don't think about it. B stated that he learnt that everyone was mortal, that no one was "God's gift to earth," or made of "steel" or "invincible" and that this, he learnt in the hospital.

4.2.2.1 What does the interview reveal about the meaning of the experience for Subject B?

Immediately after the accident, B could not feel or move anything from the neck downwards. He asked someone where his arm was which suggests that B literally felt himself to be a 'disembodied head' at that point. B also reacted with disbelief to the doctor's assertion that he would never use his hands or legs again, but he knew that he "couldn't do anything about it" at that stage. The next day however, B began to feel something like a light pinprick on his leg. Although B's leg felt like it was someone elses, it gave him an indication that the "life was coming back" into it. This suggests that prior to B's return of movement and sensation, he experienced a loss of "life" of some sort, i.e. that his body 'died.' Yet it also "came back," albeit in different form. B therefore experienced a type of rebirth or resurrection, which is evidenced by the fact that he continually refers to the "life coming back." From that moment onward B experienced a slow but consistent return of movement and feeling in all his extremities. This gave B strength and incentive to stay positive. It also enabled him to entertain realistic thoughts of walking again and to trust and believe in himself, as the return of feeling and movement provided him with a concrete physiological basis for disbelieving the initial verdict of the doctor. The three week mark was also a turning point for B. It was after three weeks that B first urinated on his own, i.e. he urinated without the aid or impediment of a catheter. This act enabled B to feel like he was "winning", i.e. that he could "do it" all, because he had **control of everything**, which was "beautiful." An interesting adjunct to this view is B's recounting of a recurrent memory of a time when he was seven years old and lost his "playing gun." B found his "playing gun" after three weeks. From a psychoanalytic perspective, it is not implausible that the "playing gun" is a symbolic representation of B's penis. Remember that this is a 'playing gun', i.e. not a real one which B "lost" and that he "found" it after three weeks. The fact that B's father features in this memory/scenario, adds weight to the interpretation that the memory is linked to B's SCI experience, as B's father himself sustained a spinal cord injury at one time. Although this interpretation seems closer to dream analysis than phenomenology, it should be remembered that SCI patients spend a substantial amount of time under the influence of powerful psycho-active medications during the acute phase, i.e. medications which produce or induce 'dream like states.' For this reason, (and for the one which follows), the aforementioned interpretation should be found to be plausible . As the three week mark was the time at which B discovered/rediscovered the possibilities of genital sexuality as well as the possibility of full bladder control and walking, it represents a critical developmental juncture for him. This period was also the time at which B regained more feeling and movement in his wrist and hands, which is a necessary prerequisite for performing crucial tasks like feeding oneself, masturbating and urinating.

Pain was another aspect of B's experience which was closely related to his altered physiological state. What is significant about B's pain is it's intensity and type. It is known that patients with incomplete SCI often experience pain and altered sensations of a heightened and hypersensitive nature as a result of physiological compression of the spinal cord (Zejdlik, 1992). B's pain at being turned was so severe that it felt as if wild animals were trying to pull his arms off. This suggests that B's pain was not only atypical but so intense as to warrant special turning attention. The way B's visitors viewed and treated him was also a significant aspect of his experience. These people often asked B intrusive and ignorant questions about his body which were degrading for him and made him feel as if he were being made fun of. When B's visitors cried, it also upset him and made him feel negative. In addition, the professor and students that were brought in to examine B made him feel like he was an object of curiosity, a freak of sorts and it angered him. B's psychological reactions to the trauma were therefore significantly and adversely affected by something other than the trauma itself, i.e. by the insensitive actions and remarks of some of his visitors and by some members of the hospital staff. B also often referred to some of his non-feeling or altered body parts as stupid. This suggests that B's body had become an object of ridicule for him and also a barrier/burden standing in the way of recovery. The fact that B felt like he had nothing to do after lunch except count the holes in the roof also suggests that he suffered from boredom, although he does say that some of this time was spent working on his weak points. The latter fact suggests that B was an active, concerned patient who took some responsibility for his own recovery by continually seeking to gain more movement and control. The fact that B's father had a spinal cord injury, combined with B's initial belief that it could never happen to him, indicates that SCI was either a submerged or known, yet unthematized possibility for B prior to his accident. B also continually refers to how he was prior to the accident. He was an active man doing heavy subcontracting work as well as firefighting and other physically demanding tasks. It is precisely against this background or horizon that B's experience takes on the particular significance or dimension that it does. B also described his experience with SCI as largely positive, as it tought him numerous things, for instance to trust and believe in himself. Also, B realized through his experience that SCI can happen to anyone and that these things can be avoided if people think more about them. Thus B's experience contributed to the enhancement of his awareness and perspective. B began to view himself and others as equally mortal, i.e. fallible and therefore vulnerable to death and the forces of chance and accident. Prior to B's accident, he was unaware of the significance of this fact. This interpretation is reinforced by the fact that B ponders the question of what he would have done if he knew at age seven that he would sustain a spinal injury at the age of thirty three. The implication here is that B would possibly have done different things with his life. This is due to B's new perspective on things, i.e. a perspective which he attributed to his experience with the trauma.

4.2.3 Summary. Subject C

Initially, C was told that he would never walk again. At first C couldn't "connect" with this idea and demanded a second opinion. He was told that the cord was so damaged that the first opinion was correct. This was reinforced physiologically by the fact that C had no feeling below the level of the L1 vertebra. Following the accident, C experienced extended, "excruciating, constant and drastic pain" i.e. pain of such intensity that he says it qualified him to have a baby. He also experienced paranoid delusions and hallucinations as well as "running" thoughts which he could neither switch off nor control. Whatever he thought about was "exposed" speedily, one fact after another in rapid uncontrollable succession. This C described as "a total sense of no control" and "pure fear of being that out of control." C also stated that he couldn't recall some things about the early stages and that he would sometimes "shift" from "lucid to loopy." He recalls some hallucinatory experiences, describing an episode in which he told a nurse that he "could be making a fortune as a comedian." C also stated that he was an up and coming patient who "organized" and "ran" the hospital. To emphasize this point, C cites examples of how he held business meetings at his bedside and took responsibility for his own medication. He also described how he succeeded in persuading the turning team to allow him to count for himself during the turning process. C discussed the usually rigid procedures that SCI patients are forced to comply with on the basis of their merits and dealt with the hospital staff on an individual/individual, as opposed to patient/staff basis. Regarding the turning procedure, C described it at one point as "highly unrelaxing" as the team would say "relax" and then count loudly. C used the threat of "I'll scream" as a means for getting the staff to listen to him on a number of occasions. Regarding C's relationship with the other patients, he found it hard to relate to many of them as they were mostly racist. C found it hard to believe that these people would exhibit their racism to black nurses who "had them absolutely helpless." C also described himself as "physically the luckiest guy in the ward almost all of the time," which served to set him apart from most of the other patients. C also recieved a lot of support from his parents and says that he built his relationship with them while in the hospital. C attributes this experience to the fact that they were able to spend time together and that "when things are so intense, you either deal with what's going down, or you bury it." C also described his parents as "amazing people" who "learn from their kids." He also described his initial experience with SCI as being similar to his experience as an activist in detention. During both experiences C felt that "someone else was in control," i.e. that C felt a "complete lack of control." He didn't decide when to sleep, whether to eat, who came to see him or when he would get out. C also emphasised important differences between the two experiences, the main one being that there wasn't any malevolent force keeping him in the hospital. C also recalled a humorous incident told by another patient which he regarded as one means for dealing with the crisis of SCI. Regarding sex, C stated that initially, due to the pain and the drugs, that he didn't actually "connect" with the "idea of sex." Only after they changed C's catheter did he realize "that if they did this to me and I had feeling there, there would be a problem." C describes this as "quite a freakout." C also described how someone from the neurology department gave a lecture on sex, which was extremely well presented. He also recalls however, that the female patients were not given this lecture. Furthermore, C stated that he experienced "severe anxiety" related to his "fear of pain" prior to his second operation. He also described how at one time he had a subconscious fantasy that he "was very sick and would become completely well" and that if anyone had asked him about it, that he would have denied it. C also says that during the early stage, walking was an issue for him, but "not now," i.e. two and a half years later. C also stated that he "redid" his "entire childhood" as a result of SCI, i.e. that he had to "learn to roll over," that he was "fed via a nose tube," that he was dressed and bathed, that he had to learn to crawl and to feed himself. In short, that he did "a rewind of" his "whole life." C also described another aspect of his experience which refers to his current, i.e. two and a half years after the event view of things. C feels that SCI patients need to come to terms with the fact that they are now "part of an oppressed group" who are discriminated against. He stated that we need to move away from "the individual tragedy model" and come to terms with our "fear and horror" of being disabled. In C's view, the disabled group are part of an oppressed minority who need to see their situation within it's appropriate political context. C feels that this is a neccessary prerequisite for emotional, social and individual growth, and that people who fail to confront this dimension will remain "stunted."

4.2.3.1 What does the interview reveal about the meaning of the experience for Subject C?

Initially, C responded with disbelief to the news that he would never walk again, as he couldn't "connect" with the idea. In addition, C explicitly stated that he was in denial at one point as he believed that he was very sick but would get completely well. This suggests that C couldn't or didn't want to believe that his disability was permanent during the earliest stages, and also that denial can assume both covert and overt forms. C also spoke of experiencing intense, excruciating, constant and drastic pain as a result of the trauma. This pain was so inexplicably intense and unremitting, that C felt as if it qualified him to have a baby. This suggests that the type of pain experienced by C was greater than the single word 'pain' is capable of describing. As Nietzsche (1878) has said, "the idea of pain is not the same as the suffering of it" (Nietzsche, 1878, p. 61), especially when the pain is constant and compression related, as was the case with subject C. C also experienced hallucinations and delusions of a paranoid type, which he attributed to the effects of pethadene. These reactions were accompanied by rapid and running thoughts which exposed ideas and facts to C which he could neither switch off nor control. C felt fear as a result of this "total sense of no control" and stated that he has difficulty recollecting some things from the early stages of the experience. C also spoke of numerous incidences where he exerted his autonomy and independence. Examples of this included holding business meetings at his bedside, i.e. an AGM meeting, taking responsibility for his own medication and counting for the turning team during the turning process. This suggests that C was an active, alert and non-submissive patient who took a large measure of responsibility for his own rehabilitation. C questioned procedures which he found unneccessary and illogical and succeeded in getting the staff to treat him as an individual as opposed to a patient. Although C threatened to scream on some occasions if he didn't get his way, this behaviour can hardly be considered abnormal, given the fact that C had little if any other means of physically exerting control over his destiny. C utilized whatever means at his disposal, be it reason or threats of damage to people's eardrums to drive home the point that he was neither passive nor helpless. As C was both non-racist and to use his words "physically, the luckiest guy in the ward", he felt that it was not easy to relate to most of the other patients. C also made positive use of his time in bed to build his relationship with his parents and to deal with, instead of bury what was happening to him. This suggests that denial was not a static state or mood for C, but rather one part of the fluid process of dealing with the trauma. C also made comparisons between his SCI experience and his experience as a political activist in detention. This suggests that for C, the experience of being an individual with SCI in the hospital was in some way similar to the experience of being in prison, i.e. because in both places someone else is in control. In both places C experienced sensory deprivation, in addition to others deciding when he slept, when he could have visitors, if he ate and when he got out. This suggests that being in the hospital for C was a form of torture, albeit a form of torture without specifically malevolent intent. The fact that an inability to move and/or to move out is characteristic of both experiences adds weight to the aforementioned assertion. C's experience also suggests that humour is one way of coping with SCI. This is evidenced by C's own pronouncements on the issue as well as his recollection of humourous incidents relayed by other patients. According to C, sex only became an issue for him following the acute phase of the trauma. The fact that C realized that there would have been a problem if he had "had feeling" in his genitals when they changed his catheter however, suggests that genital sexual functioning was a submerged, if not conscious concern for C, even at an early stage. As Wilhelm Reich (1948) has pointed out, there is often an "anti-thetical functional identity/unity" between the "defense and the repressed" (Reich, 1948, p. 102). As the repressed (problem), shows itself by the appearance of it's opposite, i.e. the defense, it seems possible that the problem for C was precisely that of 'not having feeling' and not its opposite, i.e. having feeling, which was a problem which C regarded as "quite a freakout." C also described feeling severe anxiety prior to his second operation, which he related to his fear of pain. This anxiety had a concrete basis in C's lived experience, as he stated that he saw another patient with his "eyes popping out of his head with pain" following a fusion. C also stated that he was in denial at one stage, as he had had a "subconscious fantasy" that he "was very sick" but would become "completely well." C also described how he did a "rewind" of his entire life, i.e. he went back to, and through his "entire childhood," which suggests that he was aware of experiencing some form of regression. C stated that he was fed through a nose tube, that he relearned to feed himself, to crawl, to dress and to bathe, all of which are unmistakeable signs of regression and psycho-social redevelopment. C also makes reference to an aspect of his SCI experience which is not specifically related to the dynamics of the acute phase. At this stage in C's life, i.e. two and a half years after the event, he is more concerned with the problems related to being a member of an opressed group in present day South Africa and to the resolution of this problem. This problem however, is not the subject of the present thesis, important as it is to our contextual understanding of C's experience with the trauma as a whole.

4.3 Reading across experiences for the purpose of identifying themes, patterns, directions and flows in the material

After reading 'across' interviews it becomes clear that all of the subjects experienced a number of shared and individual reactions which may be grouped into themes or categories, according to their incidence and type. The first group of reactions/themes are those common reactions which all of the subjects experienced at one time or another. In the second category I have placed those general themes and reactions which only two of the subjects experienced at any given time. In the third group I have placed those idiosyncratic reactions and themes which were of significance only for the individuals' concerned.

4.3.1 Shared reactions

One reaction common to all the subjects experiences was **disbelief**, which was in all cases the first response to the trauma. Both subject A and subject B explicitly stated that they couldn't believe what had happened, and subject

C stated that he couldn't connect with the idea, i.e. he couldn't associate it with himself and hence 'believe' it. In addition to disbelief, the reaction of **denial** appears in all three cases, albeit in highly individual form. A explicitly expresses a desire to walk, despite the completeness of her lesion and her inability to feel or move her legs. This suggests a form of **denial,** as A had no concrete physiological basis for believing that she would walk again. B's experience of denial is also evident, though less clearcut. As B eventually did walk out of the hospital, i.e. he walked out "on his own two feet," it cannot be said that he was in denial when he stated that he would walk. B's lesion was incomplete, which meant that he would have some functional return. B nevertheless experienced a form of denial when he made reference to the fact that sometimes people would make him feel like there was something "wrong" with him. This implies that B, at one point wanted or needed to believe that there was nothing "wrong" with him, despite the fact of the all consuming reality of SCI. It seems implausible to say that B was in a stage or enduring 'state of denial' however, as he also speaks of the injury in terms of acceptance, i.e. he refers to the fact that nothing can be done about it, thereby implicitly acknowledging what has occured. Subject C explicitly states that he was in denial, i.e. that at one time he had "a subconscious fantasy" that he "was very sick but would become completely well" and that if anyone had asked him if that was what he believed, he would have denied it. The experiences of all three subjects, however, suggest that the construct of 'denial' is much more complex than is usually supposed. For instance, if denial is capable of assuming radically different forms and meanings, i.e. both covert and overt, depending on the way in which it manifests itself in each individual case, then would it be accurate, to simply say that all of the subjects experienced denial? This hardly seems to adequately encompass what the various subjects were experiencing, especially when one considers the fact that the word 'denial', may easily be replaced with the term 'hope', i.e. a much less psychologically 'loaded' term, without negating the essential content of what was experienced, at least in the cases of subjects B and C. What is possibly true of denial then, may also be true of **Pain,** i.e. another theme which all three of the subjects experienced. As the intensity and particular type of pain tended to differ across cases, for instance, subject A's pain was "terrible" yet appeared to be related to the swelling from the gunshot wound in her back, while subject B's pain was of a momentary and hypersensitive type in which sensation was altered radically to render a touch into a pinch, or a pinch into a tickle, depending on where the touching took place, while subject C's pain was so constant, unremitting, excruciating and drastic, as to suggest pain of an almost inexplicably hypersensitive, heightened and intense type, that it seems impossible to group the three types of pain together, under a single heading, without destroying the unique meaning and essential content of what was experienced as pain, in each individual case.

In addition to the reactions mentioned above, all of the subjects experienced a **loss of control** as a result of the trauma. This loss of control was primarily physical, in the cases of subjects A and B and both physical and mental for Subject C. The next group of reactions and themes to be discussed are those which were experienced by at least two of the subjects, but not all three.

4.3.2 General reactions/themes

In this category are to be found the reactions of **anxiety, fear, depression/mourning, confusion, anger** and **regression,** as well as the themes of **return, acceptance** and **independence.** Both subject A and subject C experienced anxiety and fear, which were related to individually specific concerns. A's fear and anxiety seems to be of a fundamental, i.e. existential type, as it appears contiguously with the reaction of loneliness as well as the specific fear of death. C's fear and anxiety appeared shortly after the advent of the trauma and seemed related to the initial threat posed by his total lack of control, both physically and mentally. C's anxiety and fear also resurfaced just prior to his second operation, at which time he feared pain as a result of an impending vertebral fusion. Although subject B does not explicitly state that he experienced anxiety at any point, the fact that he experienced difficulty with urination and with "everything" in the genital area, i.e. including genital sexual functioning, combined with the lack of feeling in his hands and his initial uncertainty about walking, suggests that anxiety may have been a hidden/submerged aspect of B's experience as well. For this reason, anxiety may be placed in the category of common reactions mentioned in 4.3.1.

Depression/mourning were two related reactions which both A and B appear to have experienced, but which C makes no specific mention of. This is possibly due to C's realization that he was physically the luckiest patient in the ward, and to the fact that he was motivated by this realization to take a large measure of responsibility for his own rehabilitation. A explicitly stated that she was very depressed and that she often cries when she thinks of what has happened to her. Her depression therefore appears to be of a severe and enduring type, which suggests the atypical grief reaction, i.e. depressive illness.

B also stated that he felt down and negative, but attributed this negativity largely to himself. On numerous occasions however, B's negativity appears to have been triggered by the insensitive actions of his visitors and by some of the hospital staff. A was also adversely affected by the insensitive and prying questions of some of her visitors, including, possibly the interview with this researcher.

Regression was another theme forming a part of both B and C's experience, but not explicitly A's. C stated that he did a rewind of his entire life and childhood, i.e. that he had to learn to crawl, roll over, and bathe himself, all of which presuppose the existence of regression. Although B does not explicitly state that he experienced regression, the fact that he too had to be fed and bathed initially as a result of the loss of function and feeling in his hands, in addition to his loss and return of bowel and bladder control, suggests that he also needed to progress through a series of developmental tasks in order to regain control of these important functions.

Acceptance of the new reality situation was another theme experienced by both B and C, but not A. Although it is hard to pinpoint precisely when not being able to walk ceased to be a problem for C, the fact that he was an active patient who exhibited initiative on numerous occasions suggests that he accepted his disability enough to integrate it into his ego and perform tasks like holding business meetings at his bedside. B acknowledged his injury by telling himself and others that it happened to him and that nothing can be done about that fact, which suggests that he was able to accept the disability and move on from it, i.e. move towards recovery. Another theme which appeared in the experiences of both B and C was that of **independence**, i.e. the ability to exert control over one's own destiny. Independent activity is clearly visible in the experiences of both B and C as evidenced by C's initiative regarding the turning procedure, his taking responsibility for his own medication and his ability to halt some discomforting, yet routine hospital procedures. B exerted his independence by making his true feelings known to his visitors concerning the effects/affects of some of their insensitive actions upon him, and also by his reliance, trust and belief in himself concerning his ability to walk and regain bladder control.

4.3.3 Idiosyncratic themes/reactions

Loneliness and the specific **fear of death** are two reactions which only A appears to have experienced. A also shows signs of **Post-Traumatic Stress Syndrome,** which is a striking idiosyncratic feature notably absent from the experiences of both B and C. B also experienced a number of reactions which were unique to his experience alone. The most outstanding of these was the phenomenon of **return,** which he experienced throughout his hospital stay. Although C also experienced a certain amount of return, his was less striking than B's and therefore of a different quality.

B's incremental return of feeling and movement in all his extremities enabled him to stay positive and believe that he would walk again. The fact that he literally got stronger everyday added weight to B's belief in himself and provided him with the impetus to work harder on his weak points. B also degraded certain parts of his body by constantly referring to them as stupid. This shows how closely B's recovery was linked to his physical return and to his new image of himself. When B was exposed to examination he felt like he was being treated like an object and therefore began to view himself as such. By referring to the non-working parts of his body as stupid, B projected his **anger** onto his body, thereby revealing that he had partially separated himself from it. This implies a divorce of the mind-body entity, related to B's new body image, i.e. an aspect of the trauma which was a source of frustration for him. B also experienced **helplessness** initially as a result of the trauma. This is evident by his statements that he couldn't do anything as a result of the initial loss of feeling and movement in his body, from the neck downwards. This helpless feeling was not enduring however, as B eventually regained movement and feeling in all his extremities which enabled him to trust and believe in himself and in his ability to walk again. C also exhibited **anger** when he did not get his own way, yet C's anger appeared to be of a more calculated than spontaneous type, i.e. C used the threat of shouting as a mechanism for controlling the hospital staff. Another unique feature of B's experience was the **enhancement of perspective** which he attributed to his experience with the trauma. B explicitly stated that he realized his own, and others' mortality, fallibility and vulnerability while in the hospital and that events like SCI, though sometimes avoidable can happen to anyone. B thus realized the power of chance and accident as a result of his experience with the trauma, i.e. an experience which enhanced his perspective on things and which also possibly enabled him to view his accident in a (mostly) positive light. This provides some support for the argument that critical life experiences are mechanisms of psychological growth for some individuals and that SCI is possibly one such experience. C also experienced unique occurences which A and B did not, for instance **constant** pain, **paranoid delusions** and **hallucinations**, **running lucid thoughts**, the **building of relationships**, feelings similar to **imprisonment**, in addition to incidents of a light and **humorous** nature, which suggest that C's experience was highly complex, largely idiosyncratic and significantly influenced by social factors, such as the hospital staff, his parents, his previous history, political perspective and pretraumatic personality.

CHAPTER FIVE

DISCUSSION AND CONCLUSION

5.1 INTRODUCTION

The final level of interpretation involves the writing of a general nomothetic narrative account of the acute phase of TSCI which reflects both the researchers and the participants understandings of the phenomenon, situated in appropriate cultural and social context. The findings will be discussed in relation to the existing literature and evaluated on the basis of the goals of the study. Difficulties encountered during the interviewing process and reflections on the theoretical and practical implications of the study will also be structured into this section.

5.2 Level Three: Discussing The Findings

Perhaps the most striking feature of the present study was the similarity between the common and general themes identified in sections 4.3.1 and 4.3.2 and some of the stages and phenomena discussed in chapter two. All of the subjects experienced **pain, disbelief** and some form of **denial,** while at least two of the subjects experienced **anxiety/fear, depression/mourning, regression** and **acceptance** of the disability during the acute phase. These reactions did not however, appear in any specific sequence and with the possible exception of the overlapping reactions of depression and denial in the case of Subject A, did not assume the character of stages or even relatively enduring mood states. With the exception of the common initial reaction of **disbelief**, there appeared to be significant overlap between the various reactions and themes, in addition to subtle nuances and differences within them. Take, as an example the shared theme of **anxiety**, i.e. one reaction which all of the subjects experienced. Subject A's anxiety seems to be of a fundamental, i.e. existential type, as it appeared contiguously with the reaction of loneliness as well as the specific fear of death. Subject C also experienced anxiety, yet his was of a more temporary/situational type which, initially, was related to the total lack of control he experienced both physically and mentally as a result of the conjunction of spinal shock, the loss of feeling and mobility in his limbs, Morphine and the effects of 'running thoughts' which he could not control. C's anxiety again resurfaced just prior to his second operation, at which time he feared pain as a result of an impending vertebral fusion. Although Subject B did not label his 'worry' as anxiety, the fact that he experienced 'difficulty' with the idea of not being able to walk again, as well as with bowel and bladder control, in addition to the problem of not being able to feel or use his hands, suggests that anxiety may have formed a part of B's experience as well. This finding is consistent with Siller's (1969) study which identified anxiety as one of the foremost reactions to physical traumatization. As can be seen from the examples provided above however, there were subtle nuances and variations in the way in which anxiety was experienced across cases.

Depression and/or **Mourning** were two other related reactions which appeared only in the experiences of subjects A and B, but not, apparently in C. As B's experience of 'negativity' was fleeting and also 'contaminated' by other reactions such as anger, boredom and even positivity, it seems implausible to say that he experienced depression. He did however show signs of grief, as he stated that he would feel down and negative sometimes. Subject A, on the other hand experienced such severe depression that it manifestly impeded her ability to both cope with and accept the trauma. This finding is in direct opposition to the stage theory view, which holds that depression is the most important stage in the adjustment process and also a prerequisite for healthy adaptation. As the only individual who was unable to accept the disability during the acute care phase was also the only subject who experienced severe depression, i.e. subject A, the stage theory view that depression is a necessary prerequisite for acceptance appears to be innacurate. This finding is consistent with the results of Howell, Fullerton, Harvey and Klein's (1981) study on depression which found that only twenty two percent of their subjects showed signs of diagnosable depression. Furthermore, the finding that at least two of the subjects, i.e. subjects B and C experienced more than one or two stages/reactions, including **acceptance** of the disability during the acute care phase, suggests that Weller and Miller's (1977) assertion, that during the acute care phase, no more than one or two stages may be experienced is innaccurate. What is interesting to note, however, is the fact that the only patient who did not experience more than two stages was subject A, i.e. the only 'complete' patient to participate in the study. This suggests that the stage theory model may possibly be more applicable to those individuals in the category of 'complete' as opposed to 'incomplete' SCI, especially when one considers the fact that subject A was also the only patient to experience denial and depression as relatively enduring mood states, although these reactions tended to manifest themselves together, and not in stages. One reaction common to all the subjects experiences was **disbelief,** which was in all cases the first response to the trauma. Both subject A and subject B explicitly stated that they couldn't believe what had happened, and subject C stated that he couldn't connect with the idea, i.e. he couldn't associate it with himself and hence 'believe' it. This finding is consistent with the view that shock/disbelief is the first, i.e. immediate reaction to SCI. In addition to disbelief, the reaction of **denial** also appeared in all three cases, albeit in highly idiosyncratic form. A explicitly expressed a desire to walk, despite the completeness of her lesion and her inability to feel or move her legs. This suggests a form of **denial.** B's experience of denial is also evident, though less clearcut. As B eventually did walk out of the hospital, i.e. he walked out "on his own two feet", it cannot be said that he was in denial when he stated that he would walk. This raises the important question of what constitutes denial in patients with incomplete SCI. As B's lesion was incomplete, he could expect a certain amount of functional return. For this reason, some theorists, for instance Caywood (1974) have argued that information about the disability should be given in a way which does not destroy the patient's hope that his/her condition may improve. As hope may provide the individual with a motive to keep working despite the rigours and frustrations of a treatment program, Caywood (1974) has argued that hope is not the same as denial and should therefore not be placed in the same category as a defense mechanism. Subject B nevertheless did experience a form of denial when he made reference to the fact that sometimes people would make him feel like there was something "wrong" with him, despite the concrete fact of the all consuming reality of SCI. It seems implausible to say that B was in a stage or (enduring) 'state of denial' however, as he also speaks of the injury in terms of **acceptance**, i.e. he refers to the fact that nothing can be done about it, thereby implicitly acknowledging what has occured. Subject C explicitly stated that he was in denial, i.e. that at one time he had "a subconscious fantasy" that he was very sick but would become "completely well" and that if anyone had asked him if that was what he believed, he would have denied it. This provides some support for the theory that denial is a common response to SCI, but not for the view that denial is either a specific stage, or a uniform reaction, as it is capable of manifesting itself in so many different ways, and is sometimes indistinguishable from other less negative reactions, such as 'hope.'

Pain was another theme permeating all three subjects experiences, although the intensity and particular type of pain tended to differ from subject to subject. Subject A's pain for instance was "terrible" and appeared to be related to the swelling from the gunshot wound in her back. Subject B's pain was of a momentary and hypersensitive type in which sensation was altered radically to render a touch into a pinch, or a pinch into a tickle, depending on where the touching took place, while subject C's pain was so constant, unremitting, excruciating and drastic, as to suggest pain of an almost inexplicably hypersensitive, heightened and intense type. Just from these few descriptions it should be clear that the single word 'pain' does not adequately encompass what these patients experienced as a result of the trauma. Other words such as 'altered,' 'terrible,' 'drastic,' 'unremitting' and 'intense' are required to show precisely what type of pain was experienced and how it manifested itself in each case. This is one advantage offered by the hermeneutic approach, i.e. that it allows the phenomenon to show itself from itself, as described and experienced, rather than as constructed or categorized. This finding is of therapeutic value and has rehabilitative relevance for the following reason. As the turning procedure is potentially painful for some patients, it is also a source of anxiety for them. Subject B for instance, described one turning episode as so painful that he felt like wild animals were trying to pull his arms off. This is an issue which the nursing staff and turning team need to become sensitized to, as a little sensitivity can go a long way towards minimalizing pain and discomfort for someone who is experiencing pain of this hypersensitive and intense type. As the turning procedure is bound to affect different individuals in different ways, depending on the type of pain experienced in each case, the type and intensity of pain should be carefully evaluated in each patient on a continual basis and also used as a guideline for the turning process. This procedure would help to minimalize discomfort and anxiety related to the turning process, especially in incomplete patients who are experiencing compression related pain, such as an individual who experiences a light touch as a 'hammer blow,' for instance.

In addition to the aforementioned findings, the study also provided some support for the assumption that the cord injured individual experiences a natural **regression** as a result of the trauma.

Regression appeared in both B and C's experience, but not explicitly in A's. C stated that he did a rewind of his entire life and childhood, which is an unmistakeable sign of regression. Although B does not explicitly state that he experienced regression, the fact that he had to be fed initially as a result of the loss of function and feeling in his hands, as well as the fact of him having to regain bowel and bladder control, suggests that he too regressed **and** progressed through a series of developmental tasks similar to those described by Pepper (1977) in CHAPTER TWO. The themes of (1) Trust versus Mistrust and (2) Autonomy versus Doubt were particularly pervasive in the experience of Subject B, who confronted and overcame these crises almost exactly as Pepper (1977) predicted. The findings of the present study complemented Pepper's model by identifying the period of intermittent catheterization, i.e. the three week mark as an important/critical developmental period, for both subjects' B and C, as it was during this period that subject B regained bladder control, which had the effect of making him believe that he could do everything, i.e. that he now had control of vital functions which he initially lost and was unsure of regaining. The three week mark was also the time at which the ability/inability to perform sexually became a concern for subject C, as he realized that it would have been problematic for him, if he had had feeling in his genitals, when they changed his catheter. The absence of regression in the relayed experience of subject A may have been mediated by unexplored contextual factors, or by the poor quality of the research relationship, i.e. by the absence of good rapport and consequently a lack of exchange of information about sensitive or intimate issues, such as sexual functioning and psycho-social redevelopment.

Anger was another reaction/theme permeating the experiences of both B and C, but not manifestly A. Subject B exhibited anger when he was exposed to examination, at which time he felt like he was being treated as an object. He also expressed anger when he was asked to perform impossible physical tasks by his brother, who, B felt, treated his disability like a joke. Thus B's anger (and negativity) was sometimes trigerred by the insensitive actions of others, which suggests that the family of spinal cord patients and other visitors, be informed of the possible adverse effects which could result from the asking of intrusive questions about the patient's physical abilities/inabilities. Spinal cord patients are painfully aware of their disabilities, in the most literal sense of the word and therefore do not need to be reminded of them at every turn by individuals who are simply curious, or ignorant of this fact.

In addition to the aforementioned reactions and themes, the study also identified a number of other phenomena, some of which were unaccounted for by the more traditional approaches. These included the (incomplete) phenomenon of **return,** in addition to the themes of **imprisonment, independence, the enhancement of perspective,** and **Post-Traumatic Stress Syndrome.** Each of these will now be discussed in turn, beginnining with the theme of **imprisonment.**

The theme of imprisonment was one aspect of the SCI experience which is of significance if we wish to understand the meaning of the experience for subject C. C stated that he was struck initially by the inherent similarities between his SCI experience and his experience of being an activist in detention. In both places C experienced a loss of control, in addition to others deciding when he slept, if he ate, and to a certain extent, when he got out. This suggests that the SCI experience contains aspects reminiscent of imprisonment, which is of possible significance for our understanding of how some patients may psychologically structure the experience, and interpret the interpersonal dynamics of control inherent in the institutional culture of the unit itself, i.e. a culture which is inextricably embedded in the South African social and cultural context (of control). As some patients experience immense pain and feelings of entrapment as a result of the trauma, they may feel tortured by this pain, which, in turn may reactivate memories of imprisonment. This is one background/contextual issue which the rehabilitation staff need to become sensitive to, in order to comprehend precisely what some individuals may be experiencing as 'patients' in a controlled institutional setting.

The next theme to be discussed is that of **independence**, i.e. the ability to exert control over one's own destiny. This was another theme experienced by both B and C, but not A. C displayed his independence by taking the initiative regarding the turning procedure, i.e. by counting for the turning team, by taking responsibility for his own medication and also by halting some rigid and discomforting routine hospital procedures; while B exerted his independence by making his true feelings known to his visitors concerning the effects/affects of their actions upon him, and also by his reliance, trust and belief in himself concerning his ability to walk and urinate without the aid/impediment of a catheter. C's innovation regarding the turning procedure has possible therapeutic implications. As the act of C's counting for himself undoubtedly increased his level of autonomy, it is perhaps a procedure which the rehabilitation team might utilize in future with other individuals who are disturbed by the 'unrelaxed' counting of the staff, or who are showing signs of passivity, or overdependent and/or submissive behaviour. As independence from, and not compliance with, externally imposed routines, improves problem solving and fosters coping skills, Trieschmann (1985) has argued that independent acts should be encouraged and not supressed in patients with spinal cord injuries.

The **enhancement of perspective,** was another idiosyncratic feature of the SCI experience which appeared in the case of only one individual, i.e. subject B. B stated that he learnt numerous things as a result of his experience with the trauma, which helped him to realize and come to terms with his inherent fallibility, vulnerability and mortality. Subject C also showed signs of recognizing the growth promoting potential of the trauma by using his time in the hospital to build his relationships. This provides support for the argument that SCI is a mechanism of psychological growth for some individuals and that some patients may, as a consequence, view the trauma as positive on the whole. This view is consistent with some of the individual descriptions of SCI found in Corbett's (1980)

book, Options: Spinal cord injury and the future, in which some cord injured individuals express the view (held by subject B) that the experience of SCI enhanced their perspective on things, by providing certain insights which could not have been realized through any other means.
The next finding to be discussed is the phenomenon of **return**, i.e. a phenomenon which appeared most strikingly in the experience of subject B.
Whereas individuals with complete SCI usually experience a sudden and **permanent loss** of sensation and mobility in the region(s) below the level of severance (the example of subject A), some incomplete patients (the example of subject B) experience a sudden, yet **temporary loss** of feeling and mobility below the point of compression/damage accompanied by an incremental process of **return**, i.e. a return of function and feeling in the body, which in itself provides the individual with a source of hope and strength. This is one contextual aspect of the trauma which is completely absent from the existential horizon of patients in the complete category, who must face, with painful and deepening awareness, a life of permanent and irreversible disability. The type and nature of cord transection is therefore one determinant of the physiological and psychological adjustment pattern of the cord injured patient, as it is this factor which determines more than any other, which existential issues the cord injured

individual must face as a result of the trauma. Subject B for example, stated that he initially experienced great difficulty with the idea of never walking again, i.e. a problem which remained a "struggle" for him until his left leg "came back." After the return of his left side however, B felt stronger every day until he **knew** that he would walk again, at which time the problem of not walking gave way to the problem of bowel and bladder control and sexual functioning. Following B's success at urinating on his own, this function also ceased to be a problem for him, at which time B felt like he had **everything under control.** For subject A however, the problem of not walking persisted. She was unable to accept the permanency of her disability and she remained depressed. As the process of return did not occur in A, she had no concrete physiological source from which to proceed with recovery and hence had to either face, or repress the issue which B eventually avoided facing altogether, i.e. B did not have to face the **fact** of never walking again, whereas A's successful adaptation demanded that she come to terms with this particular fact of **irreversibility,** first and foremost, in order to move towards adjustment/rehabilitation at all. The psychological difference between incomplete and complete SCI then, is, in some cases as large as the difference between recovery and rehabilitation, i.e. it is a matter of difference in degree of possibility, in the strictest, physiological sense of the word, which cannot but profoundly impact on the cord injured individual's mind. Subject B's experience in particular demonstrates how crucial the phenomenon of return was for him, as without it, he may have "struggled" much more and possibly not have been able to view his experience in such a positive light. Subject C was also significantly affected by the incompleteness of his lesion, as he explicitly stated that he was the luckiest person in the ward, physically speaking, which gave him the motivation to actively participate in, and take responsibility for his own rehabilitation. Thus the extent of damage to C's cord i.e. the incompleteness of his lesion proved to be a significant existential baseline factor for him as well. This finding is important, because it suggests that there are good reasons for believing that significant differences exist between the psycho-physical experiences of patients in the complete and incomplete categories and that, as a consequence, a clearer distinction needs to be made in the literature between these two groups if we are to further enhance our understanding of the idiographic/nomothetic tension inherent in this particular type of trauma. This is not to say that there are no similarities between the psychological experiences of SCI patients in the complete and incomplete groups, for the study has clearly demonstrated that there are, but rather, that important differences exist which need to be taken into consideration if we are to adequately comprehend the complexity and true nature of the experience.

The final idiosyncratic reaction to be discussed is the appearence of Post-Traumatic Stress syndrome in the experience of subject A. Holmes (1991) has stated that the major symptom of Post-Traumatic Stress Syndrome is the reexperiencing of the traumatic event. This is clearly evident by subject A's description of what happens to her whenever she sees a fight outside or hears a door slam, i.e. she thinks of the shooting "and then it happens again." This particular aspect of A's experience may have been mediated by unexplored contextual factors, such as her pre-traumatic history, and also raises some important questions about the type of rehabilitation model appropriate for the treatment of spinal cord patients. As rehabilitation is the process of learning to live with one's disability in one's own environment, Trieschmann, (1986) has argued that it is a dynamic process which begins at the moment of injury and continues for the remainder of the disabled individual's life (Trieschmann, 1986). Health care professionals therefore need to understand the principles of learning and the multiplicity of factors involved in the process of adjustment to disability, in order to integrate this understanding into a holistic rehabilitation program for spinal cord patients (Trieschmann, 1986). Unfortunately, the operational policies and procedures of most hospitals and spinal units have been designed to dispense units of organic treatment. The individual is viewed as a patient, and the staff delivers treatments, usually according to a schedule and sequence which has been designed by the staff for the convenience of the staff (Trieschmann, 1986). This is essentialy what has become known as the medical model of rehabilitation. According to this view, the adjustment of the spinal injured person is contingent upon treatments dispensed to organic variables such as the skin, the bladder and bowels, paralysis, lack of sensation and respiratory function, unless hindered by underlying personality problems such as lack of motivation, depression, low self-esteem, anger, anxiety, frustration and dependency, in which case, units of treatment are dispensed to these variables in the form of counseling and psychotherapy. Trieschmann (1986) has argued that this is not an optimal environment in which to teach new behaviours to persons who are not sick and who are essentially students (Bloch and Basbaum, 1986, p. 304). In contrast to the medical model is the educational/learning model of rehabilitation. According to this model, adjustment is a function of the interaction of person variables, organic variables and environmental variables. Person variables include habits, locus of control, method of coping with stress, preferences, rewards, self image and creativity. Organic variables include level (and type) of injury, age, medical complications, strength and endurance; while environmental variables include hospital milieu, stigma value of the disability, family and interpersonal support, financial security, cultural influences, access to medical care, recreational and educational opportunities, architectural barriers and transportation (Trieschmann, in Bloch and Basbaum, 1986, pp. 304-305). The experience of subject A in particular, raises serious questions about the appropriateness of the medical model of rehabilitation for the care of spinal cord patients, even during the acute care phase. As it is crucial to tackle serious impediments to adjustment, of whatever nature, as early as possible, it seems improbable that the medical model is capable of doing so, especially when one considers the fact that the medical model only deals with psychological disturbances, once they have already significantly exerted themselves, often maladaptively, upon the overall course of adjustment. With this idea in mind, one may now return to chapter one to see if the study succeeded in attaining its goals.

5.2.1 Evaluating the study

It should be apparent that the study was successful in meeting both it's primary and secondary goals, which were the generation of a (complex and meaningful) phenomenologically sensitive account of the acute phase of TSCI and the articulation of a hermeneutic mode of research. This interpretation is borne out by the study's findings, which shed some light on the impact of the numerous social, subjective, contextual and idiosyncratic elements which serve to direct and shape the experience of spinal cord trauma for the individual concerned. In addition to this, the study identified numerous practical problems, such as the pain some patients experienced with regard to the turning procedure, and phenomena such as the phenomenon of **return**, which were unnacounted for by the more traditional approaches. This provides further support/justification for the statement that the study met it's goals, as the aforementiomed discoveries and elaborations would not have been possible, if the method of analysis had been less historiological in character. It is also clear from some of the similarities inherent in the findings, that both the natural scientific and the hermeneutic approach attain crucial scientific knowledge. These two approaches are therefore not in opposition to one another, but augmentative and complementary (Du Preez, 1985). The natural scientific approach has proven to be useful for two primary reasons: (1) because it is capable of systematizing knowledge through the processing of large amounts of information (Du Preez, 1985) and (2) because it has been successful in explaining the functions of many of the psychological reactions to TSCI, without which, we would lack crucial aspects of knowledge about the nature of the experience. The hermeneutic approach is also useful for two main reasons: (1) because it is capable of effectively exploring the idiographic/nomothetic tension inherent in complex human experiences (as the present study has shown) and (2) because it assists us to understand these experiences in their appropriate contexts, i.e. in holistic, meaningful and novel ways, which are of both practical and theoretical significance. This said, one may now turn to an evaluation of the methodology of hermeneutics and thereby to a more critical appraisal of the present investigation.

5.2.2 Evaluating the methodology

The argument has already been made in chapter three of this thesis that interpretive accounts cannot be evaluated on the basis of a traditional validation procedure of the type favoured by empirical-analytical science, but may instead be evaluated on the basis of the criteria for evaluating interpretive accounts (outlined in chapter three, section 3.4). As a discussion of these criteria will go some way towards answering the question of validity regarding the findings of the present study, these criteria will now be considered in turn: Regarding the first criterion, i.e. that of coherence/plausibility, the study has demonstrated that it is both coherent and plausibile, as an answer to the problem of the acute phase has been provided in the form of a complex and meaningful interpretive account of it, which effectively illuminates the idiographic/nomothetic tension inherent in this particular type of trauma. Regarding the second criterion, i.e. the account's relationship to external evidence, the study should be found to be convincing, as the findings are consistent with much of the existing literature on the topic. Regarding the last two criteria, i.e. agreement/consensus and relationship to future events, it should be remembered that agreement is no guarantor of correctness, as further material may show an interpretation to be false, or future interpretations may proceed from incommensurable perspectives. Also, it remains to be seen whether the account is sensible and communicable in a manner which allows others to interpret the material in a similar light, as the study's relationship to future events will be contingent upon how it is viewed, interpreted and acted upon by members of the scientific and rehabilitative communities.

The study nevertheless did contain a number of shortcomings which I will make brief mention of here. Firstly, regarding the interviewing process itself, I experienced difficulty both in formulating the question to be asked, and also, in remaining focused upon it, once the discussion got under way. This problem would perhaps not have existed if I had spent more time explaining the purpose of the study to the participants, and also if I had given them more time to prepare and reflect on their experiences instead of just 'jumping' in and asking them to describe everything that happened to them. This was particularly the case with subject A, who did not disclose her experiences to the extent that I would have liked. This was a result of the poor quality of the research relationship, and is possibly something that could have been avoided if I had disclosed more about my own experience and my reasons for conducting the study, prior to our interview. The value of self disclosure, was aptly demonstrated by the visibly deeper level of discussion which I enjoyed with subjects B and C, with whom I was able to strike up an immediate bond. It is therefore likely that my rapport with A was adversely affected by the fact that I was a male researcher, asking a young female in an extremely vulnerable state to tell me about her intimate experiences. This is one ethical issue which needs to be considered and acted upon, as the type of questions one asks may adversely affect the individual concerned as well as the quality of the research relationship. In some cases therefore, the interviews should perhaps be preceeded by, and followed up with, therapeutic discussion sessions (Du Preez, 1985). Another difficulty I encountered was with the lack of privacy in the ward and with the constant noises and interruptions which characterize hospital life. Thus the physical interview context itself should be taken into consideration when speaking to individuals in a hospital, or any other, controlled setting. Furthermore, it would be interesting to see how the subjects' perspectives of the trauma change over time. Subject C's view of the acute phase, for instance, might have been radically different if I had interviewed him immediately following the onset of the trauma. Also, it might have proven useful if I had gleaned more information about the subjects' behaviour from sources outside of the subjects themselves, i.e. from the nurses, doctors, family members and visitors with whom the subjects interacted. This may have had the effect of contextually 'rounding out' the interpretation in a more complete manner. Another shortcoming of the study was the lack of a historical perspective regarding the subjects' pre-traumatic experiences. This was an unexplored contextual/mediating factor which, if included in the research design, may have shed some more light on the idiosyncratic reactions experienced by the subjects. This problem may perhaps be rectified in future by including questions in the research design which are aimed specifically at gaining insight into the individual's pre-traumatic history, i.e. for instance, the asking of the question: "can you describe what your life was like before the accident?"

Regarding the interpretive procedure/data analysis, it might have proven useful if I had gone back to the respondents for further clarification on certain issues, such as regarding the respective roles played by humour and 'running lucid thoughts' for subject C. As the analysis was extremely time consuming however, this step was not included. It would not, in any event, have 'validated' the study in the traditional scientific sense of the word, as there will always be a surplus of meaning inherent in complex human experiences (Ricouer, 1976), and because the respondents' views will always remain open to further interpretation. As the subjects' experiences have been textually 'fixed' however, the reader is invited and encouraged to go back to the original interview narratives to explore the additional possibilities for interpretation inherent in them. This is one advantage of the hermeneutic approach, i.e. that it is able to render dynamic, as opposed to static, interpretations of phenomena, in ways which facilitate alterations in our understanding of them.

5.2.3 Suggestions for further research

Firstly, the finding that significant differences exist between the psycho-physical experiences of patients in the complete and incomplete categories, suggests that further research endeavours be initiated in order to provide us with a more concise illumination and understanding of the significance of the phenomenon of **return**, for patients in the incomplete category. Secondly, the numerous compensatory mechanisms for dealing with the trauma, such as humour, need to be explored and analyzed further, in order to enhance our understanding of their function and significance for the overall course of psychological adjustment. The role played by dreams, for instance, might also be investigated in this regard.

5.3 Concluding Summary

As explanation is contingent upon discourse, and discourse contingent upon language, which is inherently metaphorical, scientific inquiry is in **need** of interpretation. This is the case whether we are speaking of Traumatic Spinal Cord Injury or any other complex human experience. As interpretive inquiry illuminates the contextual and meaningful nature of knowledge, it shows complex human phenomena explicitly, sometimes for the very first time. This is in essence the main contribution of the hermeneutic approach to the field of scientific inquiry, i.e. that it allows phenomena to be shown in novel and meaningful ways which enhance our understanding of their complexity. This is also another contribution of the present study, i.e. that it demonstrated, through an analysis of the experience of the acute phase of TSCI, that complex human phenomena are totalities in themselves, which cannot be artificially compartmentalized and meaningfully understood at the same time.

APPENDIX A

Interview Narrative

Subject A

A: (in a very soft, shy voice) I was at the community hall, and there was a fight outside and I heard shots and I ran, and then I felt myself being hit.

R: And then what happened?

A: I just felt myself go down and then I felt like an electric shock in my back and I couldn't feel my legs and then I was on the ground and there was blood, and I realized I'd been shot . . . (A's eyes start to well up with tears and her voice becomes almost inaudible at this point), I tried to move my legs, but I couldn't. I was all alone, I was scared, and then someone called an ambulance and they put me into it. Then they took me to the hospital and put pipes in me, here and here, and the pain was terrible. I was all alone and then they operated on me.

R: What was the pain like. Can you tell me?

A: It hurt where the bullet went in, in my back, and it felt swollen there.

R: Do you remember what you were thinking, before they operated on you?

A: I was scared. I didn't know if I would be able to wake up again. I was worried for my life and I was scared.

R: Can you tell me what happened next.

A: They brought me to the hospital and stuck all these tubes in me, and they told me that I wasn't going to walk.

R: And what did you think when they told you that?

A: I couldn't believe it. I wanted to walk. I want to . . . (A begins to cry at this point and I decide to shut off the tape recorder. I feel like I am intruding on her and I tell her that I'll understand if she doesn't want to talk about it anymore. She is obviously experiencing great emotional turmoil and pain). After a few minutes A says that it's O.K. if we go on.

R: Can you tell me how long you were in bed for before you got into the chair?

A: For six weeks.

R: Can you describe some things that occured to you in that time, like what you were feeling or thinking?

A: I was depressed, very depressed. I would think about what happened and I would start to cry, but coming here, it helped, it helped me to be with these other people. Then I realized that I wasn't the only one.

R: You mean the other patients?

A: Yes.

R: O.K. A?

A: Yes?

R: Can you tell me a little bit more about what you did while you were lying here?

A: The teacher would come everyday, and I do schoolwork. I'm in standard nine.

R: Do you do anything else?

A: I just think, I think a lot. I think about what happened.

R: Do you have visitors?

A: Yes.

R: Does it help to have visitors?

A: I don't know. Because when they ask me what happened, I just start to cry, you know sometimes, when somebody slams the door, I think that it's a shot and then it happens again, and sometimes when I'm outside and I see somebody fighting I think of the shooting, that it's going to happen again.

(A begins to cry again and I feel like we should discontinue our discussion. The trauma is obviously very fresh in her mind and her pain at being asked these questions is obvious. I turn off the recorder and assume a counselling role. After talking for a while about people who have lived and thrived with spinal cord injuries we are interrupted by a nurse who tells A that it's time for her to go to physio. Our interview ends at this point).

APPENDIX B

Interview Narrative

Subject B

B: Just after the accident, I was lying in the veld, and I couldn't feel anything from my neck downwards. My legs, I tried to lift my legs, and I couldn't do that. I asked them, the one person, "where's my left arm?" and she says "It's right next to you." But I can't feel anything. And then they brought me to the hospital. It was about four a clock in the afternoon. They sent me for X-Rays. The first time, doctor said no, they can't see properly but there is something wrong with my neck. So they took me for a scan. Alright, they gave me some injections, and I was far away. I can't remember everything properly. It was about twelve a clock at night. Dr. De Klerk already put on this ring (halo/traction device) on my head. My wife was standing next to me and Dr. De Klerk said to her, "sorry, your husband's neck is broken. Never in his life will he use his hands or legs." But still I couldn't believe it. But I couldn't do anything. This is still the first night. I just talked to myself and said I can't believe it. I closed my eyes and prayed and honestly I wake up the next morning. I was lying there. It was about 2 o clock and I feel something. But I can't say where it is. I thought like it was somebody else.

R: You're talking about your legs now?

B: Ja. I can't believe that it's my own legs, but the life is coming back, after the doctor told my wife that I'll never use my hands again.

R: And what did you think then after you started feeling?

B: I thought, I'm mad. It must be somebody else. Something is going on but I don't know what. It felt like when you touch someone with a needle lightly. Something like that. So I was lying there and my wife came to visit me. And I told her about this story and she took my leg and asked me if I could feel something, and I said YES. You are touching my leg. And then I realized for the first time, that the life is coming back, you know, and it was going on like that, the feeling in my right arm, and then my right leg started coming back, and my left side, for the first three or four weeks, I couldn't feel it, I couldn't do anything with it and the right arm was, you know, the same story, needles, pins and needles, and then, all of a sudden I tried to move my wrist, and it moves. O.K. so during that time, I was still praying, and thanking the lord for what he'd given back to me, till that stage, and one morning I woke up again and bent my toes on my right leg, and as I do it on my right leg, I feel on my left leg, that there's something going on there as well. And then I try harder and harder and harder and realize that my left leg is coming back.

R: And up until then, up until the left leg came back, what did you think about walking. Did you think you would walk again?

B: That was, I struggled with that. I can't see myself walking with only one leg and one arm, but when the left leg came back, I thought I will walk, and before that, I just tried to stay positive, and I prayed. I couldn't see myself with one arm and one leg, just sitting in a chair all day. But when the feeling came back in my leg, I could feel, but I couldn't move it, Louise, the physio, she helped me. It took time, and everyday I did physio, went to the gym.

R: Oh, so you've been going up there already? Is this the second time you've been in traction then? Because usually you do physio in bed until they remove the ring.

B: Ja, but this is the second ring, and Louise, the physio, took me up with the bed. The first ring, I had an abcess, so they had to take it off.

R: And what was that like?

B: (Lets out a long whistle). To take it off was painful. I'll tell you something my friend. The bone in your head, you can feel the screws going in, I was just, I made my fist like this, and I was biting my teeth, and I said, Doctor, please you're hurting me and I was sweating, you won't believe it, and I kept thinking just stay strong, stay strong as he screws it in the bone. Really, really it was painful. If he comes in now and says he's going to put on another one, I won't let him do it.

R: Did you have pain any other time?

B: My neck was painful, when they brought me in. It was swollen. Then afterwards, the pain ran down my shoulders to the upper arms. Till now, if you press your finger on my arm and shoulders it's sore, it's like you're pinching me.

R: And does it last a long time, or just a second or two?

B: It lasts only for a little bit. In the beginning, when they turned me, it was like someone was trying to pull off my arms, like a wild thing trying to pull you apart. And I kept telling them, please, it's very sore. So they told the Doctor and he sent me for x-rays and they found that the ligament in my wrist was torn. And then, just before visiting time, after about the fourth week, I was in the gym doing exercises, and I feel something in my left hand, and I just pick it up like this, and then later the Doctor told me that they're gonna do an operation.

R: What did he say? Are they gonna cut out a piece of your hip?

B: Ja, he said they gonna open my hip, and chip out the bone there and stick it in my neck. How did you know?

R: Well it happened to me. I had the same thing.

B: Ja? Where was yours?

R: Mine was C5-C6. You'll lose some feeling in your hip because they have to cut through nerves to chip out the bone, but the fusion makes your bone stronger and it will protect your cord.

B: That's what the doctor said.

R: B?

B: Yes?

R: Can you tell me something more about what you've been thinking about while you've been lying here?

B: On this stage?

R: Yes.

B: Well on this stage, R, the first thing is, like this morning, they came to take my measurements for that jacket. I was told they gonna put on that jacket and I'm gonna sit up straight, for a week or two, maximum, and I'm positive, R, I'm sure I'm gonna do it. I will walk, not the same as before, for sure, but I will walk and there's nothing that's gonna put me back.

R: Looking back on this experience now B, seven weeks afterwards, how has it been?

B: Well R, I would say that it's been about 90 percent positive, and about 10 percent negative, and the ten percent negative you can say it's me, myself. Sometimes you get down, you know, you feel down, but oh no, when someone's trying to fool me, I don't know for what reason they do it. You know I'm just lying on my back here, I'm just spending time. For what I don't know. At one stage I thought they were just using me for the students.

R: What do you mean?

B: I mean there was once a professor who asked me if I minded if he brings in some students, some final year students, because he wants them to do examinations, because my injury, on the x-ray, you can't believe that this person hasn't got more damage.

R: So you thought that they wanted to keep you here for things like that?

B: Ja well, (laughs). In the beginning I was laughing about it, I thought to myself, I thought I was a special person, everybody's coming to you, to see this, and see this, but later on that feeling starts getting negative, and I didn't like it anymore, you know, everybody asks you questions, they tell you to pick up your leg, they ask you hundreds of questions about your body.

R: And what did that make you feel like?

B: Like there's something wrong, like they can't believe what they see, and I was busy playing with them, like if they'd ask me a question, I'd give them the wrong answer. That was, later, that I don't like it anymore. That was the negative part.

R: And the positive part?

B: Believing and trust. I believe in myself, I will walk. And what makes me that positive is that I can feel myself getting stronger, I can feel more power in my leg. It's not someone else telling me, I know it. The only thing

I can't do now, is move this wrist. I can feel it, but no movement. You know, Louise was telling me one day, now B, she shows me, and she says, now try to do this, and I was trying. You know I felt stupid, honestly, like I can't understand what she wants, but I know what she wants, I just can't do it. But the following day, just all of a sudden, I could do it, just like that. You know, this hand, you can put something in it and I won't look, and you can put it in my hand, and as I close my hand I can't tell you what it is. And this leg, my upper leg, if you pinch it, pinch it as hard as you can, it's not painful, it's like someone's tickling you. One day, I was at physio, I'm doing exercises with this leg, and I'll just lie there and laugh, you know I feel stupid, but it's tickling, and the other leg is normal, and the right leg is still stupid.

R: Can you tell me a bit about what it's like to be here at night? I mean what goes on? What do you do?

B: Well, at two a clock in the morning they wake you up and turn you. They turn you every few hours, and then at ten o'clock at night they give you your sleeping pills, but as I'm lying here, like after lunch, you know what can you do? I can't pick up a book properly and read, I'm just lying here and I'm going mad from counting all these holes in the roof. I've counted all these holes in this block.

R: And what else?

B: Well, I'm trying to do something about my weak points as well, to exercise them. Like this morning, for the first time, I can move this arm in this direction, towards you, I couldn't do it before. You know, I can't believe that I'm still winning. That's why I was telling the people, give me two weeks, I will stand on my feet and I will walk.

R: Can you tell me, you've had the catheter in from the beginning right?

B: I have it in for three weeks, then they take it out, and they test me, they test if I can do it myself. And at that stage it was very difficult. I can't even move my hands properly, I struggled with everything down here (gestures to the genital area). I wasn't sure where I was watering. I couldn't feel it if it was in the bed, or in the bottle, because my hands were stupid. After they took it out, it was only two times, in those three days, that I was able to get it right to water myself.

R: And how did that feel? Being able to do it yourself?

B: Beautiful, like I was winning. I can do it, I've got control of everything

R: Can you tell me a bit about your visitors, you know the people who come to see you, what is it like for you when they come here?

B: Well, R, you know they ask you a lot of questions.

They can't understand what it's like. You and me, we know what it's like because we've been through it, they haven't. They have no idea. They can't understand. Like sometimes, they're laughing about stupid things, like my twin brother, he's a joke on his own. He tells me, try and touch your left ear with your right hand over your head. Stupid things like that. You know, a normal person can do it, but, for me here, it's impossible, my wrist just falls down, and he's laughing, for him it's just a stupid movement. They can't understand it's not a joke.

R: And the nurses and doctors?

B: No, they are very, very good. I can't for one second say that they don't know what's going on.

R: Can you tell me a little bit more about what you've been thinking about while lying here?

B: I think about a lot of things. Things I want to do on the plot, things that I could have done, like building (hokke) pens for the animals. And I think about simple things. One thing I used to think about a lot was when I was seven years old. I lost my gun, my playing gun. I was playing outside with it, and my father was there and there were stacks of wood. And I hung my revolver there, and lost it, and for three weeks, I couldn't find my playing gun, and I thought to myself, what would I have done then, if I knew, that at a later stage, at the age of thirty-three, that I would break my neck. Stupid things like that. And sometimes I'm thinking about my wife and my kids, my work. I was a subcontractor, doing heavy work. You know, my father, he had the same injury as me, also C3 and C4, but he had a shooting accident. His left arm, he lost nearly 80 percent of its use. But my accident was a motor car accident. It was so quick, you can't believe it. Still now, I can't believe that it happened, stupid thing, front wheel burst, I was a passenger, my friend was driving, and why he done it I don't know, you don't hit the brakes. The bakkie rolled about four times. I flew out of his window. I can't believe it. It's a stupid thing. The first thing I saw was his legs and he hit brakes and I told him, DON'T HIT BRAKES. When I close my eyes I still see it. You know, right in the beginning, I don't remember much, I was very deurmekaar (confused), feeling very stupid. I don't remember it, but the nurses told me that when the doctor asked me, "how are you feeling?" I said "with my hands" and the sisters, they still laugh about it. I can't remember that stage. You know another thing, my wife comes everyday, she comes to visit me and she tells me about the plot, what's going on there, and she sends regards from my sons, and she tells me about the plot, and I'll think about something else and tomorrow night I'll ask her a question and she'll look at me and say, "but I told you about that last night." I listen, but small things like that I can't remember, and it bothers me, because my wife, you know, it's, she's a part of me. Maybe I got a bump on the head, sometimes I feel stupid. But I think it will go away, I just think that. My biggest enemy in life, I wouldn't wish this on him. I don't know why it happened to me, but it happened, for what reason I don't know. Maybe I'm wrong, but I never thought it would happen to me. I worked in the fire brigade for five years. There were lots of car accidents. I used to dive off cliffs into the sea. I never got hurt. I once fell through the roof of a building when I was a fireman and I got up and walked. Now I know that I could have broken my neck. I never, never thought it would happen to me, but it shows you, it just shows you that it can happen to me, it can happen to you, it can happen to anyone. Never say that that or that will never happen to you. That's the biggest thing I've learnt out of this story, and I've got a big shock out of it. And I thought, can't people think about it, because they can avoid it. I learnt that you are a person like everybody else, you're not God's gift to earth. You are not invincible. You are not a piece of machinery or steel that can't break. I know, I learnt it here.

You know, the first week, a lot of family came to see me, and they can't believe that it happened, that it happened to me. When they first came here, they started to cry, and it made me negative, like I'm going down, and I don't like it, so after that I told the family, it happened to me, there's nothing we can do about it. I'm not dead, it's a big thing that happened to me, but don't cry, when you see me lying here, because it hurts me inside.

APPENDIX C

Interview Narrative

Subject C

C: Initially, they told me that I was never going to walk again. The first time around, I didn't actually connect with this, the second time around, I demanded a second opinion and basically, the person I requested to be called in for the second opinion said the same thing. The amount of trauma and swelling around the spinal cord even though it was only damaged, had just blocked all contact. At that time, anything below L1 had no feeling and there was excruciating pain from the break itself.

R: And what was that pain like?

C: Well, I've never had such constant pain, and such drastic pain for so long. That qualifies me to have a baby, no question about it. I have the distinction of being the loudest male they ever had at that place. The other thing that was problematic was, that they put me on Pethadene.

R: And what was that like?

C: The worst trip I've had in my life. Not that I've had anything to do with drugs, but it's a very rare side effect, and the only person who picked it up was a friend of mine who's a very hot shot pharmacist, and a very rare side effect is that you get extreme paranoia.

R: Can you describe it? Can you give me an example?

C: The worst was that I, I mean a lot of stuff I don't actually recall myself. The worst though was this sensation of running down your brain, running thoughts, in the same way as when you're running down a hill and you can't stop, you can't switch them off. All I remember was that anything I started to think about, or tried to consider, it exposed them, with speed, and it was like this total sense of no control.

R: So these thoughts were not lucid?

C: No, that was lucid. High speed delivery. It wasn't just like you were dwelling on something, it was like, one fact two fact three fact, go! go! go! The overwhelming impression was fear, pure fear of being that out of control. Then I'd be like trying to introduce people, and I'd shift from lucid to completely loopy, like oh, I can't introduce you to these people, because they've turned into a snake, or there was this very funny thing, this nurse was working nightshift and I checked her little badges and it was very odd, I checked one badge and it was a little french loaf (laughs). At one time I was told that I declared that somebody was spying on me and walking around my bed with little chinese feet and then I said that it was my mother and then my sister just packed up laughing because she couldn't handle it anymore and went over to call my father to see if he could make any sense of it, and then I saw this nurse walk past and I yelled at her "come here!" and

I said to her, "do you realize that I have wasted my entire professional life," I said "that I could be making a fortune as a comedian," and then these highly serious people just packed up laughing.

The rest of it, you know I was described as being extremely up and coming, I like, I ran the hospital, I organized it. Throughout my stay in hospital I had the place cased. Even the turning, every two hours and every four hours, first they would tell you to relax and then they would count and shout ONE TWO THREE! It's like the idea of how you get a kid to jump off a cupboard, you know, ONE TWO THREE! it's a highly unrelaxing noise. And then, there was a young nursing assistant named X, and one day she came along with some people, like of her own rank and in a very calm voice she said, just try and relax, breathe, O.K. one, two, three, turn, and this was like the best turn going, not ONE TWO THREE! The next time she arrived, there were a whole lot of other nurses around, four who outranked her, and they arrived at my bed, and I said listen, I'd like to discuss something before we start this, I want X to do the counting. X says NO! And they all say ugh, you're just being difficult again, and I said, if X doesn't count, I scream, take your choice.

R: Can you tell me a little about your relationship with the other patients, I mean what was it like?

C: It was quite difficult, because quite a lot of them were Afrikaans and they were racist to the core, and also, I was the most physically lucky guy in that ward, just about all of the time.

R: Can you tell me a little more about the racist thing?

C: Well, the fact that they would actually exhibit their racism to black nurses who had them absolutely helpless, blew me away. I thought, are you okes crazy or what. One night, there was some comment about this woman, about Y, a black woman being appointed the head of the SABC, and they were saying that this was a real fuck up, and what's going to happen, and so on, and it was then that I said, well actually, what do you think is going to happen because of this, and it was then that they actually twigged, Uh Oh . . .

R: We have a links, liberaal creature in our midst?

C: Yes, but not only that, but also, more interestingly, that the old flag was taken down.

R: You mean metaphorically?

C: Yes, that the old system was gone, that they are actually oddballs these days. So it was quite hard, because there weren't too many people I could relate to, among the other patients.

R: Where would you say that most of your support came from?

C: My parents. My parents came up from P.E. and they were staying in a convent nearby, and they would come and see me everyday, between three o'clock and five o'clock, and I would say that it built our relationship. You know, one is able to spend time, and two, when things are that intense, you either deal with what's going down, or you bury it. And my folks are really amazing people, they learn from their kids. So, by the way, to add to this thing with X, you know, I eventually twigged, that I can count. I mean what do I do if X is not there, so I said, O.K. I count, and for a second they wanted to argue with me, and I said you're gonna argue and you're losing the seconds anyway. I count, I count slower than you, but I count, or else I'll scream, and they would go into this whole sort of thing like, men shouldn't scream, and other things, like there was this one time when there was something wrong with the E.C.G. machine before my second operation, and there was something wrong with the stickers, they put them on and then they pulled them off and they had this really strong view on it, and I said I'll be damned if you're pulling my chest hairs off again because it's damn sore, and she said, no man, don't be such a baby, and I said no, I'm not available, we're not debating whether I'm masculine or not, what we're debating is the state of your eardrums, I said if you do it, then I'm gonna make sure that your eardrums get as painful as my chest.

R: O.K. I think I'm seeing a pattern here. What you seem to be saying here is that there is a lot of illogicality on the part of some of the staff, regarding procedure, and you seem to have dealt with it on a logical, and rational level, by debating the merits of the procedure and, in so doing, take more responsibility for yourself? and also show to them, that you're not just a piece of meat to be shoved around?

C: Absolutely. Like I took complete responsibility for my medication, I would not take anything unless they could explain to me what it was.

R: O.K. there's another thing I'd still like to touch on, if you don't mind. The first time I spoke to you, you said that there were similarities, between your experience in detention, and your experience in the hospital, could you tell me a little more about that?

C: Well, the similarity is the complete lack of control, you don't decide when to sleep, like whether to eat, you don't decide who comes to see you. Ja, the sense that, that somebody else is in control. And also, the time. I was in detention for 5½ months and in the hospital for 5½ months, and also, there were different pros and cons as well. The fact that there wasn't any kind of malevolence, you know, a force that was keeping me there, that's a different thing to deal with. The fact that you have so much access to people, instead of half an hour a week. And another similarity was, that you have no idea when you're going to get out.

R: Before, when we first spoke, you mentioned the fact that there were some humorous moments in the hospital. Could you give me an example, something you recall?

C: There were actually lots of funny things. One of the guys, a really chauvinist Afrikaner, one night he tells us this story, you know, he's trying to deal with this crisis, so he started off saying "a pomp is a pomp, maar as jy eers getroud is, is dit 'n avontuur." You know, a fuck is a fuck until you're married and then it becomes an adventure. And he was going on about his sexploits, one of the delirious moments he had, he kept on telling his brother that the S.A.P. were looking for him and they were coming to get him, right here and now, and his brother says, like why are they coming to get you, and he says, no, it's because I fucked around too much, and then he remembers that he picked up some woman in some dorpie while he was in the army, and he was screwing her in the graveyard and the cops checked people moving in the graveyard, and he ran, all the way back to the army camp, through the town without his clothes on.

R: Can you tell me a little about your attitude to sex, you know how you felt about it, initially after the accident?

C: Initially, there was so much pain and drugs and what-not, that I didn't actually connect with the idea of sex, and then, one day, they changed my catheter, and

I realized that, shit, you know If they did this to me and I had feeling here, there would be a problem. Oh, it was quite a freakout, Ja. There were lectures by this guy from the neurology department and this guy had the most incredibly dry sense of humour, and he starts saying, I haven't come here to teach you any kinky positions, so let's just deal with a couple of facts first, the largest sexual organ in your body is your skin, and the most important sexual organ is your brain, and he made an extremely good presentation, and then went on to sex aids and what, and he also covered a couple of social-sexual issues, and I thought he was good, but also extremely male orientated. And I understood after speaking to some other patients that the women were never spoken to.

C: You know, I went into severe anxiety, before my second OP, which was three weeks after the first one. The first OP was a major OP, they sliced me from the back around the front and fused the front of the vertebra, and they had to go into my chest cavity as well as my stomach cavity, T12 to L2, to cover L1 which was smashed, and I was worried, because I'd seen someone have a fusion, and I'd seen him coming out of the operating room with his eyes popping out of his head with pain. Then the second OP, I was vomiting, I couldn't eat, I went into major anxiety. My main fear was pain. I was still involved with stuff outside, while I was totally bed ridden. I had been involved, just before my accident, trying to set up a job creation program that was operating in the townships. I recruited someone from his bed, to become one of our local directors, and we actually ended up having an AGM around my bed, which was amazing.

R: Let me just ask you something straight out. Do you think that you were in denial at any stage?

C: Yes. You know, I suddenly realized one day after coming out of a meeting, that I had a subconscious fantasy that I was very sick and that I would become completely well. If anybody had questioned me at any point, I would not have said that this is what I believe. Initially they said that I was not going to walk at all, and then I got this return and they said that I was going to walk on crutches, they said they were pretty sure that some nerves were completely dead, but that I would walk on crutches. At a very early stage it was an issue for me, but not now. And I also want so say something else, vis-a-vis being in the hospital, that one of the things that people need to be told is "welcome to an oppressed group." Let's get away from this individual tragedy model and come to terms with the fact that part of anybody's life is that they're a political animal, and that everyone has a fear and a horror of being disabled. It's like during apartheid you had these coloured people who were always trying for white. Some disabled people are still trying for white, i.e trying for able bodied, but it will never happen, they will always be part of an oppressed group. Discrimination is real, and until you deal with that fact, you will remain a stunted individual, emotionally, individually and socially. And one other thing that I'd like to say about this entire thing is that I redid my entire childhood, I had to learn to roll over, I was fed via a nose tube, I was dressed, bathed, learnt to roll over, learnt to crawl, learned to feed myself. I felt as if I redid my childhood, that I did a rewind of my whole life.

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