

Family experiences of physical trauma

By

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It really hurts and it's not going away

Bodies human
Containers restrainers
Boundaries
Too

Day in, day out
Chased goals
Human throttles
Pushed

Do this, do that
Take me here or
There
NOW

Going, going
Gone
Sleep and recharge
Repeat

Feeling good?
Haven't thought about
IT
Say most people

Silence of good health
Mirrors matters
Taken for granted

(Snyder, 2005, p. 53)

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ABSTRACT

Trauma is an event during which individuals are confronted with a threat to their own or to someone else's integrity. If intense fear, horror and helplessness are experienced during the event there may be psychological traumatising. However, individuals may experience physical trauma and require hospitalisation. The patients' subjective experiences from the hospitalisations may precipitate further trauma. Although families of patients are not involved in the traumatic event, they may experience their own traumatising. The individuals and their families experience the trauma on the biological, psychological and social levels.

Medical literature is mostly positivistic and there is little qualitative research on the experience of hospitalisation, particularly of family experiences of the intensive care unit (ICU). There is also a paucity of research on psychological experiences in the medical world. The research that has been conducted in psychology is mostly with psychiatrists.

The aim of this research is to explain the sense families make of physical trauma using narrative. Narrative is the sense individuals make of experiences across time through telling and re-telling stories. Qualitative research is most suited to explore these subjective experiences of individuals. Social constructionism is one form of qualitative research and a process exploring the world of individuals in the context of culture, history and social interaction. Individuals arrange these stories using myths, symbols and archetypes that will provide coherence to the lived experience. Languaging the experiences facilitates meaning attribution that informs behaviour.

Data was collected through photographs taken by the participants and individual interviews were conducted. The co-construction of this text occurred in the context of the researcher as a counsellor, the researcher as a previous physical trauma patient and the family perspectives of the participants. The exploration of the photographs and their sequence are followed by a narrative analysis of the interview texts using storymaps. Narratives were co-created in this context.

The participants selected the stories and created coherence by narrating and ordering the sequence of photographs. Since the family language this lived experience, the members explored various *selves* and their relationships with their worlds. The family was impacted biopsychosocially and is writing an alternate story in the discourse of the medical world that says further rehabilitation is difficult, if not impossible. They have made sense of the physical

trauma by searching for unique outcomes and narrating on a temporal framework: stories of their *self*, relationships with others, their physical self and their physical environments. This will create space for their alternate story.

Key Terms

Trauma, physical trauma, intensive care unit, medical psychology, rehabilitation, family, narrative analysis, photography, social constructionism, co-construction, storymaps

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Chapter 1

INTRODUCTION

South Africa has a high incidence of trauma that impacts the community, family and individuals. Lives and perceptions of the world are changed to accommodate and incorporate these lived experiences into their story. Narrating these stories, using symbols and myths from society, allows individuals to organise and sequence their narratives. Since individuals are in relationship with others these stories become co-constructed and lived out as the preferred realities. For some individuals meaning may be attributed to such an extent that the narrated problem-saturated stories are perpetuated by the dominant discourse of the problem found in society. Society's discourse of trauma purports that individuals experiencing traumatic events have psychological responses that cannot be overcome. Challenging this discourse requires new scripts and re-arranging and re-authoring the events of the story.

The admission of a family member to hospital requires writing and re-writing a story that has a natural beginning and ending. Events are sequenced, the context is taken into account and the trauma the family experiences watching another member admitted to hospital becomes their own trauma. This is more pronounced if the patient is in the intensive care unit (ICU), since there is a greater degree of life threat. Meaning and sense needs to be made of this experience that interrupted their lives. The admission of the family member is the story of each individual and the family narrative.

Although there has been an increase in research and literature overseas on the family and patient's experience of ICU and physical trauma, there is still a paucity of qualitative literature in the medical and psychological worlds. In South Africa, to the best of my knowledge, no psychological research has been conducted on the individual or family ICU experience and little on the rehabilitation process following physical trauma. There is little psychological knowledge to guide the therapists.

Since this is a study on family experiences I invite you, the reader, to share a family experience of mine. Each Sunday afternoon when I was in Standard 3 we would go to the Durban City Hall and attend performances by the Natal Philharmonic Orchestra. Some pieces were familiar and felt comfortable, whereas others were unknown and I needed to

listen carefully to each note and the contribution they made to the whole piece. My unfamiliarity with these compositions extended my boundaries of musical appreciation.

I journey with this family through their experience of physical trauma and extend an invitation to you, the reader, to accompany us through their symphony. This journey may initially be unfamiliar for you, but I believe listening to each note the musicians play will create a unique sound and introduce you to the narration of a family experiencing physical trauma. Initially we observe the musicians entering the stage in preparation for the performance. Each musician carries an instrument that will produce a unique sound. These instruments are trauma, the family and the family experience of physical trauma and are deconstructed and examined in Chapter 2. The programme explaining the musical pieces and the sequence for the afternoon's performance follows in Chapter 3 and details the epistemology and methodology for this study. Chapter 4 introduces the musicians of this orchestra. In this chapter participants narrate their perspectives and relationships with each instrument. The researcher is the fourth participant since the sound is co-constructed to create a new sound and the score changes key. The musicians prepare for the concert, await the conductor and play the symphony of family experiences of physical trauma in Chapter 5. Individual stories gain new meaning if the context of the experience is viewed against the backdrop of those of other family members. A coherent co-constructed story is then written. Finally the concert is over and acknowledgement given to the musicians. Chapter 6, a letter from the researcher to the participants concludes the performance.

Let us turn to Chapter 2 to observe the preparation of the stage for this afternoon's performance and the three instruments that will be played.

Chapter 2

LITERATURE REVIEW

The musicians enter on stage. Some instruments are already in position; the musicians carry others. No matter the size or shape, each instrument is important and contributes a unique sound. If played individually the instrument produces a beautiful sound. Each musician is the master of his instrument. Movement on stage continues as preparation for the performance unfolds.

2.1. Introduction

This chapter prepares the stage for the performance of family experiences of physical trauma. Three different instruments will be heard: trauma, family systems and the family experience of physical trauma. Trauma, defined as an unexpected event, impacts individuals and their communities and manifests on the biological, psychological and social levels. A traumatic event influences the whole family when a family member is admitted to hospital following physical trauma. Family members experience the trauma both individually and as a family system because they witness the experience of the patient in hospital. The system restructures to accommodate the disequilibrium caused through the physical trauma, hospitalisation and uncertainty of recovery.

2.2. Trauma

The DSM-IV-TR (American Psychiatric Association, 2000) describes a **traumatic event** as an experience in which individuals confront a threat to their own physical integrity or witness another person who has recently been, or is seriously injured or killed because of an accident or physical violence. These traumatic events are infrequent, sudden in nature, of a high intensity and unexpected. Even though the duration of trauma may vary, it is accompanied by feelings of fear, horror and helplessness (American Psychiatric Association, 2000; Leedham & Meyerowitz, 2000).

Baldwin (2006a) and Freyd, Klest, and Allard (2005) suggest the term *trauma* extend beyond only requiring exposure and survival in a life-threatening situation. Trauma may include relationships incorporating violations of trust between institutions or persons and others

involved in the relationship. This is known as betrayal trauma and this experience may result in trauma symptoms with an increased risk of psychogenic amnesia. Furthermore, Harvey (2000) argues trauma is the experience of loss, whereas Hudnall Stamm (1999) claims trauma is the “interaction between the person and the event” (p. 4).

A variety of traumatic events may be identified. Distinctions may be made between: single and multiple traumatic events, simple or complex trauma, and natural or human trauma (Giller, 2003). Single traumatic events, such as accidents, causing physical trauma are considered infrequent. Those that incorporate life threat or exposure to injury and death are described as multiple traumas. Most traumas are multiple traumas. Simple trauma is unidirectional and has an easily identifiable cause. On the other hand, trauma is complex when the intrinsic aspects of the trauma are considered: the extent of choices available during the trauma and the ambiguity of other responses to the trauma. Natural trauma or disasters, such as floods, are perceived as unavoidable and an act of God, whereas human traumas, which could include hijackings, are believed to be avoidable. Understanding cause and effect in natural disasters and human trauma is important when exploring the extent of post-traumatic adaptation (Wilson, 1989).

The effect of the traumatic event may impact three systems namely, the biological, the psychological and the social systems. At the time of trauma, **the biological system** has a response of fight or flight, which will either facilitate a coping response or allow individuals flee the threatening situation. An additional freezing response may occur. This involves cognitive distortions (Carlson & Dalenberg, 2000). These physiological responses may continue post-trauma and include aches and pains, sweating, a startle response, increase in the use of medication or alcohol, or changes in eating patterns (Levin, 2004). Giller (2003) suggests prolonged trauma may also change the physiological responses to stress as recent neurological research indicates that high cortisol levels may reduce hippocampal volume. This change in hippocampal volume may exacerbate learning, memory and concentration difficulties (Lindauer, Olff, Van Meijl, Carlier, & Gersons, 2006). In addition, sleep patterns may become disturbed. Mellman and Hipolito (2006) purport that changes in rapid eye movement (REM) sleep patterns may precipitate and maintain posttraumatic stress disorder (PTSD).

The biological system could also experience physical trauma that is defined as an injury to any part of the body (“Physical trauma”, n.d.). If there are many injuries to various parts of the body, the trauma is diagnosed as polytrauma (“Trauma”, n.d.). Furthermore, physical trauma may be differentiated as either blunt or penetrating trauma. Blunt trauma is a result of

a force exerted outside and against an individual's body by a large object, such as being hit by a truck. It frequently results in multiple system organ injuries (Fantus & Fildes, 2003). Penetrating trauma, which results in the skin being penetrated, may be caused through assault or accidents, from stab wounds or missile injuries ("Penetrating trauma", n.d.). Although the incidences of each trauma vary from country to country, in South Africa penetrating trauma is more common and frequently associated with illegal activities and in those areas with higher unemployment rates (Reed, Smith, Helmer, Lancaster, & Carman, 2003).

The second system is the **psychological system**. Psychological trauma is the subjective experience of the ability to cope with a traumatic event (Allen, 1995). If individuals feel overwhelmed emotionally, cognitively or physically by the demands of the situation, psychological traumatisation may result. This traumatisation may manifest as: shock or disbelief at the event occurring, fear or anxiety, grief, irritability, nightmares, flashbacks, social detachment, feelings of distrust and shame (Levin, 2004).

Despite individuals experiencing a traumatic event, the personal interpretation and integration of the experience determines the impact on their lives (Giller, 2003). Ursano, Fullerton, and McCaughy (1995) describe the appraisal of trauma as evaluating the meaning or significance of the experience against the backdrop of previous well-being, which Crossley (2000) believes facilitates an appreciation of life. Attributing meaning assists individuals integrate the event into their everyday lives (Ursano et al., 1995) because it is an active process and a by-product of the individual's past, present and future time frames. Harvey (2000) states meaning attribution allows hope and the belief in coping with the loss (Ursano et al., 1995). In this process, family relationships, self-actualisation, self-awareness, and personal activities gain pre-eminence. This meaning determines who takes responsibility for the trauma occurring and allows priorities to be re-evaluated.

Attributing blame, guilt and responsibility for the trauma is one outcome of meaning attribution, which may lead to a re-interpretation of life. Blame may be divided into character and behavioural self-blame. Character may be implicated in trauma where those who experienced the trauma were too trusting of others or were involved in situations that could have been avoided. For example, the cause of a severe car accident could be attributed to the red traffic light changing too quickly, whereas the driver was speeding and had insufficient time and distance to reduce speed. Attributing blame to external factors allows the belief that the world is controllable and such traumatic events may be curtailed. Behavioural self-blame occurs where individuals believe the impact of the event could be

reduced through behaviour. Society frequently identifies activities or precautions that could have been taken to avoid the traumatic event (Kleber & Brom, 1992; Peltzer & Renner, 2004). A family experiencing a robbery in their home during the day could be blamed for the event, since they left their front door open even though the security gate was locked.

Another outcome of attributing meaning is that traumatic events create a platform for the re-writing of life scripts. New identities and self-images may be re-constituted. Values and priorities may be re-organised, personalities may change and new characters formed as life is viewed from different perspectives. Trauma is frequently related to death, therefore new rules, expectations and norms are developed to cope with the pain, anxiety and the new awareness of mortality (Bloom, 1999). Lifton (1993) names this the *death imprint* that proceeds into a renewed existential and moral dimension. This new dimension may impact interpersonal as well as relationships in the community. Dalton, Elias, and Wandersman (2001) describe the community as a system of people located in a geographical area.

Other than the biological and psychological systems, trauma may impact individuals in **the social system** or the community itself (Bryant & Njenga, 2006). In individual traumatic experiences, social support is instrumental in reducing the negative effects of the trauma (Updegraaf & Taylor, 2000). Furthermore, the social context affects individual interpretations of the trauma and determines whether the individual becomes a victim or a survivor (Harvey, 2000; Wilson, 1989) because cultural expectations, rituals, social norms and attitudes facilitate acceptance and meaning attribution of the trauma (Kleber, Figley, & Gersons, 1995). Society may label and blame the individual, which influences the individual's interpretation or meaning making. These social and cultural discourses may lead to long term changes in adjustment and personality (Ursano et al., 1995) and could contribute positively to psychological growth and a more positive mood (Macais, Young, & Barreira, 2000). The individual does have the ability to transcend traumatic events and turn the negative experience into positive traumatic growth. Trauma in a community may create cohesion since the experience is shared. Natural disasters, in particular, create cohesion. Sometimes the cohesion extends beyond the immediate community and impacts the world. The Tsunami in 2004 evoked an international response addressing the physical and psychosocial needs of the communities (Silove & Zwi, 2005).

Although trauma impacts the physical, psychological and social systems, various models have been constructed to explain the response to traumatic events. Allen (1995) developed a model to explain two general responses to traumatic events: the objective and subjective responses. The objective response is external and presents a threat to the physical *being* as

either a possible injury or death. He purports that this subjective response determines the impact and interpretation of the trauma. Janoff-Bulman (1995) uses the construct of cognitive schemas to explain individual adaptations to trauma. Traumatic events shatter the schemas of the sense of *self*, the illusions of trustworthiness and the belief that the world is a safe place. Individuals are forced to face their own mortality in a malevolent world. Since these schemas accommodate the experience, intense anxiety, depression and disorientation may follow (Janoff-Bulman & Berger, 2000). Ehlers and Clarke (2000) have proposed a cognitive model in which the appraisal of the trauma and its consequences, combined with differences and fragmented autobiographical memory of the event, produce many trauma symptoms. Each of these models may contribute to an understanding of the traumatic response to the event.

The cognitive models of Janoff-Bulman (1995) and Ehlers and Clarke (2000) may be used to evaluate the impact of trauma on the trauma narrative. Disruption in the autobiographical memory of the event shows as more sensory, perceptual and emotional references in the trauma narrative. Since these sensory impressions do not offer temporal, causal or logical connections, intrusive thoughts occur in the present time frame and flashbacks are expressed in the present tense (Hellawel & Brewin, 2004). Autobiographical memories will be less coherent and connected to other narratives. Some researchers also suggest that individuals who experienced trauma show less reference to the *self*. If references to the *self* are present, these references will be mostly negative evaluations suggesting mental defeat or a loss of agency. However, O’Kearney and Perrott (2006) challenge statements that trauma narratives are fragmented. They believe operational definitions of fragmentation are limited and present research has provided insufficient findings regarding PTSD and fragmentation. They purport fragmentation should be semantically construed as “narrative cohesion (connectedness) and narrative coherence (conceptual organisation)” (O’Kearney & Perrott, 2006, p. 90). Narrative cohesion includes temporality, causal relationships and the associations between sentences. On the other hand, narrative coherence implies the interconnectedness amongst goals, activities and their consequences, themes, or the plot of the stories. They believe that this cohesion and coherence should be explored separately when researching trauma narratives.

Despite various models being constructed to explain the impact of trauma and changes in the trauma narrative, not all responses to trauma should be considered pathological. Rothbaum and Foa (1993) emphasise it is essential to distinguish between normal and pathological responses and Baldwin (2006a) emphasises trauma symptoms should initially be considered as adaptive. Recovery from the traumatic event may occur over a short period

and functioning may not be impaired. The subjective interpretation of the event determines the psychological response.

If trauma symptoms continue and cause psychological, social and work impairment in the life of individuals, a diagnosis of adjustment disorder (Appendix A) or acute stress disorder (ASD) (Appendix B) could be made within four weeks of the traumatic event. However, the pervasive, persistent and extreme symptoms of avoidance, intrusive thoughts and increased arousal extending beyond a thirty day period may suggest a diagnosis of posttraumatic stress disorder (PTSD) (Appendix C). Traumatic events that may lead to the development of PTSD were traditionally categorised as combat, criminal, sexual assault, natural disasters or human accidents (American Psychological Association, 2006).¹ However, this classification of events has been extended to include physical illness including human immunodeficiency (HIV), intensive care medicine and vascular medicine (Tedstone & Tarrier, 2003). Experiencing physical trauma during a traumatic event increases the risk of psychopathology. The DSM-IV-TR (American Psychiatric Association, 2000) notes an 8% incidence of PTSD in the United States, however, a study on the psychological impact of vehicle accidents stated that 46% of the participants had PTSD and a further 20% were experiencing subsyndromal PTSD (Bloom, 1999).

Some researchers believe the diagnosis of PTSD be extended beyond the criteria of the DSM-IV. Harvey (2000) believes the core element of PTSD is the difficulty integrating the memory of this event. Schnyder, Moergli, Trentz, Klaghofer, and Buddeberg (2001) and Mylle and Maes (2004) claim that subsyndromal PTSD be recognised formally in the DSM, as physical trauma patients may be found to meet the criteria for Criterion B (re-experiencing the trauma) plus either Criterion C (avoidance and numbing) or Criterion D (hyperarousal), but not Criteria C and D simultaneously. Spitzer, First, and Wakefield (2007) also emphasise that secondary gain and pre-existing personality disorders be identified when exploring the failure to recover from PTSD.

The **risk factors for developing PTSD** may be experienced on the biological, psychological and social levels. A genetic vulnerability may make some individuals more vulnerable if they have first-degree relatives with depression or PTSD (American Psychiatric Association, 2000). Coping strategies, intelligence quotients, negative affect or a persistent pessimistic mood, personality, preparation for the trauma and previous traumatic experiences may

¹ From here on the American Psychological Association will be referred to as the APA when cited in the text. This will distinguish it from the American Psychiatric Association, which publishes the DSM-IV.

increase the risk for PTSD. Poverty, level of violence during the event, social support, financial resources available for treatment and cultural factors may also influence the ability to cope with the trauma (American Psychiatric Association, 2000; Litz, Gray, Bryant, Adler, & Reed, 2002; Naggan, 2001; Noyes & Hoehn-Saric, 1998). Increases in the degree of life threat, the bereavement of important persons and the intensity of moral conflict also have the potential for increasing PTSD (Carlson & Dalenberg, 2000; Ursano et al., 1995; Vash, 1981).

Co-morbid psychiatric disorders, such as depression, panic disorder, agoraphobia, obsessive-compulsive disorder, phobias, eating disorders, somatisation, generalised anxiety disorder and substance abuse may manifest simultaneously with PTSD and inhibit psychiatric recovery (Allen, 1995; American Psychiatric Association, 2000; Noyes & Hoehn-Saric, 1998). Secondary symptoms may further impede psychological recovery. These include increased levels of aggression, physical illnesses, decreased self-esteem, identity confusion, guilt and shame (Levin, 2004).

The **treatment of trauma** depends on the origin of the trauma (Baldwin, 2006b). The emergency medical team treats physical trauma (Toubkin, 2000). On admission to hospital, the multidisciplinary team of specialists and nursing staff assist with the resuscitation of the patient (Bradford, 2002). Rehabilitation in cases of severe trauma may require the services of a physiotherapist, psychiatrist, psychologist, occupational therapist and industrial psychologist (Toubkin, 2000). Psychological traumatisation requires the services of a psychiatrist and psychologist. A psychiatrist may prescribe psychotropic medication including anti-psychotics, anti-depressants, benzodiazepines or anti-convulsants (Sadock & Sadock, 2003), and the psychologist will use therapy to reduce traumatisation and PTSD. The therapeutic techniques utilise the resources of the client to interpret the trauma and reduce its effect, process the peripheral events related to the trauma and process the memories of the traumatic event (Baldwin, 2006b). Counselling and debriefing immediately after the traumatic event may also assist those who experienced the trauma. During this counselling process it is essential individuals discuss the facts and the accompanying emotions so that cognitive processing combine the emotional and objective features of the event (Stephens, 2002).

A psychologist may use various **therapeutic techniques** for individual, group and community based interventions. These should be selected according to the developmental level of clients. Interventions for individuals include narrative therapy that uses appropriate cultural and historical motifs to integrate the event into individuals' identity (Crossly, 2000; Stephens, 2002). Cognitive behavioural therapy (CBT) addresses the context and cognitive

appraisal of the traumatic experience by the therapist and client (APA, 2006). However, there is growing interest in the somatic treatment approaches of trauma, such as eye movement desensitisation and reprocessing (EDMR). This helps individuals rebuild their resources and process the memories of the trauma (Baldwin, 2006b). There has been much research to determine the efficacy of each technique. Furthermore, treatment should be selected for the needs of individuals and culturally sensitive to obtain maximum benefit (Baldwin, 2006b; Bryant & Njenga, 2006; Seidler & Wagner, 2006). Treatment offered to communities who have experienced disasters may include group interventions (Baldwin, 2006b). If a community has experienced its own trauma, the community will benefit more from a combination of psychosocial and institutionalised interventions than either approach alone (Somasundaram & Van de Put, 2006).

Trauma frequently has a negative connotation, but it is possible to resolve difficulties experienced after the trauma and report the event as a positive experience. Joseph, Williams, and Yule (1997) as well as Updegraaf and Taylor (2000) comment that at least half of those individuals who experience trauma report positive change following a reinterpretation of the traumatic event. These include: changes in self-perception, social relationships, life perspective and activities. Positive traumatic growth is possible, but will depend on the coping styles used at the time of the event (Noyes & Hoehn-Saric, 1998). Coping styles are, therefore, important in facilitating adjustment to the trauma.

Malt (1995) identified three categories of **coping styles** that may be used:

- The active coping style includes problem solving and action that reduces the impact of the trauma. Psychosocial factors, such as an awareness of control during the trauma, self-confidence in the ability to cope, access to and the availability of social support reduce the negative impact of the event.
- Accepting and re-interpreting the traumatic event as a positive event implies the trauma was unavoidable and requires accommodation in the cognitive schemas. There is a conscious decision to find the positive features of the trauma.
- The avoidance coping style has the potential of reducing distress through denial or withdrawing from the situation. However, this reaction is less adaptive for long term trauma.

A new paradigm, focusing on wellness, developed in health psychology. The **salutogenic paradigm** emphasises adaptive behaviour and describes the ability of individuals adapting to a stressor, which in this study is trauma (Updegraaf & Taylor, 2000). Antonovsky (1979) called this new construct salutogenesis and incorporated constructs developed by other

theorists. These included a sense of coherence, a hardy personality, potency, stamina, learned resourcefulness, internal-external locus of control, personal causation, self-efficacy, a sense of humour and a sense of purpose. These constructs allow individuals adjust to stressors and use its existence advantageously (Strümpfer, 1990).

2.3. The family

Socio-historical discourses construct the structure and function of families in any given society (Dallos & Draper, 2003; Georgas, 2003). Family structure is defined through membership and the interwoven relationships of its members, whereas family functioning is the ability of these members to address their own needs in and through this social system (Georgas, 2003). Jones (1993) identifies the importance of evolving family rules to explain behaviour in a family. There is the socio-cultural and historical context of individuals' lives, combined with transgenerational myths, roles and patterns (Jones, 1993).

Families have their own life cycle. Various stages incorporate the changes experienced when children are born, children become independent and leave home, and members pass away. These difficult periods of transition are facilitated by the coping skills and tasks that reflect the belief system of the family. These transitions are experienced on three dimensions:

- The socio-cultural and spiritual dimension where acceptable behaviour is desired and maintained.
- The dimension of the family itself, in which family decisions are based on cultural and family discourses.
- The personal dimension where the uniqueness of each family member functioning in the system is respected (Dallos & Draper, 2003).

A longitudinal investigation of family therapy identifies three phases over the years. The first phase named systems theory or first order cybernetics, which originated during the 1940s, exhibited the influence of modernism. Identified as a circular process, self-correcting feedback maintained the systemic process. Within the system there are subsystems (Dallos & Draper, 2003). Jones (1993) explores the complexity of a system and describes it as a group of individuals who are related socially and have reached a consensus on particular matters. Members present themselves as a system, but individuality is maintained by participating in various activities. Pathologies manifesting in individuals were attributed to the context and the recursive interpersonal and repetitive patterns of interaction within the system (Dallos & Draper, 2003; Jones, 1993; Krause, 2002). Changes implemented and directed in the system will impact on all subsystems in the family. Jones (1993) states that

individuals observing the system delineate the size and structure of the family system rather than interpreting the system from a socio-cultural context. Four distinct features are found in an open system. These features include: interdependent behaviors that unite the family as a whole system; the system as a whole is greater than the sum of the parts; feedback into the system impacts the same system and equifinality is a process initiated at different starting points in the system that produces the same result irrespective of where it starts (Jones, 1993). The prime aim of the system is to maintain stability or homeostasis.

The second phase was second order cybernetics. This began as the Milan team focused on family systems co-constructing meanings and communicating these meanings on multifaceted levels (Dallos & Draper, 2003). Second order cybernetics differs from the first order, as the therapist is included as part of the system. Validating family members, hypothesising about family alliances and determining the rank of members in the family provides a rich description of the interconnectedness of family members. Space is created for the marginalised and silent voices. During therapy alternate perspectives of family dynamics and communication are constructed, and intergenerational patterns of relating are explored (Jones, 1993). Exploring communication within the system entails interpreting the act of communication and the message. Communication within a family ensures family activities occur and offers a meta-perspective on the motivations, intentions and utilisation of relationships by members in the system. Relationships and the expectations between couples may be interpreted through exploring meaning attribution, the belief system and individual assumptions (Dallos & Draper, 2003). In second order cybernetics the beliefs of individuals determine behaviour, but interpersonal patterns and predictability may still impact on relationships. Bateson (1978) states that even silence or disengaging from a relationship communicates its status and health.

While Milan therapy assumes individuals are incapable of completely controlling others, Bateson (1978) describes power relationships as either complimentary or symmetrical. Complimentary interaction is reciprocal and the protagonist evokes the opposite response. One family member striving to protect another could evoke dependent behaviour in the other family member. Symmetrical interaction mirrors the behaviour of the other family member. If a family member is competitive, the response will be mirrored by a similar competitive nature. Bateson (1978) believes each family member has an equal influence in the relationship.

Social constructionism explains the third phase of family therapy where families manifest behaviour co-constructed within the cultural and historical community in which they live. Culture creates a lens. These behaviours are found in evolving social discourses that

perpetuate power relations through institutional structures and practice. Unlike first order cybernetics, meanings are created through contexts of interpersonal and social experience. Individuals express different *selves* in a family (Krause, 2002). Mead (1934) uses the metaphor of the looking glass *self*, as the various contexts mirror a *self* to individuals. These reflections combine to create an enduring sense of *self* and occur historically, contextually and culturally. An identity is constructed.

Recursive interpersonal patterns are constructed through language and families follow previously learned responses. These responses and knowledge gained through experience are informed by the culture (Jones, 1993). Although Dallos and Draper (2003) describe language as inert, language becomes a creative force when describing the world and helps the family create a coherent story. Power relations are constructed in interpersonal family relations as well. These power relations are expressed through language, either in the ability of family members verbalising thoughts and feelings, or using specialised terminology that suggests further education. Identities within families are dynamic and a family member could be polarised when assigned an identity by other family members. This could be an identity of a sick role when injured.

Anderson and Goolishian (1988) describe families as problem determined systems where discussing problems could maintain these problems instead of bringing a resolve. Meaning attribution is constructed within the relationships of the family and generated through language. These conversations have the potential of chaining the family in negative experiences and restrict the possible shift to alternate interpretations of the intersubjective reality. Therefore, a family system focusing on any challenge creates its own communication and expression regarding the experience. Assumptions that individuals and the family hold should be explored in therapy within the context of these interpersonal relationships because dialogic relationships open opportunities for new interpretations, solutions and change.

2.4. The family experience of physical trauma

Deconstructing the historical and prevailing medical discourses incorporates terms of illness and health. These narratives have large economic, social and legal consequences. The term *health* has an Anglo-Saxon root, meaning “wholeness” (Kumar, 2006, p. 1). Centuries ago physical healing incorporated spiritual healing and religious leaders cared for the infirm. However, as medicine became a science this religious aspect lessened (Kumar, 2006). Two predominant discourses prevailed over the last two centuries in the medical world. The dominant medical discourse through the 20th Century was the **biomedical** model. Cartesian

Dualism in which the mind and body were perceived as separate entities influenced this perspective. The model was based on positivism as scientific research was the ultimate truth and psychological and social influences ignored. The patient was a passive recipient of healing and considered ill. A health practitioner identified illness and disability as the pathological problem and medication or surgery administered. This discourse evolved into the **biopsychosocial** model because the interaction between the mind and body was acknowledged. Health and disease are placed on a continuum. Based on systems theory, the treatment addresses biological and psychosocial needs of the patient from the micro- to the macro-level. Wellness, quality of life and strong relationships are emphasised. In this model disease is a pathological process, whereas illness is the perception and the effects of this perception on the individual's health (Kumar, 2006; Lakhan, 2006).

These narrative discourses influence the lived experience, the interpretation and meaning attributed to physical trauma. On admission to hospital the biomedical discourse predominates, as the patient is often critical and survival essential. After individuals experience physical trauma they are admitted to a casualty unit in hospital. The initial examinations in the resuscitation bays precede the traumatologist spending time in theatre with the polytrauma patient (Mangram et al., 2005). If the condition of the patient is serious or critical, the patient may be admitted to the **intensive care unit**. During the ensuing recovery, the medical fraternity, using the biopsychosocial model, views the patient holistically.

Kirchhoff, Song, and Kehl (2004) identify the family as the primary source of information regarding the ICU patient because the patient is frequently unable to verbalise needs or is intubated. A relationship of "sacred trust" (Mangram et al., 2005, p. 889) is established between the medical staff and family, and not the patient. This complicates patient confidentiality since the family and multidisciplinary team receive information before the patient. Despite families receiving information first, communication is limited and sporadic. Half of all ICU families report inadequate communication. Medical staff tend to conduct ward rounds outside of ICU visiting hours (Azoulay et al., 2000). If traumatologists do communicate with family, medical complications are discussed and consent obtained for intervention procedures (Mangram et al., 2005). Furthermore, ICU communication is difficult because emotional arousal is high, the needs of family members evolve over time and family members struggle to understand complex information (Hughes, Robbins, & Bryan, 2004).

Azoulay et al. (2002) identifies the need for communication with the family that is appropriate, critical, clear and compassionate. This encourages favourable interaction between nursing staff and family, and assists adjustment to the uneasiness of the patient's admission.

Azoulay et al. (2002) suggest that 25% of family members involved in decision-making for the patient did not understand the treatment or prognosis. If a family, on behalf of a patient make medical decisions, good communication facilitates these informed decisions. Improved communication with families include conducting family conferences on a regular basis, the presence of a healthcare professional re-interpreting the information for the family, discussing the treatment and prognosis with a family representative rather than a spouse, and knowing the role of each staff member in the team (Curtis, Patrick, Shannon, Treece, Engelberg, & Rubenfield, 2001; McDonagh et al., 2004). Receiving consistent information from different specialists and providing the family with an information brochure also improves communication (Azoulay et al., 2002). Patients also require adequate communication about their progress in ICU. A study by Backman and Walther (2001) suggest photographs and journals kept by the nursing staff of patients are a useful tool when debriefing ICU patients on discharge.

The impact of a family member admitted to ICU occurs on several levels for the family. Initially there is confusion as the family waits to see the patient, receive the diagnosis, prognosis and results of surgery. Roles in the family are altered, members become isolated, and transport difficulties and financial complications combine with the fear of losing someone. These aspects all contribute to the crisis and disequilibrium in the family. Qualitative studies identify emotional responses in the family to the patient's admission as shock, stress, insecurity, fear and helpless. This emotional turmoil manifests behaviourally as the family hovers around the ICU. They frequently lack concern regarding their own needs (Jamerson et al., 1996). The initial shock subsides; the family refocuses, seeks information and begin tracking the patient's care and prognosis. The tracking phase includes the family's evaluation of ICU treatment and equipment. Family members value medical staff showing privacy, respect and dignity to the patient and compassion, truthfulness and appropriate humour to the family (Jamerson et al., 1996; Kirchhoff et al., 2004). During this phase the family members express their own physical and psychosocial needs of rest, nutrition, diversionary activities, personal space, spiritual religious activities, support from friends or from families of other ICU patients. These needs differ on gender, religious background and previous experiences of visiting ICUs (Lederer, Goode, & Dowling, 2005; Lee & Lau, 2003; Patel, 1996). Coping strategies are identified by the family and used to retain hope (Jamerson et al., 1996).

Families facing death in ICU have needs in two categories. The first category focuses on the family's relationship with the patient, ensuring that the patient is receiving the best medical care. The medical team fulfils this need. The second category contains psychological needs

of family members, which are provided by their support system. However, family and friends rendering support are restricted by physical limitations of ICU. Restricted visiting hours are strictly adhered to and the number of visitors limited. Waiting rooms are small, lack privacy and sometimes far from the ICU, so family members would rather stand in the corridors near the patient to receive any important information from the medical team (Kirchhoff et al., 2004).

If the family knows the patient is dying, anticipatory grief, shock and disbelief precipitate many emotional responses, which may include complicated grief. If undiagnosed this leads to major depression, bipolar disorder and anxiety disorder (Jones et al., 2004; Kirchhoff et al., 2004). Anticipatory grief is the subjective, emotional reaction to the potential death of the patient and described as a positive, emotionally healthy state (Kirchhoff et al., 2004). Although family members frequently hide this reaction, it manifests somatically as headaches, exhaustion, muscular aches, insomnia, loss of appetite, breathlessness and dizziness. The family may feel anger, guilt, anxiety, sadness, numbness, yearning, self-blame and helplessness. They may also have cognitive symptoms of confusion, concentration and disbelief. Gender differences are noticeable in anticipatory grief as females experience more despair, somatisation and death anxiety, while males exhibit more denial. These reactions are significant since the family may have been awarded power of attorney for the patient and these responses may impede decision-making (Kirchhoff et al., 2004).

Emotional responses to the trauma vary amongst family members, but anxiety, depression and PTSD are common. Anxiety levels in family members are influenced by their relationship to the patient (Mitchell & Courtney, 2004) and their perception of unethical behaviour of staff (Abbott, Sago, Breen, Abernethy, & Tulsy, 2001). Reducing this anxiety and depression is essential, as psychological distress in family members impacts negatively on the decision-making process of the family and is correlated to high levels of distress in the patient (Jones et al., 2004; Lee & Lau, 2003). Furthermore, this anxiety has the potential of developing into PTSD. One third of family members were diagnosed with PTSD three months after the discharge or death of the patient. Azoulay et al. (2005) identified factors contributing to the development of PTSD. Family members who experienced inadequate information from medical staff had an incidence of 48%, those who were included in decision-making 47%, those who experienced bereavement 50%, family members who followed end-of-life decisions experienced 60% and those families sharing in the process of end-of-life decisions had an incidence of 81% (Kirchhoff et al., 2004; Jones et al., 2004). The high incidence of PTSD could represent survivor guilt in family members.

Being the partner of an ICU patient, the experience of physical trauma is shared as a couple. Partners experience high levels of stress, which impacts negatively on their own health (Engström & Söderberg, 2004). Observing physical changes in the patient, realising wounds were open, identifying ICU equipment or witnessing patient confusion after intubation may precipitate this stress. Partners of unconscious patients wanted nurses showing respect to the patient by treating them as if they were conscious and listening. The partner also sought proximity to the patient and offered assistance, but showed respect by leaving when nurses needed direct access to their partner. The most difficult task for the partner was waiting for news from the traumatologist. As the partner's focus was on the survival of their spouse, values changed, daily routine became unimportant, and sleep and food intake altered. Leaving hospital after visits was difficult and partners were on continual alert for a hospital phone call.

Partners identified emotions of sadness, vulnerability and shock, but awe at their inner strength to face the challenges. A qualitative study revealed themes of abandonment, vulnerability, helplessness, a sense of insignificance and ambivalence of the experience (Chaboyer, Kendall, & Foster, 2005; Mitchell & Courtney, 2004). Partners expressed concern over the future of their spouse, every day practical matters and how the extended family would cope with the re-allocation of responsibilities. However, family support removed isolation and provided comfort for the partner (Engström & Söderberg, 2004).

From ICU, patients are transferred to **High Care** or normal ward. This is stressful for the patient and family, may limit coping strategies of family members and create further disequilibrium. However, closure of the ICU experience was obtained by visiting the ICU after transfer. It was during closure that partners became aware of their emotional and physical tiredness, but until then had not had time to think about themselves (Engström & Söderberg, 2004).

The patient has a different experience of physical trauma. Prior to admission the patient has endured the traumatic event, physical trauma, paramedic attention, and transfer to the hospital (Mohta, Sethi, Tyagi, & Mohta, 2003). Although most patients recall little of ICU, Tedstone and Tarrier (2003), and Scragg, Jones, and Fauvel (2001) recognise the ICU experience as exceptionally stressful for the patient. Admitted to ICU in a critical condition for life threatening injuries, patients receive medical support for breathing, circulation and other bodily functions. Medical staff administer analgesics and sedatives to ensure patient compliance during ventilation (Brandes et al., 2002). However, those patients who are

sedated for longer receive neuromuscular blockades or are “therapeutically paralysed without being completely sedated could ... be [at] risk...for PTSD” (Tedstone & Tarrier, 2003, p. 436).

Remembering factual events from the hospitalisation may prevent pathology in patients, even if the memories are unpleasant (Jones, Griffiths, Humphris, & Skirrow, 2001). However, ICU patients often experience delusional memories and not memories of factual events caused by the illness and treatment. Physical constraints, social isolation and the extent of life threat may increase hallucinations. Additionally, episodic memory may be influenced by delirium, sleep deprivation and the administration and withdrawal of particular drugs, although researchers are unsure of the exact impact (Jones et al., 2001). Patients also experience attention shifts manifesting as a reduction of memory for external events and the enhancement of memory for internal events. This causes ICU patients retaining memories and paranoid delusions of medical staff attempting to kill them. Hypnogogic hallucinations, and medication may cause this. These beliefs are difficult to challenge because there is little recall of other memories (Jones, Griffiths, & Humphris, 2000; Tedstone & Tarrier, 2003).

Irrespective of the severity of injury, respiratory distress, anxiety, pain or nightmares were experienced by 78,7% of ICU patients with nightmares being most frequent. Trait anxiety and being of a younger age increases the risk of pathology developing. However, Higgins et al. (2003) believe age is less significant and that infection, mechanical ventilation and the lack of full time ICU doctors are more predictive of longer ICU stays. Patak, Gawlinski, Fung, Doering, and Berg (2003) report ventilated patients experience frustration communicating with medical staff. These attempts include mouthing, gesticulating, controlled blinking, nodding and reading written communication on a notepad. This all requires extra energy and emotion as patients try to be understood. Most patients report the usefulness of a communication board, however, some patients are restrained or unable to grip a pencil. Apart from anxiety related to the transfer from ICU, the feeling of helplessness (Maes, Delmeire, Mylle, & Altamura, 2001), “the trauma ward environment, sleep deprivation, impact of injury on the central nervous system (CNS), medications and associated pre-morbid conditions” (Mohta et al., 2003, p. 17) influence the experience of physical trauma.

Further difficulties for the patient are relationships. Patients experience rejection and may be blamed for the traumatic event by members of their support system. Post-trauma relationships with rescue personnel, negative interactions with health care staff and the expectation that the hospital environment is a healing and safe environment may be challenged during painful medical procedures. This may precipitate sanctuary trauma

(Bloom, 2004; Tedstone & Tarrier, 2003). Schnyder et al. (2001) purport medical staff avoid emphasising the severity of injuries or its implications because the subjective interpretation of the information determines the psychological adjustment to the injuries.

If the medical profession discharges patients earlier, patients return to families physically and psychologically impaired. Family members are already physically and psychologically exhausted from the hospital admission, and personal and financial resources limited. Social support assists with these extra demands particularly if patients need practical assistance with daily activities. Using emotion or problem focused coping strategies depend on the family member and inherent coping style (Johansson, Fridlund, & Hildingh, 2004). Post-discharge patients have trouble with mobility, reduced energy and sleep. At least 40% require assistance with some activities of daily living one year post-discharge. Half the patients experienced weight loss and 25% experienced depression. Although one third of the patients were fully employed before the trauma, less than 10% returned to work within a year (Chaboyer & Grace, 2003).

Frequently physical trauma patients return home and re-enter society as physically disabled *beings*. The consequence of being labeled as disabled may cause stigmatisation. Patients may internalise this response and construct a belief system that the disability was through their own wrongdoing or a character fault. Family, strangers and the medical profession may devalue the personhood of the disabled individuals. This could facilitate the development of self-fulfilling prophecies or the acting out of behaviours in accordance with their disability. Furthermore, the label may precipitate less self-acceptance, social isolation and a loss of purpose in life, particularly if their capacity for employment has been affected. This loss of social identity is defined as *social death* and may create an existential crisis (Martz, 2004).

Cognitive dissonance in individuals may occur following physical trauma. Those with permanent disabilities could experience difficulties adjusting to their physical limitations. This dissonance occurs because individuals try incorporating their new physical *beings* with their previous body images. There may be further complications if the disability occurs during individuals' life spans and they previously held demeaning views of the disabled. Furthermore, adjustment is particularly difficult if individuals perceived themselves as decent prior to the injury and now undeserving of being disabled (Martz, 2004).

Another difficulty patients experience is chronic pain. They may respond by adapting their approach to life. This pain could cause and be exacerbated by anxiety, depression, loneliness, hostility and sleep disturbances (Mohta et al., 2003). Apart from medical causes,

the psychosocial system has a significant impact on recovery from pain (The National Pain Foundation, 2004). Snyder (2005) suggests various approaches reduce the impact of pain. Activities may be broken into small goals and celebrated when achieved. He identified the importance of remaining grounded in nature and determining the time of day pain is least. Furthermore, social relationships, controlling pain thought processes, being ready to accept help from others and laughing at oneself brought relief.

Richmond, Thompson, Deatrack, and Kauder (2000) studied patients on the complex journey of recovery from physical trauma and recorded three distinct phases of recovery: the event, fallout and moving-on. The *event* divides individuals' lives in two phases and delineates the beginning of new lives. The traumatic event is transient, but the injury and the effects not. This causes a re-evaluation of meaning in life and a heightened awareness of mortality. As individuals evaluate the impact of the physical injury they deal with the legal, financial, psychosocial and physical adjustments. The period named *fallout* includes a realisation they would not return to previous employment, but there is a renewed appreciation for enjoying life. The journey of recovery requires individuals evaluate life from new perspectives and re-evaluate priorities. The last phase described as *moving-on* is energising. This phase is highly individualistic because it requires internal and external resources. It is an active process and uses much emotional and physical energy. Resilience to the trauma leads to a complex interaction of social support and inner strength. Support received from others is viewed as both positive and negative. Although individuals found it positive listening to the stories of those who had already recovered, they commented on the poor advice given from medical staff after discharge and a need to hear more experiences from others who had similar physical trauma. An important part of moving-on in recovery is accepting life has changed and although recovered, life would not return to its previous state. Learning new skills facilitates this transition to the changed life.

2.5. Conclusion

Trauma visits unexpectedly and is experienced on physical, psychological and social levels. Adjustments are required by the patient and family as they co-construct new realities of the new physical *being* and determine the altered abilities of the patient. The patient and family sculpt their lives as they create meaning from this event that divided their existence into a before and after phase.

The shuffling of chairs, feet and music stands are heard as each musician prepares for the performance. Music scores are taken out and placed on the music stands. Each musician

and instrument has a specific place and purpose. Positioning themselves carefully the musicians ensure they can read the music score, hear the accompanying instruments and view the conductor. The stage is prepared.

Chapter 3

RESEARCH METHODOLOGY

On arrival the audience receive the programme. This explains the composing of the symphony and details the sequence of pieces for the performance. I invite you as the reader to join me as we explore the programme for this afternoon's symphony.

3.1. Introduction

Knowledge is found when individuals ask questions and then obtain answers. Although various methods obtain this knowledge, psychology uses scientific methodology to obtain truths. In this study, social constructionism explores the lived experiences and co-construction of stories in the historical, cultural and social context of a family's experience of physical trauma. These stories or narratives are represented visually through photographs taken by the participants and the transcriptions analysed using the storymap method in narrative analysis.

3.2. Discourses surrounding psychology as a science

Although Hergenhahn (1997) describes **science** as answering questions through examining nature, Neuman (2000) defines science as a social institution producing knowledge. Initially the scientific field researched the natural world, but then studied the social life of people. This study of people, their behaviour, beliefs and experiences is classified as the *soft sciences*. According to Neuman (2000) social research uses three scientific methodologies:

- Positivism uses quantitative data from empirical observations to determine, explain and predict human behaviour.
- Interpretive social science explores meanings attributed by individuals that guide decisions and motivate behaviours. Narrative analysis is one scientific technique to gain insight into the subjective meaning of the event. This technique comprises an in-depth study of social relationships and the composition of every day life.
- Critical social science reveals the workings of ordinary events, so individuals are empowered and able to structure an improved world.

However, despite three distinct methodologies, social research still leans towards positivism and interpretive social science. Social research includes psychology, which Hergenhahn

(1997) believes is the study of the psyche. Elmes, Kantowitz, and Roerdiger (1999) explain that psychological research attempts “to understand why people and animals behave as they do” (p.4). Therefore, psychological research observes overt behaviours, covert psychological processes, creates scientific understanding and addresses the practical challenges found in every day life.

The methodological approach a researcher selects reflects the spirit of the times or *Zeitgeist* (Hergenhahn, 1997). This *Zeitgeist* allows the incorporation of new ideas, research methods and techniques into the already existing body of knowledge and is defined as a paradigm. A paradigm is a set of philosophical assumptions on what researchers know: of the world, people, knowledge and the truth and provides a guide and broad framework for scientific theory and research (Elmes et al., 1999; Hergenhahn, 1997). For the researcher a paradigm provides an ontological, epistemological and methodological base and determines the methodology selected (Schurink, 1998). Although there are different methodologies social research may be divided into two **paradigms**, namely the quantitative and qualitative paradigms.

The **quantitative paradigm**, developed from the 1600s to the early 1800s, was originally accepted as the only approach to science. This paradigm proposes the aim of science is to collect data systematically, to test hypotheses and to develop theories that may be re-tested. Based on empirical observation, statistical measures quantify reality, examine cause and effect, plus prediction and control. This exposes the natural laws of observable behaviour. Truth is viewed as objective and absolute because the results are free of both context and the value judgements of the researcher (Hergenhahn, 1997; Neuman, 2000). The paradigm produces results that may be generalised across further populations, therefore, reliability and validity are important (Neuman, 2000). This method is also known as **modernism** and incorporated into positivism (Hergenhahn, 1997).

In the social sciences there is an inherent need to accommodate the subjective experience of human beings and to understand the qualities of human behaviour. Individuals are self-directing and conscious beings with the *self* being the centre of the world. In this world a number of multiple realities and roles are acted out against a backdrop of knowledge, language, culture and myth (Kvale, 1992). Polkinghorne (1991) believes these human experiences and structures cannot be accessed by traditional research methods. Labelled **anti-positivism** or **postmodernism, qualitative research** examines this subjective interpretation of events. It was in the early 1900s the term postmodernism was conceived formally to identify this new scientific approach. Schurink (1998) purports the aim of

qualitative research is to: comprehend rather than explain, perform field research rather than empirical research, explore the subjective experience instead of objective facts. There is a shift from abstract knowledge to social knowledge, “from the knower to the known, from the knowing subject to the subject known, from the psychology of cognitive processes to the nature of the knowledge sought” (Kvale, 1992, p.12).

Postmodernism creates an understanding of individuals’ experiences from a reflexive position and identifies how sense is made in their world (Parker, 2002). Qualitative research is interpretive, ideographic and holistic because phenomena are placed and understood in context. Therefore, the research is inductive. Patterns, perspectives and multiple realities of meaning are explored in the context of individuals’ value systems (Schurink, 1998). The sampling technique for qualitative research is small, purposeful, and non-random because specificity rather than replication is important (Merriam, 1998). Data collection is systematic, gained through observing the participants, and by conducting structured, unstructured or open-ended interviews. Thoughts are expressed in the everyday language of the participants, since data is transcribed by the researcher and presented in words, documents and transcripts (Polkinghorne, 1991). During the analysis, data is structured into hierarchies, themes, categories or tentative hypotheses, which the researcher identifies (Merriam, 1998; Schurink, 1998). This research becomes richly descriptive; multiple meanings and the interrelationships of different contexts are verbalised and become illuminated (De Vos & Fouché, 1998; Parker, 2002). Qualitative research embraces various methods within the postmodern paradigm, it strives to reflect the world and concentrate on real life problems (Burman, 2002).

3.3. Purpose of the study

The purpose of the study is to explore the sense a family makes of physical trauma by using narrative. Trauma not only affects injured individuals, but the whole family. The family supports the patient during hospitalisation and frequently participates in the rehabilitation process of the patient. Through this hospitalisation the family may experience their own trauma and create meaning of their lived experience.

3.4. Social constructionism

All research in the social sciences is founded on experience (Clandinin & Connelly, 1994). Parker (2002) identifies two forms of qualitative research, namely realism and social constructionism. **Realism** describes the underlying structures and qualities of the world,

while **social construction** emerged from Gergen's paper *Social psychology as history*. Social constructionism is a social process, whereby individuals explain their world in the context of culture, history and social interactions. Experiences and events are arranged into meaningful episodes in stories and provide coherence to the different lived experiences. Meaning is then construed and informs behaviour. Stories are closest to expressing an experience because the stories function on internal and existential levels. (Burr, 1996; Crossley, 2000; Gergen, 1985; Polkinghorne, 1988; Riessman, 1993).

Foucault (1972, 1979) emphasised the power of being able to language an experience and construct an understanding of the world. Therefore, language is used to understand the world and is the outcome of discourse, as language produces reality, but does not reflect it (Edley, 2001; Gergen, 1985). The perception of truth depends on the perspective of the discourse and the interpretation by society rather than on the absolute truth (Gergen, 1985). Foucault (1972) stated that discourse constructs an object and helps form individuals' identities. Discourses are pivots in the lives of individuals as norms are created that require obedience. When the discourses have similar content or style they may be arranged around a metaphor (Breakwell, Hammond, & Fife-Schaw, 2000). These discourses are negotiated, flexible, open to interpretation and identified by examining texts of written or spoken material (Crossley, 2000). They form the building blocks of social reality and are related to the temporal social process. The dominant discourses are experienced in a larger socio-political context and this meta-perspective frames experiences and interpersonal relationships. Foucault (1979, 1980, 1984) describes the repressive nature and power of these discourses or normalising truths and knowledge in society. Conformity to these discourses is promoted by the interrelationship of power and knowledge. Burkitt (1996) maintains "relations of power and practices of social control and government shape the everyday lives of individuals" (p. 72). Knowledge is arranged in a hierarchy and may be subjugated, where previously established knowledge is hidden in the new body of knowledge, or where indigenous knowledge is present, but may not be performed. This creates conflict in society as soon as the subjugated knowledge requires performance.

Individuals have a reflexive relationship in their world of knowledge. Through recollecting and reflecting on the primary experience of their embodiment, individuals gain access into experiences of the lived world. The experiences and perceptions that emerge from their physical *being* are different. Malik and Krause (2005) caution that whenever Cartesian Dualism is ignored, the embodied aspect of being human is disregarded as a restraining factor in co-constructing reality. Physical bodies are both biologically and socially construed. This embodiment and difference between the subjective and objective world manifests when

the thoughts of individuals are verbalised, particularly in individuals who have restricted power and control. Through embodiment individuals interact socially and participate in various activities. This allows individuals exert agency and influence in their world (Gergen, 1985). Although embodiment may restrict some activities on a biological level, this biological construction provides a context for communicating identities, the *self* and self-identity. Humanness is experienced in the shared features of individuals, such as muscles and teeth, but the body is also a resource and social symbol for individuals. Socially constructing and interpreting the physical differences and experience constructs individuality and social divisions, such as ethnicity. Embodiment is also co-constructed with other individuals and performed in a socially constructed world (Burr, 1996).

Individuals carefully select and include parts of their lived experience as they narrate a story. Gergen (1994) and Burr (1996) propose that the various *sel/ves* sharing a theme or pattern emerge as a continuous narrative. The *sel/ves* are storied and each time the stories are retold, lives are reconstituted. If this story is successful, a feeling of continuity and meaning of the experience is provided (Clandinin & Connelly, 1994; Crossly, 2000; White & Epston, 1990; Polkinghorne, 1988; Riessman, 1993). Subjective bias is introduced by including personal, cultural and social historical elements that contribute value and emphasise the meaning of the story (Gergen, 1994). There are multiple realities in the present and multiple stories of the past that will impact on the story of the present. The story provides a map for the present because it includes events from the past (history) and contains plans for the future. Past and future become united in the present. Gergen (1994) emphasises these multiple constructions of stories provide multiple constructions of reality. Individuals who have multiple constructions of reality are more successful in relationships, since second order *sel/ves* emerge (Burr, 1996). The identity of the storyteller is determined by content, the stance assumed by the narrator as a protagonist or a victim as well as the relationship with the audience (Gergen, 1994). This story incorporates a plot and has people or characters (Crossley, 2000; Polkinghorne, 1988; Riessman, 1993).

Because individuals explore who they are and interact with others, identities are constructed (Burr, 1996). The dominant story of their identities are a self-relational discourse (Burr, 1996; Gergen, 1994; White & Epston, 1990). If the story becomes unfulfilling, opportunities open for constructing new stories (Burr, 1996; Gergen, 1994). Externalising a problem constructs new stories though identifying experiences outside the dominant story that become unique outcomes. These are performed in front of an audience until these outcomes become the dominant story. This story becomes the alternate story of the lived experience. The

performance empowers individuals further, as the audience attributes new meanings, become witnesses to or extend the alternate story (White & Epston, 1990).

The aim of the study is to explore the sense families make of physical trauma by using narrative. In this study the terms narrative and story are used interchangeably. The dominant discourse of severe physical trauma is one of hopelessness and hardship, but through social constructionism and narrative the participants are offered an opportunity of exploring and re-authoring their stories. Redefining their identities and selecting different stories meaningful to themselves facilitates performing this alternate story. This will occur in front of other witnesses, such as myself the researcher and you the reader.

3.5. The research process

Social constructionism includes a wide range of approaches for studying the social sciences and encourages a critical approach to assumptions of the world (Burr, 1996). In the research process, research questions allow the co-construction of a preferred reality between the researcher and participant (Parker, 2002). Different meanings brought into the relationship are explored through a personal and functional reflexive analysis, where personal reflexivity explores the researcher's identity and functional reflexivity deconstructs the choice of research topic and selection of method (Wilkinson, 1988). In the analysis of data, the signature and voice of participant and researcher should be reflected in the research report. As the researcher translates the participant's experience from the field text, the **voice** of the participant and researcher should be balanced in the research text. **Signature**, which is the expression of the researcher's identity in the research text, should not overshadow the participant's identity. There is a reflexive relationship between the researcher and participant as each lives, tells, retells and then relives the story. The reader may even offer alternate explanations for the data. This tension between the participants, researcher and audience should maintain a constant balance so that neither the voice or signature become the privileged voice (Clandinin & Connelly, 1994).

To maintain this balance and to understand the co-construction of the narrative, I will begin with the process of personal reflexivity by exploring my researcher identity. I was involved in a serious car accident in 1995 and through the long process of recovery felt the injuries and prognosis had a louder voice than my own. The medical discourse predominated, but some members of the medical profession and my own family guided me. They were my audience during the re-authoring of my own alternate story. After completing my Honours degree in psychology, I returned to the Trauma ICU and Trauma Ward of an academic hospital to

counsel patients, families and staff who were experiencing trauma. The lens I used during counselling altered between that of being a patient and counsellor. I viewed trauma from alternate perspectives. Counselling the patient and family was restricted to the duration of the hospital stay, so the process of re-authoring their story began in hospital and could continue at home during rehabilitation.

My choice of topic came from my work in the ICU. Families would request I provide a map of expectations and possible experiences of the new journey. Little qualitative research is available on the hospital experience because medical research is mostly positivistic. I also observed families wanted photographs of the patient soon after admission and then at regular intervals during recovery. The families explained these photographs would story the experience. As the patient's health improved, these photographs became incorporated in the patient's own story to illustrate and contribute to the credibility. It later became difficult for these patients to narrate their experience without these photographs. The selected research methodology is social constructionism since the story is co-constructed between the participant and researcher. This occurred by asking the participants during the pre-interview to photograph items that could represent their experience during the open-ended interview. The story unfolded whilst the participants expressed their lived experience visually and verbally. It will be a challenge to balance the voice and signature of the participants with my own, but having been on both sides of the coin, I am aware of the perspective I assume.

The participating family was selected through purposive sampling. It was difficult obtaining a family willing to participate because those I approached indicated the trauma was still too fresh in their minds. I asked someone I know who heads a prayer chain if they knew of a family fitting the criteria. They were also friends of the family and were informed of the accident on the day it occurred. The criteria for selection were that a family member had experienced physical trauma in the past three years and had been admitted to ICU. The family was contacted telephonically and the purpose of the research explained. Those family members who agreed to participate attended a meeting with the researcher during which the purpose of the research was outlined. They were also provided with the information letter and the letter of consent (Appendix D).

Although first order cybernetics in systems theory proposes a system is defined by the observer, which would have been myself as researcher (Jones, 1993), the family decided who would be included in the interviews. The family was given the option of including close friends who had acted in the support role of family during the trauma. In social constructionism and some medical research, family is not necessarily delineated by

bloodline. Mitchell and Courtney (2004) used this sampling process in a study on *Reducing family member's anxiety and uncertainty in illness around transfer from Intensive Care*. This family selected the patient, his wife who was also involved in the accident and his biological mother. A disposable camera was given to his mother, and the patient and his wife used their digital camera for each to take photographs. They had two weeks to photograph anything that could story the family experience of physical trauma. Allowing this two week time frame gave the participants time to select the stories they wanted to incorporate into a coherent narrative. To obtain the narrative, data was produced in two forms. I selected photography as my first technique, followed by an open-ended interview.

Although photography is a marginalised research technique, in this study it had two functions. Firstly, trauma memory is frequently described as fragmented memory. Pauses, intonations, disruptions in thought, changes in the tenses and flashback experiences are frequently found in trauma narrative (Ehlers & Clarke, 2000; Janoff-Bulman, 1995; O'Kearney & Perrott, 2006). These photographs would provide a tangible structure for the narration of the experience and assist the family in narrating a coherent lived experience (White & Epston, 1990). Secondly, photography narrates the lives of individuals as a social construction of reality (Harper, 1994). It is a discourse between the photographer, the subject of the photographer and the viewer, since each interprets the photograph from their own discourse. The meaning of each photograph is co-constructed because the photograph is a text representing the *self* (Harper, 1994; Ziller, 1990). Including specific images and its position in the narrative contribute to the meaning. The photograph may also be interpreted metaphorically because the image represents words (Harper, 1987, 1994).

In photography the researcher-participant relationship changes temporarily because participants select and narrate their visual images. They become artists and share control in the research relationship when they are given a camera. This technique is known as photo elicitation. In this research, participants are actively involved because photographers assume a reflexive position, scan the environment, and interpret the stimulus and the significance for the story. The photographer searches for a shared "definition of the meaning" (Emmison & Smith, 2000, p.29). This technique will be combined with photo observation, which expresses the *self*. As photo observation involves dealing with the physical and social environment, individual perceptions of identity become integrated into the story of *self*. The photographs produce various stories that are incorporated into various behavioral contexts and environments (Harper, 1987, 1994; Ziller, 1990).

Once the photographs were taken an interview time was arranged. The patient's mother withdrew from the research the day before the interview since too many unpleasant memories surfaced. Consequently his sister participated in the interview process, but had insufficient time to take photographs. The patient and his wife arranged the photographs in a sequence of their choice and participated in an audiotaped open-ended interview. They were asked the research question. The individual interviews of the participants were conducted using narrative inquiry. As researcher, I transcribed the interviews verbatim. This allowed me time to become familiar with the content of the narrative. These transcriptions were then analysed using the storymap method. To retain confidentiality in the transcripts and in the discussion of results the participants have been given pseudonyms.

Richmond (2002) perceives narrative as a process and product where the narrator is positioned from a particular perspective. Both Clandinin and Connelly (1994) and Richmond (2002) identify three dimensions in narrative study: temporal, personal and experiential. Participants narrating their stories with a future and a historical foundation perceive temporality; the personal aspect is constructed as the story becomes unified; and the experiential aspect situates the story in the *self*, family and physical world. For this study, a storymap has been adapted from Richmond (2002) for each of the family members. This map arranges the experience of each in the form of a rubric and shapes the story. A meta-perspective is provided and facilitates an in-depth analysis of the narrative. These maps are then compared to obtain one story representing the family experience. The research question is answered through this analysis.

As the participant stories various experiences, events are reconstructed and an identity and *self* narrated. Each story reflected the lived experience and was analysed according to the narrative framework. This narrative framework allowed an analysis of the core elements of all stories: setting, characters and action. This formal narrative analysis structured the core into five areas: orientation of the story that describes the plot and characters, an abstract that summates specific events, a complicating action evaluating events, disagreements and themes, as well as a resolution of the story or disagreements experienced. In the story the narrators portrayed themselves as either a victim or survivor using cultural traditions or mythical symbols, while the plot was explored on a temporal level. Descriptive knowledge was also compiled that could be understood in context. Since there is a comparison of the experiences of family members there is a multiple perspective on the experience of hospitalisation (Richmond, 2002).

3.6. Validity and ethics

Validity is defined as consistency in a measuring technique (Winter, 2000). Two views of validity transpire in qualitative research. Foucault (1972) believes that for truth to be considered valid, the research method should be selected according to the nature of truth required. Because this study required an analysis of the family experience of physical trauma, a personal experience method was selected. Open-ended interviewing is also the reverse process for photo elicitation (Harper, 1994). On the other hand, Sparkes (1998) believes validity is “socially constructed within specific discourses and communities, at specific historical moments, for specific sets of purposes and interests” (p. 375). In this research co-constructing a story creates a relationship between the researcher and participant (Clandinin & Connelly, 1994). This relationship allowed the researcher, namely myself, explore the sense a family makes of physical trauma. Physical, medical, rehabilitation and family discourses are predominant.

Sparkes (1998) suggests that for research to be valid it should be authentic. The text should invite the reader to share the life experiences and narrative in the way it has been told and should be congruent with other experiences the researcher and reader may have had. This occurs if the reader actively participates in interpreting the narrative and co-constructs a reality with the narrator represented by the text.

Ethical considerations were met by applying for ethical clearance from the Ethics Committee of the University of Pretoria. After the researcher explained the purpose of the research, the family members were given time to decide whether they wanted to participate and who would be involved. When the mother withdrew from the research the camera that had been given to her was returned to the researcher and her data destroyed. Debriefing was offered to his mother. For those who participated, informed consent was obtained by signing letters of consent. Debriefing was offered immediately after the interview in the event of distressing memories resurfacing. The family was phoned two weeks later and a further debriefing offered if needed. Confidentiality was also maintained by using pseudonyms for each participant. The original data was destroyed on completion of the research.

3.7. Conclusion

Co-constructing reality creates new stories. Social constructionism and narrative inquiry explore the sense family members make of the experience of physical trauma that the

participants language visually and verbally. Photographs of cultural, social and historical metaphors enrich the verbal descriptions that are analysed using storymaps.

Now that we have examined the programme, the tuning of a few discordant instruments arrests the audience's attention. The sound reaches a crescendo and then dissipates. Sporadically, lone instruments are played. In the following chapter, four musicians will play their instruments as they narrate their story.

Chapter 4

RESULTS OF THE INTERVIEWS

Each musician plays a musical instrument that has a distinct timbre and resonance and will contribute a unique sound in the score. Different bars introduce the sounds that gain meaning from their position in the full composition. No instrument can play a symphony alone, but gains significance from the other instruments playing in a context. This chapter will present the various musicians playing the instruments.

4.1. Introduction

There are three participants in this research. The researcher is the fourth voice in co-constructing the reality. The researcher's voice will be heard in the pre- and post-interview impressions of each participant. This chapter will, therefore, produce four distinct perspectives using the storymap method of narrative analysis.

4.2. Rubric for the analysis

The narrative of each interviewed participant is presented in the form of a rubric. Through this technique the voice of every participant is heard in context, in a time frame and in a setting. The framework for this rubric is adapted from Richmond's (2002) schematic representation of the storymap and presented below.

Table 1. Rubric framework for the analysis of verbal narratives

	Self	Other relationships	Physical self	Physical world
Past				
Present				
Future				

Presenting this rubric suggests stories may be reduced to a simplified schematic representation. However, these lived experiences are rich and presented as a constructed reality in the participant's language.

4.3. The personal context of the family

David², a qualified electrician, is married to Anne. They were involved in a car accident outside Nelspruit roughly two years ago. David was transferred by ambulance to Johannesburg the following day and admitted to ICU for 23 days. His lungs collapsed and he went into cardiac arrest for twenty minutes. Although doctors said he would not recover, he returned to work in an altered capacity. Anne also works full time. She sustained injuries in the accident and was admitted to High Care for a few days. They were both admitted to the same hospital, but discharged separately. Anne has a son, Michael 18 years of age, from a previous marriage who is currently staying with them. David's sister, Sarah, also participated in the interview. Sarah agreed as David's mother experienced stress through reliving the experience and withdrew. Sarah was unable to take photographs because of the time constraint. However, she could provide a narrative of the family experience.

4.4. David's story

In co-constructing a reality with the participants I explore my own position so that my voice is not the privileged voice in this research. Therefore, I present my expectations of the interview, before I present the results of the interview with David. Having had the perspective as a rehabilitated patient, my voice could predominate and impact negatively on the results.

4.4.1. The researcher's expectations of David's story

As I listen to David's story, I believe I will relate to some experiences. Consequently I am careful David is allowed space to create meaning, have his own voice and narrate his story. I anticipate that two years post-accident David is restructuring his life, grieving his loss and involved in the rehabilitation process. Defining a new body image, integrating these limitations and defining a new value system would precipitate changes in the reconstruction of his world. Courage and determination are needed to confront the predominant cultural and social discourses of pity, hopelessness and despair.

As a historical being, he will actively create a coherent story from the fragmented trauma, since parts of his story could be forgotten or exaggerated through the medication and medical treatment he received during the initial stages of recovery. The medical discourse and social support play an important role in the interpretation and social construction of his

² All names of the participants and places where incidents occurred have been changed to maintain confidentiality and protect their identity.

injuries. David is in the process of socially constructing an alternate story in his altered embodiment. Depending on the severity and recovery from these injuries, David may choose the predominant discourse, or map his unique outcomes to narrate his alternate story. With the possibility of fluctuating between hope and despair, I will be sensitive to his recovery process and refrain from imposing my experiences and expectations.

4.4.2. David's photography

David presented twenty photographs. Most of his photographs are metaphoric. Those referred to in this chapter may be viewed in Appendix E. The photograph of the money has been excluded since it is illegal to photocopy money. David began his story with the photograph of a fifty-rand note to illustrate the change in his value system and then proceeded to photographs expressing his ICU experience. In the presented sequence these photographs were of a black background, the pills, the fist, the screw, the knife and the empty glass. To demonstrate his coping technique of setting goals, he photographed the clock. A photograph of scrap, a light illustrating hope and a distribution board illustrated his personal interpretation of the accident on his life. The photograph of the walker, the shoulder operation, the bible, the flight of steps, the binoculars and the clock followed the picture of the house they are presently building.

Two photographs presented a theme throughout David's verbal narrative. The first photograph was the photograph of money that started his narrative. If David had to retell this story in the future, the first photograph he would change would be the fifty-rand. Its position would be later in the sequence. The second photograph was the glass that illustrated the temporality of his life. It was empty immediately after the accident and then became half full when he began getting hope. He believes the glass will overflow in the future.

4.4.3. Narrative analysis of David's story

A schematic representation of David's story follows.

Table 2. David's storymap

	Self	Other relationships	Physical self	Physical world
Past	<ul style="list-style-type: none"> • Communication difficulties • Conflict 	<ul style="list-style-type: none"> • God • Mother-in-law • Relationships 	<ul style="list-style-type: none"> • Blindness • Hospitalisation • Physical 	<ul style="list-style-type: none"> • House • ICU • Money

	<ul style="list-style-type: none"> • Coping strategies • Emotional pain and responses • Prognosis • Response to the trauma 	<ul style="list-style-type: none"> • with immediate family • Support system 	<ul style="list-style-type: none"> • limitations • Physical progress • Power of the medical discourse • Rehabilitation 	<ul style="list-style-type: none"> • Step down facility
Present	<ul style="list-style-type: none"> • Coping strategies • Employment • Emotional pain and responses • Goals • Hope for the future • Increased self-worth • Interpretation of the accident • Responsibility • Suffering 	<ul style="list-style-type: none"> • Conflict • Family as a system • Mother-in-law • Support system 	<ul style="list-style-type: none"> • Hyperactivity • Pain and pills • Physical limitations • Physical progress 	<ul style="list-style-type: none"> • Driving • House • Money
Future	<ul style="list-style-type: none"> • Employment • Emotional needs and congruency • Hope • Recovery 	<ul style="list-style-type: none"> • Pets and animals • Relationships with the immediate family 	<ul style="list-style-type: none"> • Improvement of short-term memory • Physical Improvement • Rehabilitation 	<ul style="list-style-type: none"> • Driving • House • Money

Past experiences

David narrated his experience of physical trauma from when he opened his eyes in the ICU and entered a world of darkness. Although he could hear and individuals explained what had happened, he was unable to communicate in any form. He heard the voices of family members around his bedside fighting over who could be with him during visiting hours. These family members and friends had different understandings of his needs and this made him feel “bad”. A doctor’s comment that he had a “screw loose and won’t get better”, together with the diapers he had to wear caused embarrassment, feelings of hopelessness, severe depression and suicide ideation. David says he “lost his pride” through the accident. He considered alternate forms of suicide and thought of swallowing pills or using a knife.

However, he believed he had to select a method that would leave him dead and not worse off. He considered his relationships with his wife and family and this motivated him to stay alive. His wife, mom and dad were positive from the beginning, but doctors gave him a poor prognosis. His relationship with his mother-in-law appeared problematic, since she did not predict full recovery, described him as lazy and reprimanded him when she saw him resting in a chair. He also describes a disagreement between his family and his mother-in-law while he was in ICU. They argued over who would pay the bill for coffee at the coffee shop. His mother-in-law said David's family could not afford the bill. This comment hurt him. Similar monetary themes are a thread through his story.

For a long time in ICU, David's throat was closed because of his paralysed vocal chords. He was unable to swallow pills or verbalise his needs. Once he could speak his emotions affected his ability to communicate. If he got angry his voice would disappear which would infuriate him. The angrier he got, the more he became mute. To communicate with the nursing staff he learnt to bite the pipes of the alarmed drips, but would release the pipe before the nurses arrived. This way they would not know it was him. When asked by the staff he would deny having set off the alarm, but could then ask for what he wanted. As David explained "that was all I could do, I could bite that's all and I used it to help myself." He was humorous as he explained his control of the staff since the staff were restraining him to keep him immobile. The medical world could not contain him.

David explained relationships with other medical personnel. He distinguished between doctors who cared, asked and listened to how he was and those who prescribed pills and then sent the bill. Relationships with some of the other staff were difficult. One nurse in the step down facility removed his bell, so that staff could have quiet during duty that evening. He also smacked another staff member who refused to assist him to the bathroom when he was able to go with assistance. The therapists also evoked strong emotions in David. He described his responses with an assertive voice and admits to swearing at a therapist. She treated him like he was crazy and then another therapist called a patient like a dog. David differentiates between nursing sisters who were superb and those who "wanted to push you down." He responded with anger when nurses tried to suppress him. He often experienced aggression.

During this period of early recovery David questioned his survival. He asked God what he had done wrong, since he was successful and at the peak of his life. He sounded sad explaining that after the accident he felt isolated in his world, like a piece of scrap with no value, that his life was empty and he had no reason to live. However, with encouragement

from his wife and family, he began to hope and contemplate the future. This occurred through witnessing his physical improvement and regaining mobility. David said he would pray for strength, but was unable to see it. He then believed God wasn't listening or was unwilling to help him. He explained he sometimes needed other individuals help him physically and hoped those helping him understood this physical state was not his fault. The helplessness he experienced was verbalised often as not "his fault". David was determined to prove the negative prognosis wrong and set personal goals for himself. Because these initial goals were not achieved in the set time frame he adjusted his pace and expectations. He experienced a change of roles in his family particularly in building their house. Anne began making these decisions.

Present experiences

David is more positive about his life because he acquired new responsibilities at work. This includes becoming a mentor and compiling a course to train four students in electrical wiring, which he describes as his speciality. These additional responsibilities half filled the empty glass and he describes himself as an "improved" person, particularly in the emotional domain. Work raises his self-esteem and he believes he is no longer "scrap". However, David represents his life as the incomplete distribution board he photographed and wants his life perfect. Sometimes he still feels that he is carrying the whole world on his shoulders, so his approach to life is on a practical, survival level. He considers whether he can cope with a situation physically, anticipates possible problems and then considers all available options before making a choice. David describes this thinking as "vertical". He reaffirms he will not give up, but if he lapses will readjust his goals and time frame. Individuals can become all things in his eyes and the "sky is the limit". He lives step by step and moves one step at a time. David also observes changes in his value system and the impact of these on his experience of life. This is reflected in building the house.

He speaks of the house in both practical and metaphoric terms. He describes it as a white elephant and says it is too big. There are five bedrooms and once Michael moves out, only Anne and he will reside there. As the owner David feels responsible for the house debt, but indicates he would rather "live in a shed and be happy, than live in this house and feel awful about having to use money to improve...". He uses two opposite ideas by identifying the shed and the white elephant. There is no continuum. The white elephant must become a shed not a smaller house, suggesting that the present house is overwhelming him and he cannot cope. There is also conflict surrounding the employment of the builders and the

quality of their work. David shows he is upset that the family does not hear his opinion on the house. David is restricted in expressing his opinion and restricted physically.

David experiences physical limitations and wants his strength returned completely. His voice is his greatest difficulty, but is not attending speech therapy because there are no funds left in their medical aid package. He takes fifteen pills a day and physical pain is a major problem. Pain medication makes him dizzy and some medication changes his behavior and he becomes aggressive. Since he is regaining strength, he walks around looking for something to do. This movement has reduced the success rate of the shoulder operation from two months ago. The physical difficulty with his foot requires he drive a manual rather than an automatic vehicle. He has a petrol bakkie, but as diesel is economical he is converting the engine. Although he requires physical assistance to complete the adjustments he instructs the person assisting what to do. Physical limitations are not the only difficulties David has.

Conflict between David and Anne's biological families continue to create problems. Neither mother communicates voluntarily with the other. The relationship with his mother-in-law is strained; he experiences pressure to contend with her and feels inadequate that he cannot. He says "I am not at that stage where you can compete with people." He first considers his physical ability for a task, but may decline because of the risk of further injury. However, sometimes he will risk injury to dispel false accusations. David described that he swallowed his pills simultaneously though it hurt him physically. His mother-in-law had called him a "sissy" because he was swallowing pills in smaller amounts since he could not swallow properly. David's relationship with Michael has also changed. David believes Michael has lost respect for him since the accident and that Michael treats him like a child. Although David experiences anger and depression when thinking of Michael and his present behaviour, David believes he has insight into Michael's life, but feels afraid to share it for fear of creating conflict in the marriage.

Future intentions

David's greatest need is to see into and beyond the future, so that he can see where his life would be in ten years time. Knowing the outcome would provide calm and patience. David believes he has already stepped into the future through compiling the course at work and he wants to study engineering. David wants his life to return to its previous state, but would exclude the marriage problems prior to the accident. David maintains his cup will overflow again and he will return to the former position of being the leader. David has many dreams

for his future. He wants to reduce the importance of money in his life and strives to be congruent with who he is. He says, “I am who I am... I don’t want to be somebody I am not”. He used animal metaphors of a cat and dog to explain their lack of hidden agendas and said the parrot on the roof only wants love from him. Possibly he wants a life free from expectations he cannot attain. David says he could find this calm if he lived in a little shed on the beach where there was no fighting, no money, and the house was not that “nice”. He also strives to reduce his aggression, to improve his short-term memory, regain his physical voice and return to speech therapy. Finishing the bakkie’s conversion to diesel is another important personal goal, while the family goal is to complete the present house. He also anticipates Michael will leave home again and become independent.

4.4.4. The researcher’s experience of the interview

At the start of the interview, I was surprised David immediately presented the photograph of money. I was expecting a narration of the accident and details of the physical injuries. The photograph of money illustrated his altered value system and creates meaning for the trauma. The position in his sequence suggests this was the most significant change. Little detail was provided on the immediate aftermath of the accident, but stories of physical difficulties in hospital and a recent operation were described. His description of ICU is very authentic and I chuckled silently at his description of biting the pipes to call the nurses. Patients frequently bite the pipes to gain attention.

Although experiencing limitations, David’s physical progress, family and work environment continue to motivate him. Frustrated by these physical limitations he assesses whether he can complete an activity physically before embarking on a project. He is very aware of and influenced by his embodiment. Individuals with physical disabilities perceive their world first in physical terms and make physical adjustments or reframe the activity. Breaking activities into manageable pieces, requesting assistance from others and goal setting are coping strategies David used to exceed his prognosis. Having experienced rehabilitation I relate to these techniques. As he spoke, I was wondering whether he had not reached a plateau phase and would spurt again this year. This is dependant on his motivation and emotional state.

David included illustrations of his emotional world. He constructed the narrative, but became stressed during parts of his story. He was very frank and honest with himself and did not try to conceal his darkest hours. Most of his photographs illustrated this world. This corresponds with his need for congruency. Despite times of uncertainty, he is still motivated and adamant

to create an alternate story. I believe David's determination, sincerity and personal investment in rehabilitation will ensure continued progress.

4.5. Anne's story

Anne is David's wife. She was also injured and will narrate this event from the perspective as a partner and that of a patient. I will listen carefully during her narration because I worked with the dynamic of the complete family in ICU and seldom with particular individuals. If the partner of a patient was involved in the support system we would arrange for someone to ensure practical things were done, like accompanying the partner to hospital. My experience as a trauma counsellor could colour the co-construction of her story if I do not create space for her to narrate.

4.5.1. The researcher's expectations of Anne's story

Anne was willing to participate and very practical with the arrangements needed for the study. During the pre-interview one of her first comments was that she would never divorce David. Many people expected her to do so. I am aware of literature suggesting many marriages end in divorce following an experience like this, but the pre-interview dismissed this perception. Although she would assume the role of a caregiver, I perceived she would allow David remain head of the household and make his own decisions. I went into the interview expecting a dedicated wife who still respected her husband despite his physical disabilities. I expected her to be actively involved in his therapies or arranging for others to take the responsibilities when the strain as main caregiver exceeded her ability.

4.5.2. Anne's photography

Anne presented fifty-three photographs. Many of these reflected people involved in her story. The photographs that do not reveal the identity of the participants are found in Appendix F. Anne began her story with three photographs from their days of dating, which represented the happy times. Prior to the accident David was always busy, so nine photographs illustrated him working through the day and night. Those of David in ICU followed photographs of her injuries. David's photographs were close up pictures of his injuries and his support system. Photographs of their minister, who was actively involved in their lives, were also included. The next photographs illustrated the dentists fixing David's front teeth and their domestic worker who assisted the family after Anne had returned to work. Two photographs show the domestic worker feeding David through the peg in his stomach. Close

up shots of David’s swollen saliva glands precede a photograph of the bakkie involved in the accident. A photograph of the front door David began constructing prior to the accident is followed by the ramp built for the wheelchair. Six photographs of her son, Michael, illustrate Michael’s admission to ICU after his motorbike accident. The last photographs were metaphoric representations. These were the red chair, the drawer of pills and plasters, play dough from the occupational therapist, the bulldog soft toy she bought David, the medical gloves, the clock radio, a story David typed on the computer called “David se storie” and the weekly pill box.

Most of Anne’s photographs represented relationships and people who were significant in her life. Her narration followed the time sequence of their relationship and represented their lives interwoven with others. Her son, Michael, was also prominent. The metaphoric photos suggested a world that has been structured, ordered and provide a contained environment.

4.5.3. Narrative analysis of Anne’s story

A schematic representation of Anne’s story follows.

Table 3: Anne’s storymap

	Self	Other relationships	Physical self	Physical world
Past	<ul style="list-style-type: none"> • Communication • Conflict • Coping strategies • Difficulties in the marriage • Legal system • Prognosis of David • Relationship with David from the dating days • Response to the trauma 	<ul style="list-style-type: none"> • Biological mother • Domestic worker • God • Michael • Relationships with the immediate family • Support system 	<ul style="list-style-type: none"> • Hospitalisation • Power of the medical discourse 	<ul style="list-style-type: none"> • Adaptations to the house • Chair • Events of the accident • Front door of the house • House • ICU • Rehabilitation • Step down facilities • Time
Present	<ul style="list-style-type: none"> • Conflict • Coping 	<ul style="list-style-type: none"> • Biological mother 	<ul style="list-style-type: none"> • Influence of David’s 	<ul style="list-style-type: none"> • House • Medical aid

	<p>strategies</p> <ul style="list-style-type: none"> • Emotional pain and responses • Employment for David • Hope for David • Interpretation of the accident • Suffering of David 	<ul style="list-style-type: none"> • Conflict • David • David as a socially constructed being • Support system 	<p>hyperactivity on her <i>being</i></p> <ul style="list-style-type: none"> • Physical experience of David's physical progress. 	<ul style="list-style-type: none"> • Medical world • Time • Rehabilitation
Future	<ul style="list-style-type: none"> • Adjustments • Hope for David • Recovery of David • Studying • Unsure 			<ul style="list-style-type: none"> • House

Past experiences

Anne reminisces about their dating days and that they had time to build their relationship and laugh together. David's ability to do everything, his humour and the fast pace of life attracted her to David. David worked exceptionally hard, was a practical handy man and remained undaunted by tasks. They enjoyed the fast life. However, as work became important they had less time for each other. They were to divorce a month before the accident, but decided to rebuild their relationship. This reassessment of the marriage has impacted Anne's interpretation of the accident, since she believes God used the accident to keep them together.

As part of the healing process for the marriage Anne accompanied David on a journey for work to Nelspruit. She does not remember much of accident and was intermittingly unconscious afterwards. She describes that despite her condition she instructed her mother immediately after the accident to care for Michael and tell him where he could find his white socks. Anne cannot understand her motivation for this, but she continued her motherly role although injured. Anne was admitted to High Care for a few days because she had a broken collarbone, three cracked ribs and severe bruising. Drainage pipes were inserted into her lungs. Anne was told of David's condition, but externalises her misunderstanding. "My brain didn't want to accept it". This denial changed once she saw David in ICU. However, despite the prognosis Anne did not doubt David's ability to recover. Anne respects the medical world

for saving David's life, but is quick to demonstrate their limited experiential knowledge of her husband.

Close family and relatives, who previously had little interest in David's life, visited him in hospital and fought to spend time with him in ICU. The inadequate waiting room facilities and strict visiting hours complicated issues. Again Anne took charge and informed everyone proceedings would not follow their personal agendas. Initially the family tried communicating with David by printing letters on A4 paper, which he could identify with a laser light. They were unaware he was blind. They then communicated through tactile means. The doctors would not accept David was communicating and quoted the results of the scans to illustrate this impossibility. The doctors initially looked at her with an expression of "What did you smoke?" Anne retorted assertively with, "So ag...you know what doctor you just go on...we know what he wants and we know what he wants to tell us." Communicating with David was time consuming and he would get angry when misunderstood or lose his place while spelling a word. Once he could whisper communication was easier. For Anne, communicating with David was a 100% improvement on the prognosis he would be a "vegetable". When communication was difficult in ICU, David used his eyes and would enlarge them if a mistake was made. David communicated in alternate forms. Although David was confused regarding his admittance, he was asking "normal questions a normal person would ask" regarding insurance compensation and was trying to sell his bakkie from the ICU bed.

The stay in hospital was difficult for David and he demanded that he not spend another night there. He was instrumental in organising his own discharge from hospital and was transferred to a step down facility. Anne was visibly upset when she related how her family left him in the step down facility on the first night. The poor reception they received from the night staff unnerved her. She compared David's capabilities at that point to a baby and speaks as though he was abandoned. He was put in a corner bed unable to communicate. Anne responded to his distress at being left alone and cried incessantly when she got home. She continued and said, "There is no way in hell that I'm leaving him here," and proceeded to find another step down facility. While he was there she bought him a bulldog soft toy for comfort. She selected the bulldog because it reminded her of David as he goes "Grrrrr...". Anne also relates the story of David's bell been removed at the step down facility so the nurse could have peace.

David's condition created other problems. Anne experienced legal difficulties during this period because David had removed her power of attorney on his bank accounts and she needed access to pay bills. Her mother knew someone in the bank and with Anne took these

papers for David to sign. The doctor threatened legal action if David signed and insinuated he was not “normal”. This evoked an angry response from David and precipitated his demand for immediate discharge.

Bringing David home from the step down facility was difficult and required much support. David needed 24-hour care so friends and family slept over to relieve Anne during the night. However, David would call for Anne, so no one slept. In the morning the visitors requested they be excluded the next time. Adjustments were also made to the house. A ramp was built for his wheelchair that now represents Anne’s gratitude for David’s mobility. The lounge was converted into the bedroom for easy access to facilities downstairs and their domestic assisted feeding David through a tube in his stomach. Anne photographed medical gloves to represent this period of her life. They represent the sterile, clinical medical world and procedures she had to do to David. Anne photographed the chair representing where David felt comfortable. If he was not in bed, he would be sitting in the chair. She reminisces of her mother arriving and scolding David for sitting in the chair and doing nothing. Her mother wanted him mobile. Anne has also been motivating David to increase his speed of movement by timing him and encouraging him to beat the previous time. The photograph of the play dough represented occupational therapy, an activity David described suitable for children. He then drew to keep his hands busy.

Medical operations and complications continued after David’s discharge. Anne had further medical treatment and had a foot operation last December. David has also had his front teeth rebuilt and his saliva glands became swollen. Anne made the decisions regarding David’s medical treatment. She describes her relationship with the medical world with some contempt. A doctor examining David said he was disabled because he lacked time orientation and had poor short-term memory. Anne bought him a clock with large figures to re-orientate him and would test him morning and night on the day, date and time.

David’s admission was not the only one that year. Four months after their accident her son Michael was in a motorbike accident. Anne was driving down Cedar Road and went cold when she saw an accident up ahead. Ambulances had arrived and to avoid the scene turned around and drove the other way. Unbeknown to her, her son was involved. Michael was admitted for four days in ICU. On Michael’s discharge she had two patients at home. She describes her coping mechanism as “just make the best of the situation. It’s not going to help sitting in the corner and crying.”

In order to cope with the accident trauma and with the increased conflict in their relationship, as David has become “like a snail” and cannot do some activities at all, Anne has learnt to compensate by fulfilling his role in some activities. Anne used empathy and tried to understand she could have been in David’s position. She believes the outcome would have been different.

Present experiences

Anne continues to believe David will improve and has given him ten years or however long it takes. She does feel bitter towards the medical aid that they would not airlift David. If they had she believes he would be normal, since the complications would have been detected earlier. She respects David’s determination and spirit to win. However, she is uncertain on where he is. She thinks he may have reached a comfort zone as he can shout at the cats without difficulty, but cannot speak loudly to people. Returning to physiotherapy or speech therapy may improve David’s rehabilitation, but Anne is not sure if it will help. She thinks he is happy with his current physical state and lacks motivation to improve. The public response to David’s physical state hurts Anne. If someone talks to David and he replies they withdraw from him when they hear his speech. Sometimes he does not speak clearly and should repeat what he says, but individuals are afraid to offend and laugh if he laughs.

Anne’s understanding of the accident is that everything happens for a purpose. This accident was to save the marriage and she would go through it again. She was visibly upset explaining that David commented to her mother he never realised the love she had for him. Anne also relates that her mother was asked whether she would divorce David since society described him “useless”. These comments hurt her since she has always loved him and will never consider divorce. Even if David cannot rehabilitate completely, Anne says his attitude and heart is still the same and there is no one like him.

Anne’s relationship with time has altered and she still uses coping strategies. “I don’t want to put my heart into something because you never know what’s going to happen tomorrow...don’t run away with the Blue train...because [if] something happens then it’s like more of a shock than if you had just planned for one or two days in advance.” Anne says that although her life has been full of disappointments she moves forward and does not resort to anti-depressants. She recognises the recent difficulties with Michael cannot leave her hopeless, because she could be admitted to Weskoppies. That would leave no one to care for David. She feels David is dependent on her as he is like a child, but at the same time creates space for him to maintain as much independence as possible. Two months ago he

began packing his own pillbox. His life is “Pills, pills and more pills” She bought this box since he would suddenly announce his pills had finished. Plasters are also important because David frequently falls from poor balance. Anne uses other coping strategies. David must be busy otherwise he starts complaining about everything and Anne gets irritated. When this irritation starts Anne distracts herself. She counts to ten, bites on her teeth and withholds comments to prevent arguments. She also learnt to do some practical tasks he previously did, such as use a drill. Anne is still adjusting to David being around the house so much because prior to the accident their lives were previously very separate. David is still busy, but works much slower. This pace reduces Anne to tears because she feels sorry for him. She burst into tears at that point during the interview. Her impatience causes her to reflect on his struggle to regain what he had. She informs herself she must cope with the obstacles and there is no easier path. Helping her cope is her support structure that has changed from family to her work colleagues.

Building the house continues and that morning the builders were collected at 6am. The progression of the house is a record of Anne’s life because the significant changes, such as starting the garden and throwing the slab, have occurred on 14 February. That date is a time of reflection of the past year. David was also busy carving the front door he had begun prior to the accident. For Anne this door delineates their life before and after the accident and reflects David’s perseverance since she thought he would never finish it.

Future intentions

When asked a direct question about the future, Anne was silent for a long time and then replied, “I don’t know.” However, there were suggestions of future aspirations. Anne wants to study further, which she postponed after their and Michael’s accidents. She plans on completing the house before they retire because they have been building for ten years and she will allow David ten years to recover, as it is a progressive process. Furthermore, she will continue adjusting to his slower pace.

4.5.4. The researcher’s experience of the interview

Anne sequenced her story temporally and chronologically. She gave a detailed narration of her present context suggesting structure and routine and appears to live life cautiously. There were many references to her physical world and building this house plays a significant role. I wondered whether building provides security in its routine or provides a distraction. The house will be completed before retirement and the hope of its completion reflects the

hope for David's recovery. I had the impression Anne is living in two worlds at the moment, one full of hope and the other providing a reality check and insecurity. The initial response to a number of questions was "I don't know" and probing was needed to obtain answers. It was not that she was unable to answer, but I felt she is coping with so much; she reacts to her world and protects herself from further hurt. Anne is very practical with the every day needs of David, Michael and maintaining the household. I had an impression that Michael's current circumstances have overwhelmed her. Coping requires letting go of Michael and focusing her attention on David. I was amazed that there was no overt resentment towards David or Michael and that she felt obliged to take care of David. There appears to be a conscious choice to remain in the marriage. References of "a child" were quite frequent in Anne's narrative. She left home because she was treated like a child, David is like a child and David described the occupational therapy as an activity for children. Anne's relationship with time is a golden thread through her narrative and she faces the challenges of each day on that day. As Valentine's Day was the following week, I left this interview wondering how she would evaluate the past year.

4.6. Sarah's story

Sarah, David's sister, assumes a different voice because they grew up together and she has memories of childhood. Her narrative will incorporate experiences from her youth. The story we co-construct will be different.

4.6.1. The researcher's expectations of Sarah's story

My expectation of Sarah's story is that she will experience shock, confusion and uncertainty on receiving the news. Her initial days at ICU will appear that time has stopped because the journey will be an emotional roller coaster, fluctuating between David's survival and dying. She will experience her family either uniting or fragmenting under the emotional strain. Sarah's involvement in David's rehabilitation will depend on their prior relationship, the involvement of other family members and her immediate experience of the hospitalisation. As we were doing an impromptu interview, I expect her story to be more factual since she has not had time to think of metaphors and plan her story.

4.6.2. Narrative analysis of Sarah's story

A schematic representation of Sarah's story follows.

Table 4. Sarah's storymap

	Self	Other relationships	Physical self	Physical world
Past	<ul style="list-style-type: none"> • Communication • Coping strategies • Emotional pain and response • Growing up with David • Prognosis of David • Response to the trauma • Wedding 	<ul style="list-style-type: none"> • Baby • Communication • God • Husband • Mother-in-law on husband's side • Relationships with the immediate family of David 	<ul style="list-style-type: none"> • Power of the medical discourse • Pregnancy and birth • Stress and panic attacks 	<ul style="list-style-type: none"> • ICU • Rehabilitation • Step down facility • Transporting David from Nelspruit
Present	<ul style="list-style-type: none"> • Coping strategies • Emotional pain and responses. • Experiencing physical changes in David • Impact of the accident on her biological family • Interpretation of the accident • Relationships within her biological family • Suffering 	<ul style="list-style-type: none"> • Conflict • David's relationship with his mother-in-law • Family as a system • Support system • God 	<ul style="list-style-type: none"> • David's hyperactivity 	<ul style="list-style-type: none"> • House
Future	<ul style="list-style-type: none"> • Employment for David • Hope for David • Recovery of David 			

Past experiences

As we began the interview, Sarah became tearful and explained she did not realise the story still made her emotional. Sarah begins with a factual account of the day she was given the news. She was notified telephonically that David had been involved in the accident. Although the helicopter was summoned it would not airlift David to Johannesburg and he was transferred by ambulance the next day. Her mother followed David's transfer. Sarah arrived at the hospital and was informed David had lost 4 or 8 pints of blood, which had entered his lungs. Although doctors wanted to operate, he went into cardiac arrest for twenty minutes. In her narration Sarah describes her emotional response only after she saw David. "That's when I had it heartsore...and the first time he basically looked dead. Couldn't see any life or anything and that was like bad for... I can't remember... a month or so he couldn't talk to anyone."

The first two days following admission were the most difficult because they were unsure of the outcome. She stayed at hospital for the full day and found comfort by praying to God. She received much support from her parents and relatives who came to the hospital. Sarah falters and becomes tearful again. It took three weeks before the family realised David could only hear. "He couldn't move at all and then we realised he couldn't see, he couldn't...the only thing he could do was hear, that's all". She describes the laborious process of communicating where a family member would go through the alphabet. He spelt a word by squeezing one's hand at the correct letter. They would then start the alphabet again and continue this process for each letter until the word was spelt. These communication difficulties, watching the nurses suction his lungs, observing the pain he was in, and not knowing if he would survive were difficult experiences for her. Sarah associates ICU with death and indicates she could not work in that environment. "Seeing all those people die. Seeing them die and ...I don't know." Comparing the death of patients to David being alive in ICU she describes his survival as miraculous.

This ICU experience extended beyond David and included the doctors. Even though the family communicated daily with doctors, doctors provided little comfort. They would not predict the outcome or indicate if David would survive. However, doctors did discuss possible complications and the family felt relief when these did not occur. Sarah uses the word "vegetable" when describing David's prognosis and compares this word to his present progress. Rehabilitation was difficult for David. Sarah describes a nurse in one step down facility who removed David's bell. His helpless condition contrasted to the nurse's personal

need for rest. This nurse was unaware David could communicate and did not expect the infuriated family to report her behaviour to the authorities.

That year was particularly difficult for Sarah: her company was retrenching, her fiancé had his bakkie broken into twice in one week, her fiancé was face to face with one of the bakkie thieves the day of his mother's stroke, and her mother-in-law passed away. Sarah described in detail the events of contacting her fiancé's mother, not having a reply and then going to see if something was wrong. She was actively involved from her admittance and watched her fiancé experience his mother dying. All his siblings were overseas and he went through it alone. Sarah snapped her fingers when she compared the two ICU experiences and said her mother-in-law went just "like that", while David is still alive. Sarah became afraid of dying after her mother-in-law died. She was also admitted to hospital for stress and panic attacks. She describes with irritation that she would have the attack and then sitting in casualty would be as "calm as a lamb". She was prescribed anti-depressants. Sarah has had a daughter since then who has brought her much joy and fulfillment. Her relationship with the medical world from that year did not influence the birth. When she was on maternity leave David would visit her and she would encourage him during times of depression. They have had little contact since then.

Other significant events have been affected by the accident. Her wedding day, two months after her mother-in-law passed away, was another difficult time. Sarah is tearful again because David was to drive the wedding car and had a seizure that morning. The family thought he was having a stroke and he was taken to hospital. Not only were they without a driver for the wedding car, but David also missed the wedding.

Sarah describes David as very active before the accident. She reminisces of her high school days and the fun they had dancing together, but emphasises he can no longer dance. She compares his energy and love for life, to his dedication in rehabilitation. After the injuries he would regularly attend gym and horse therapy. Initially David needed four people at horse therapy to keep him on the horse because he could not balance. Towards the end of therapy he could ride with arms outstretched.

Present experience

Sarah believes God has given David a second chance and an opportunity to address his value system. She would like David and Anne to attend a Christian life enrichment course because she believes this will solve their problems. She also indicated the importance of

building the house and its pivotal role in their lives. Although David is still the same person and jokes a lot, she believes his life was too busy. She is emotional when she describes David's suffering because she wants him leading a normal life. He still has his personality and is outgoing, but is not the same person and has physical limitations. He cannot walk properly, has lost finger dexterity and Sarah internalises his unhappiness. She believes his life, even before the accident, brought him constant challenges. She observes he is pressurised to achieve, particularly by his mother-in-law. His present physical state will exacerbate his perfectionism because achievements are more difficult to attain. Sarah describes a promise David made to himself and its impact on his present life. Their father retired in his forties through ill health and David promised he would not do the same. Sarah is concerned David may face a similar predicament, but at an earlier age.

Sarah's family did not anticipate this traumatic experience, but the accident has brought them closer. They realised they could have lost David. Commenting on their support system, she says people still care, but stopped asking after David returned to work. Ironically she perceives David and Anne's life as "work, work, work". He still needs to be kept busy. Sarah believes they have re-evaluated their value system, but would have preferred to elude this traumatic experience. She deems it was unnecessary. Sarah is happy with her own life and her faith gives her meaning. She has also overcome her fear of dying.

Future intentions

Sarah's perception of the future is that David will recover and she will support him where possible in the work he does.

4.6.3. The researcher's experience of the interview

Sarah was very willing to participate in this study, but was quite emotional during the interview. Possibly the short notice prevented her preparing emotionally for re-entering the trauma from the year of the accident. The interview was cut short because Sarah was looking after her baby. Twice we stopped and finally the baby opened the can of formula and fell face first into the powder. We stopped the interview there. It was interesting comparing this interview to the pre-interview with her mother. Sarah chose to exclude that the weather was perfectly clear the day they wanted to airlift David from Nelspruit. Other family members blame the medical aid for the lost time and David's present state. It also appeared that she became actively involved once David arrived at Johannesburg and that losing her mother-in-law affected her more than David's accident. This is suggested by the detail and time spent

narrating both experiences. Some questions Sarah answered during the interview were not answered directly. Replies were sometimes a list of events, which we then explored further. However, since the accident Sarah has created her own family with its own identity.

4.7. Conclusion

Each participant is heard, each providing a unique lived experience. In co-constructing this story with my participants, I was in a privileged position of selecting the content incorporated in the story for this chapter. During transcription different thoughts came to mind. Reflecting on my interpretation my signature was dominant and I had to return to the transcriptions for the participant's experience. Neither the voices nor the signature could predominate and I have tried to maintain a fair balance between both.

The orchestra stills and the lights dim. The stage is set for the performance. All we await is for the conductor to walk on stage and guide the musicians into the score.

Chapter 5

DISCUSSION

The applause from the audience indicates the conductor has entered. They continue clapping until he has faced the audience, taken his bow and acknowledged the presence of the lead violinist. Turning to the orchestra he raises his baton. The clapping subsides and silence pervades the auditorium. Everyone sits listening for the first strains of the first bar. The performance is about to start. Join me, as the reader, to hear the musicians play their instruments and perform the symphony.

5.1. Introduction

Although there were numerous similarities amongst the stories, the perspectives taken and lenses worn by the participants during the construction of their story determined the colours they applied to their canvas of words and the shape their story acquired. In my role as co-creator of the narrative I have taken the predominant stories found simultaneously in all three narratives to present the family experience of physical trauma. The family has made sense of the experience of physical trauma narrating from a perspective of temporality and using stories of their *self*, relationships with others, their physical self and their physical world. The rubric (Figure 5) summarises the family experiences of physical trauma.

5.2. Narrative analysis on a temporal dimension

White and Epston (2000) state that narratives are structured on a temporal dimension. This temporality reflects change, facilitates a performance of the story's meaning and depicts agency. Temporality is frequently overlooked in therapy. Although many research articles using narrative analysis discuss the results under the headings of agency, voices of the community, historical and cultural symbols, this co-constructed story is written as an alternate story. The discussion follows the temporal sequencing of the previous two years of the experience. Furthermore, my personal rehabilitation and counselling experience suggest rehabilitation follows distinct stages. The narration of the family experience of physical trauma forms a coherent, plotted story framed by a natural beginning and an end. An alternate story may be plotted from their lived experience.

5.3. The family experience of physical trauma

Since this is a narrative study I must be careful that the family narrative of physical trauma is not drowned by the voice of the predominant medical discourse in society. At times the two discourses could challenge each other. I would like you, the reader to be conscious of your own experience of the medical discourse and its impact on your understanding and interpretation of this discussion.

Table 5. The family experience of physical trauma

	Self	Other relationships	Physical self	Physical world
Past	<ul style="list-style-type: none"> • Communication • Conflict • Coping strategies • Emotional pain and response • Personal experience of others in the family • Prognosis of David 	<ul style="list-style-type: none"> • Mother-in-law of David • Relationships with immediate family of David • Support system • God 	<ul style="list-style-type: none"> • Hospitalisation of each participant • Power of the medical discourse • Rehabilitation of David 	<ul style="list-style-type: none"> • House of David and Anne • ICU • Step down facility
Present	<ul style="list-style-type: none"> • Coping strategies • Emotional pain and responses • Employment for David • Hope • Interpretation of the accident • Suffering 	<ul style="list-style-type: none"> • Conflict • David as a socially constructed being • Family as a system • Mother-in-law • Support system 	<ul style="list-style-type: none"> • David's hyperactivity • Physical limitations 	<ul style="list-style-type: none"> • House
Future	<ul style="list-style-type: none"> • Hope for David • Recovery 			

Past experiences

Narrating the past was the predominant temporal aspect. It was interesting that no participant could story the events of the actual accident. Interwoven relationships, the hospitalisation and the rehabilitation of David were the main stories. Participants mapped the problem of the ICU admission, its influence in their lives and their personal relationship with the problem.

The needs of the family with another family member in **ICU** fall into two categories. Kirchoff et al. (2004) describes medical treatment as the first need when families are about to lose the admitted patient. The second need was fulfilled by their **support system**. A community discourse is that patients should be visited soon after admission, particularly if they are critically injured. This is a fearful response that the patient may not survive. This family hovered around ICU as they assimilated and accommodated the disequilibrium caused by the trauma (Jamerson et al., 1996). The extended family waited in the small waiting room and some resorted to standing in the corridors for news. This inadequate space was another difficulty for the family. Anne noted that family members who hardly saw David arrived to visit and she took charge when **conflict** occurred. The vested interests of each family member and anticipatory grief outweighed the needs of other family members. This anger is symptomatic of anticipatory grief (Kirchoff et al., 2004). Anne demanded she spend more time with David since she was his partner. The social discourse of a partner having a closer relationship to the patient allowed her exert her authority (Mitchell & Courtney, 2004) otherwise the family or medical staff would make her relationship with David insignificant (Chaboyer et al., 2005). David also relates his hurt at the conflict caused in his family by the accident and who would pay for coffee at the cafeteria. Their distress increased his own (Jones et al., 2004; Lee & Lau, 2003). Sarah commented the support system at the hospital was large, but described their role positively. The conflict she experienced was internalised when she considered losing David.

Communication is difficult for ICU patients and David experienced this (Patak, Gawlinski, Fung, Doerling, & Berg, 2003). Challenged by his physical state, he was unable to verbalise his thoughts and needs. His family printed the alphabet; a series of culturally accepted symbols, but this was inappropriate since he was blind. His family sounded the alphabet while he squeezed their hands to spell words. Although communication was slow, agency was returned to David and his family members. They were able to co-construct a form of communication. The initial response of the medical staff was disbelief, but David developed other techniques of communication. He ruled his family by widening his eyes whenever he was angry and David described how he bit pipes to communicate with the staff. David's

embodiment rendered him physically helpless and unable to language his experience, however, he held power and created choices.

The medical fraternity established a relationship of confidentiality and trust with the family (Mangram et al., 2005). Medical terminology used by the doctors was simplified for the family, and doctors used cultural metaphors of David having a “screw loose” to suggest he had lost mental capabilities. However, even David understood this metaphor, although he was supposed to be a “vegetable”. The **power of the medical discourse** and the authority invested in medical technology, expressed through David’s scans, dominated the prognosis. Azoulay et al. (2002) states that communication to a family should be clear and compassionate. Communication was clear, but sometimes insensitive for the family and patient. This instilled anger towards some nursing staff. However, Sarah indicated communication with most doctors during the ICU period was excellent. The family was informed daily of David’s status and a nurse came immediately to inform them of David’s cardiac arrest. This communication reassured the family David was receiving good medical care.

David’s voice was marginalised in the step down facility. The nurse in the **step down facility** removed his bell. This bell suggests an ability to summons people and is intrusive when sounded. It requires a change in activity. All the participants told of their fury at this nurse and the possible consequences of this insensitive action. The medical fraternity had failed the family and withheld help from David in his greatest time of need. **Rehabilitation** was another difficult period for the family, but more from its temporal aspect. Time restraints put on the process have since been altered to accommodate the slower progress.

Foucault (1979, 1980, 1984) states that power and knowledge decreases individual identity and prescribes the behaviour of individuals. Foucault (1979, 1980, 1984) also recognises the role of indigenous knowledge, which is knowledge circulating in society and given inadequate space for its performance. David’s treatment and rehabilitation were from the powerful medical discourse. However, the family did explore indigenous knowledge repressed in this hierarchy of knowledge. The family sent David to horse therapy. David was already attending physiotherapy, but Sarah recalls the significant improvement in David’s balance after this therapy. He began horse therapy with four people holding him, but on termination rode with arms outstretched. Anne qualified that despite this improvement David still experiences difficulties balancing.

The **family's emotional pain and response to the trauma and prognosis** depended on their perspective. David's ranged from despair to hope. As researcher, I noticed David was touched when his wife and mother said, "...if you sit in a wheelchair it doesn't matter we will still love you. If you can't see, don't worry we are here for you." David acknowledged that was a turning point for him. Feeling like scrap, a piece of metal discarded, a man of no value, his family would remain committed to him. Although the community would view David through the lens precipitating rejection (Martz, 2004), some family expressed unconditional love immediately after the accident. He chose to internalise this belief that he was wanted and gradually this increased his self-acceptance. David also created unique outcomes when he demanded earlier discharges from medical facilities, sometimes against medical advice. His embodiment exaggerated his helplessness and vulnerability. Although unable to vocalise his needs, he could report the unprofessional nurse. David was always making choices and seeking options (White & Epston, 1990). Suicide ideation was a choice of swallowing pills or using a knife, but his conscious choice was to ultimately live. He reasoned his family needed him. David continually attributed meaning to his experiences.

Engström and Söderberg (2004) suggest the partner of an ICU patient would experience severe stress. This occurred when Anne put David in a bed in the corner of the room at the step down facility. She expresses her helplessness in abandoning David at the facility and resorted to tears. The stress motivated her to look for another facility because she lacked confidence in the staff's competency. Her reaction to the trauma manifested more severely when Michael had his accident. She saw the accident scene and turned direction to avoid it. Avoidance of stimuli and hyperarousal are symptoms of traumatisation (American Psychiatric Association, 2000). Exploring the meaning of her metaphorical photographs, Anne represented a world contained by routine and order: the pills in a drawer, the clock and the pillbox. Practical items to assist David, they also suggest a world of predictability and safety amidst the helplessness and chaos of the trauma (Janoff-Bulman, 1995).

Sarah spoke of the pain she experienced when she saw David in ICU. She describes in detail the medical procedures she observed and her fear David may die. The unknown and unpredictability of ICU created helplessness (Engström & Söderberg, 2004). She experienced a direct loss on her wedding day a few months later. This helplessness and grief at his absence manifested when she burst into tears as she was narrating the story (Mohta et al., 2003). The community ascribes a wedding day as one of the most important days in an individual's life. They had shared their younger days growing up, but David was unable to share this day with her. These stories suggest a *self* experiencing helpless.

Coping strategies among family members varied. Immediately after the accident Anne arranged for Michael to be cared for by her mother. She ensured he knew where his white socks were. Her practical approach and role of mothering continued. Although family members provided practical assistance and removed her isolation, the assistance was more out of necessity (Engström & Söderberg, 2004). Despite powerful medical and legal discourses preventing David giving Anne power of attorney these were overcome by determination. As a couple they had written a unique outcome. Anne's coping strategies evolved and she began lowering her expectations of a quick recovery. As David and Anne narrate their separate stories, both externalise their problems and take responsibility for new choices (White & Epston, 1990). David expresses the physical difficulties as "not my fault" and Anne suggests her brain was unable to comprehend the news of David's injuries. Sarah described few coping strategies. She used her family support system and faith to cope during the ICU period, and explored in detail how her belief has assisted her re-evaluating her life generally.

God played a significant role in the meaning attribution of the trauma. David questioned God on the purpose of the accident and when God didn't reply it showed He didn't care. Anne believed God used the accident to prevent the divorce and Sarah perceived God as the answer to all her troubles. Adding this spiritual dimension to the interpretation of the trauma presented another *self*.

David explained that **relationships within his family** have changed. His brother-in-law, to whom he taught electronics, ruffled his hair like he is a child. Michael also treated him as though he is a child. Decisions surrounding Michael and the house remain unheeded. David had previously gained his self-worth from work. This and his ability to work decreased immediately after the accident (Martz, 2004). Anne spoke of the changes in their own relationship and indicated she made decisions regarding further surgery for David. She also regained power of attorney. Roles had changed (Engström & Söderberg, 2004). Sarah conceded her biological family experienced altered schemas described in the model of Janoff-Bulman (1995). Their sense of safety was challenged and did not believe their family could lose David. Sarah experienced other stress that year following David's trauma. Losing her mother-in-law developed into her fear of dying. This fear of death linked the story of David's seizure on her wedding day to a possible stroke their deceased grandmother had had. It was interesting that Sarah perceives David's mortality, but has not transferred that perception to her own life. The experiences of multiple, complex traumas without sufficient recovery time took their toll.

Since David's ICU experience each of the participants have been in hospital. Their **relationships with their hospitalisation** differed. David returned for further surgery and for his teeth to be repaired. He does not comment on most of the surgeries, except that the last operation has failed. Anne had a foot operation. Although she is grateful the doctors saved David's life she expressed ambivalence towards the medical world. Sarah experienced her mother-in-law's stroke and gave birth to her daughter.

Each narrative provided a different perspective on David's **mother-in-law**. David perceives competition in this relationship, which produces tremendous conflict in him and the feeling he is disrespected. David strives for perfection and is very sensitive to any form of belittlement. He has felt reprimanded like a child and believed his mother-in-law had impractical suggestions for rehabilitation. For David, the red chair Anne photographed, is the symbol for this conflict. Ironically this chair is soft and comfortable, and until the conflict provided a retreat for David during the day. Anne relates the same incident of the red chair, but in a more factual way. Her interpretation is that her mother was trying to motivate David. This parent-child relationship David has with his mother-in-law was also experienced in Anne's relationship with her mother. Anne named this treatment as a contributing factor for moving in with David. Milan systems therapy explores intergenerational patterns of behaviour and this pattern appears to be transferring to the next generation (Jones, 1993). David referred to Michael as "the child" even though Michael is eighteen years old, has been on drugs, been admitted to jail for theft, and has failed Grade 12. In the eyes of the law Michael is no child. Sarah also explains the conflict and competition between David and his mother-in-law. However, Sarah introduces and speaks with great affection of her late mother-in-law. Sarah provides an alternate story for the community discourse that every mother-in-law is an ogre.

Another thread through the narratives was the **house** David and Anne are building. A house should provide a place of comfort, express the personality of the individual and be more than a physical structure. It should be a home. Even if the family moves house, the home and relationships should not change. Each family member has a different perception of the importance of the house. Enormous in size, David believes the house inappropriate for their present needs. It was interesting for me that in the middle of the house between the kitchen and lounge is the large, spiral step case. This David photographed to illustrate his approach of taking life one step at a time. However, to walk between rooms an individual must walk around it. Although rails may be added later David has difficulty balancing and moving and the main bedroom is now upstairs. I wondered how he coped with the steps. David perceived himself as the financial source for the bond, but having little influence in the actual construction. His voice and identity is restricted to the design of the front door. Metaphorically

this door can be interpreted as a means of letting people in and out, not only of the house, but his life. David speaks of few interpersonal relationships. Anne views the same door as a symbol of the pre- and post-accident experience. Anne further interprets the house symbolically as representing their relationship. It was the first house they owned and began building straight away. The milestones of the house, such as throwing the slab, also occurred on Valentine's Day, the day of romance. Sarah perceives the house as something that kept this couple busy and restricting interpersonal relationships. She says if David and Anne were not at work, they were building the house.

Present experiences

Interpreting the accident occurs through attributing meaning to the trauma. This interpretation determines the impact of the trauma on the life of the individual and the family experience, and facilitates coping. Ursano et al. (1995) describe this attribution as a comparison of the present life against the pre-trauma life. David believes the trauma caused him to re-evaluate his materialism and he now desires a calm life. He strives to reduce his aggression and conflict in his family. This aggression was represented in the metaphor of the clenched fist as though he was ready for a boxing match. Anne has attributed different meaning to the trauma. She believes the accident has rescued her marriage, which was in difficulty one month prior to the accident. She recognises both their efforts to facilitate the healing, but attributes the defining factor as this accident. She strives to maintain emotional stability to fulfill the caregiver role for David. Anne also portrayed David as a victim of the medical aid. She is bitter the medical aid refused to airlift David. The medical aid represents tangible support during physical injuries. She believes it failed David since he would not have had these complications. Blaming the medical aid allows Sarah regain the belief the world is controllable (Kleber & Brom, 1992; Peltzer & Renner, 2004). Sarah initially commented the trauma was a time for David and Anne to re-evaluate their priorities and materialism, but believes they are returning to their previous lifestyle. However, she said the accident was unnecessary and held no value for David.

David still experiences **physical limitations**. His greatest need is to recover his voice, short-term memory and physical strength. He experiences physical pain, struggles to walk and move from a sitting to a standing position. These limitations impact Anne and Sarah. Their **emotional response** to these changes in David is sorrow. They feel his discontent, frustrations and empathise with him. However, this response extends beyond the physical limitations. They observe his broken and yet determined spirit, his discouragement, and perceive his losses and suffering. This affects them emotionally as they evaluate David's life

on an existential level (Martz, 2004). Schyder (2005) in his article on chronic pain comments, “pain gains its power when [you] let it become suffering” (p.51). I believe this is true not only for physical pain, but emotional pain as well. Although David does not use the word **suffering** like Anne and Sarah, he describes the same emotions.

Conflict and aggression is observed or experienced by all three members. David indicated his aggression had decreased since the accident, but was still present. He reported increased conflict in his immediate family and experiences frustration striving to be perfect. This creates further discontent because his disabilities restrict his functioning. Anne experiences tremendous conflict in their relationship caused by David’s physical limitations and Anne observes the conflict in the family.

David is still **hyperactive**. Both Anne and Sarah describe David as busy with “work, work, work”. He would work late into the night and on Saturdays. This hyperactive lifestyle was reduced through his injuries and Anne is still adjusting to his slower pace. Sarah commented that the only time David was still was when he was in hospital, but has resumed his need to be constantly active.

The **family system** has changed since the accident. The immediate family system consists of three members. David perceives the family as Anne and himself, with Michael on the point of leaving home permanently. There is a split in the relationship between David and his stepson, Michael. Michael’s name was the only name David used in his whole narrative. He referred to everyone else according to the roles they play in his life. David believes Michael disrespects him and David has tested Michael on some issues, but is afraid to inform Anne of the outcome. David and Michael have developed socially constructed behaviours in the present situation. David wants the respect as the head of the house, while Michael reflects the voice of society to David. David detailed the problems they have been experiencing with Michael that have intensified since the accident. From a first order cybernetic perspective, Michael is reflecting the changes in the family system precipitated by the accident (Jones, 1993). The evening of the interviews Michael came home unexpectedly and brought a friend to spend the night. During the interview David commented he was not asked whether it would be acceptable for the friend to stay. This disregard angered him. The disengagement in this relationship conveys to David the health of his relationship with Michael (Bateson, 1978). Since there is no dialogue between these two family members their problem saturated story will continue (Anderson & Goolishian, 1988). Against this backdrop, I found it significant that Anne gave the clock to David for Father’s Day.

Anne, however, perceives the family system consisting of three members. She appears divided in loyalty between being responsible for David or Michael and realised this during the recent events with Michael. She needed to maintain sanity at all costs because caring for David is like looking after a child. Presently he needs her most. Sarah refers to the larger family system consisting of bloodline family although smaller subsystems have formed within the family. This system includes all the relatives who visited David in hospital. She has different relationships with David and Anne, but is closer to David. However, her present relationship with both of them has drifted and she sees little of them. This family system is not the only system she has.

A **good support system** is essential in recovering from trauma (Updegraaf & Taylor, 2000). The support system has changed since the accident. Initially there was an overabundance of family members visiting David in ICU. Anne noted that from this extended family, only one uncle occasionally enquires after David. In a recent conversation Anne and David had, they discussed the change in their support system from family to work colleagues. Anne's colleagues, who had never met David, were still enquiring about David's recovery and she believes display real concern for them. David returns home after a day's work and moans the ladies always complain about their lives. However, he enjoys listening to their news. Sarah's understanding of the family response is that the family still care, but stopped enquiring once David returned to work. Systems and society relate differently to David since the accident.

David believes his closest friends are the birds on the roof of his house. I wondered if this is not a response to his **socially constructed embodiment** and social withdrawal caused by the trauma (Malt, 1995). Anne noted the medical world conveyed to David he is abnormal and incapable of making decisions. Strangers have a similar response and recoil when he replies with his paralysed vocal chords to their conversation. Injuries resulting in a noticeable disability cause rejection that is often internalised by the patient (Martz, 2004). Sarah believes the family still care about David, although they don't ask about him. This changed when David returned to work. Possibly they believe if he can work, he has recovered.

All three members maintain **hope** for David's recovery. David and Anne are making plans for the future that incorporate further recovery. Sarah also maintains hope. I suspect this family would resign themselves to David's condition and leave him alone if they lost this hope. This hope provides a goal to strive for. To maintain hope **coping strategies** have evolved for each family member. David adjusts on a physical and emotional level. He accommodates his physical needs by changing his environment and avoids discussing Michael's current situation with Anne. Both avoid discussing any contentious issues. Anne has her own coping

skills. She is adjusting to David's slow pace, withholds criticism and walks away. She prioritises her needs and admitted she had no choice but to cope with the change in Michael's behaviour because she could not go to Weskoppies, a symbol for mental illness. Sarah uses her faith to cope, explain her life and have hope for the future. When she feels troubled she attends a church course that aims at enriching the lives of the participants and addressing their emotional needs.

David's **employment** is a concern for all family members. David has returned to work and is adapting to his new position. He is planning for promotion in the future and to study further. Anne commented that the support David received from his work environment was helping him adjust and cope emotionally. Sarah expressed her concern that David would not cope in the future and would need to seek other business opportunities.

Metaphorically a **house** suggests a home, a place providing comfort and rest. As researcher, it was interesting that building this house continued relentlessly despite the challenges this family experienced. Foucault (1984) states social control is gained through using language to construct knowledge about people. I would extend this concept to include non-verbal language expressed in this activity of building. I believe Anne is exerting social control and writing her story into the house. Previously David was responsible for building, whereas Anne presently arranges everything. Through the accident and David's physical condition there has been a change of power in their relationship. This challenges the discourse that the husband is the breadwinner and makes the decisions. Many of the metaphors Anne used suggest a need for structure, order and control; this house could be an extension of the same need. It may be her physical space to exert control in the midst of uncertainty and helplessness regarding David's recovery. It could also express her need for more intimate and successful relationships since it has five rooms and she describes her life as one of heartache and many broken relationships.

Future experiences

There were two predominant outcomes for the family in the future. These were that **David would continue recovering** and secondly the **hope** he will return as a fully functioning member of society. Although the family members do not identify their sources, the hope is present. This hope is a continuation of the hope they had during David's ICU stay (Patel, 1996). However, Janoff-Bulman (1992) questions the reality of hope in physical trauma patients. Patients hope for a complete recovery and a return to their former life, however,

they do not return to that life completely. They may regain complete health, but individuals report adjustments and new coping skills to compensate for the changes experienced.

Although the outcomes are evident, there were differences in the participants' expectations. David had the most dreams suggesting he is still mapping his unique outcomes to write his alternate story. He is invested in his recovery and describes the goals and the time frame he set for himself. Some goals appear unrealistic when compared to his present physical state, but creativity and imagination allow David create a world of the impossible. Acting the preferred reality will influence David's relationship with himself, his community, his physical being and his world (White & Epston, 1990). His agency is expressed through the metaphor of the empty glass because rehabilitation and work will cause the half filled glass to overflow. The glass is a metaphor of his life. He anticipates a return to the abundant life.

Martz (2004) states that disabled individuals experience stigmatisation and may internalise the voice that the community devalues them. David wants to reverse this socially constructed embodiment regarding his disabilities and regain his power (White & Epston, 1990). He will achieve this by recovering physically. He wants to regain his speech and return to speech therapy. On a metaphoric level, he has also lost his voice and hopes to regain leadership in his family and society. He also hopes to write an alternate story for the discourse of discontent in his family. The need for simplicity is reflected in his dream of living in a little shed on the beach, instead of living in the "white elephant". His recovery will continue reflecting his need for congruency.

Anne has an ambivalence regarding the future and narrates from two perspectives. She hopes David will rehabilitate completely in the next ten years, but qualifies this may be insufficient time. She makes things concrete to maintain control and provides a goal so far in the future that if it is not attained it will not matter. However, Anne is uncertain how David feels about his rehabilitation, he may be at a comfort zone or unmotivated to continue. She will continue adjusting and accepting David's slower pace. Anne also wants their house finished before they retire, which could be in twenty years.

Finally, Sarah had few future expectations for the future, except the hope and belief in David's recovery. She would assist David with employment and had a few ideas for him to start his own business if he wanted to. She was satisfied with her personal life and did not disclose any needs.

5.4. The impact of trauma on the narratives of the participants

White and Epston (2000) purport individuals “are rich in lived experience, that only a fraction of this experience can be storied and expressed at any one time” (p.150). Meaning attribution occurs by creating a coherent story from the lived experiences. The narratives of these participants consist of stories meaningful to them. This was clear when David presented his photographs. He apologised for their simplicity, but emphasised their significance. Each photograph contained a complete story in itself and these combined to narrate a final family narrative. Given two weeks to photograph the participants could select the stories to include.

Narrating these stories may be influenced by the traumatic event itself. Narration involves structuring a coherent story, whereas trauma fragments the narrative. This research design would allow participants time to reflect and order their narrative. Furthermore, Ehlers and Clark (2000) state adjustment to trauma is centered on autobiographical memory. Studies on autobiographical memory and PTSD using self-report methods record there are many sensory, perceptual and emotional references during flashback episodes, particularly in the auditory and visual domains. Hellawell and Brewin (2004) state traumatised individuals speak in the present tense during flashback episodes particularly when someone’s life is threatened. This impact of the experience of physical trauma and its influence on each narrative is discussed below.

David’s narrative reflected some of the difficulties he has following the accident. He struggles with his short-term memory. Subsequently, the idea units he verbalised were shorter than the two narratives from the other participants and he changed topics frequently. David explained his altered value system and then narrated his story from an emotional and perceptual perspective. He had lost his physical vision and speech. Explaining his depression and suicide ideation he uses direct speech and then reverts to past tense. He said, “Ok I’m going to take my own life drinking pills’, then I thought ‘Hey, what about my wife and family?’ I got over...I passed that one.” David’s story focused initially on his depression and inability to comprehend the detail of what happened. He uses many negative references narrating his ICU stay from arguing with himself, wanting to die, the conflict in the family and negative prognosis, which could suggest mental defeat. The negative memories David used to story his ICU experience suggest he was internally focused and experienced a shift in attention. Jones et al (2001) suggests that attention shifting from external to internal stimuli during ICU may be attributed to various causes, such as hypnagogic hallucinations. As David gained hope the images were of less emotional intensity, but David would convert immediately to direct speech when narrating an upsetting event. He spoke a lot of his anger and aggression,

and he is still struggling in his rehabilitation process. There were flashback episodes when David narrated his story.

Most of Anne's story is factual, relaying details of events that were sequenced chronologically. However, when she narrates her relationship with David after the accident she speaks in the present tense, as though he is in the room and listening. Most of the traumatic events use direct speech. To emphasise some aspects Anne would repeat a word three times. "This is just David working, working, working." There were a few emotional references during her flashbacks ranging from laughter, to tears and confusion. However, Anne narrated most of her story from autobiographical memory.

Sarah found it difficult to narrate some aspects of the trauma and I probed to gain detail. She was emotional at the start of the interview and flashbacked when David went into cardiac arrest. "Then the [nursing] sister came back and she said 'No, his heart just stopped, collapsed,' and then they had to get him going again." Auditory, visual and emotional references predominate her story. She says, "I remember thinking that I don't know what I'm going to do if he doesn't make it because I just love him too much." Watching his medical treatment was as difficult. "It was heartbreaking for me because they would suck his lungs every now and then, and when they put the pipe in I could see it was very painful when they do it." Sarah also fluctuated between flashbacks and autobiographical memory.

Memories of the traumatic event impacted each narration because flashback episodes could be identified. Although it varied, each participant fluctuated between present and past tense. The process of the family members integrating their lived experiences of trauma into a coherent story is not yet complete. The emotional stress and tears shed during this reflexive process confirmed this.

5.5. Conclusion

The family experience co-constructed with the researcher tells the story of a family impacted by the physical trauma. Affected on all levels the family adjusts physically, psychologically and socially. Some of the changes are personal, others occur as a family. No member escapes the incident. They have made sense of the experience by relating stories across a temporal dimension of relationships with themselves, with others, with their physical self and their physical world.

The performance is over. The timing was perfect, not one musician played out of time or an incorrect note. Each sound harmonised with the other. For the musicians, this was the culmination and the return from their personal investment in the world of music. Despite all the frustrations, dedication, commitment and months of unseen practice, the performance was perfect this afternoon. The audience applauds the musicians and recognise the hours spent reflecting on and interpreting the score. The applause fades and the audience stands to leave and return home. The programme is complete.

As researcher, the use of this music metaphor allowed me construct the symphony of the sense a family makes of physical trauma using narrative. This metaphor clarified and sequenced the study into clearly defined chapters, since I had to simultaneously consider the symphonic performance and the process of exploring the performance of the lived experiences. These performances culminated and symbolised months of hard work and patience the musicians and participants endured. Although the symphonic orchestra were using sheet music and instruments to sound the thoughts of the composer, this family were living and verbalising their own thoughts. They were the musicians playing the instruments of trauma, the family and the family experience of physical trauma. Their sheet music was titled "Family experiences of physical trauma". The notes of the score were the interwoven relationships with their *self*, with others, their physical self and their physical world. Played over time they sound the final piece of the lived experiences. The family is making sense of their experience. Both the symphonic and family performances have a history and although this performance is over today, tomorrow will bring a new sound.

Chapter 6

RECOMMENDATIONS AND CONCLUSION

31 March 2007

To my participating family,

Thank you for allowing me into your lives for that two week period and for your honesty and openness in which you shared the joys and pain of your experience. The road you are walking is long and it may feel you keep reaching a cul-de-sac. Those cul-de-sacs often lead to a detour and another path ahead. Sometimes you will need to create a path no one has walked before. Despite the fear and negative voices saying your journey is impossible, forge ahead. No one truly knows the courage and will needed to overcome the obstacles families require after an experience of physical trauma. Your family does since you have walked part of the road! Continue to challenge the discourse that says you may go no further because you have reached the standard two year recovery period. In time to come you will be able to share your lived experience and preferred reality with a larger audience. As witnesses to your journey, other people will see the possibility of writing their own alternate story as your family is doing.

Our paths often cross with other people for a purpose. I think you have experienced that. The day of the pre-interview you were able to name and identify many other families who were in a similar predicament. We learn to speak the same language after a life-changing event like this. No textbook or lecture can teach us these words or knowledge. Family members learn different lessons because each views the experience from another perspective and wears an alternate lense for interpretation. Cultural, historical and social motifs influence the interpretation since the narrative is co-constructed from your social relationships and interactions with people everyday. No family member escapes this experience, since perceptions of life are changed forever. This change is experienced on all levels: the physical, social and psychological. Each family member had many *sel/ves* on these levels represented in your stories. Continue exploring these *sel/ves* and ways of expressing and experiencing this event.

This field of research in psychology has also begun its own story. I believe there are many other stories waiting to be written and performed. During the pre-interview you mentioned

your experience and hurt from the treatment your third party claim has received in the legal discourse. My counselling experience showed similar responses in other patients I worked with. Possibly this could be studied further because litigation has a significant impact on recovery. O’Kearney and Perrott (2006) also challenge the concept trauma memory is fragmented. They believe narratives should be explored separately on levels of cohesion and coherence. I wonder what results such a study would yield if the same research data was used? That comparison may support or challenge the belief that trauma is fragmented. Furthermore, I never had the opportunity to interview Michael, I was wondering how he would have storied his experience because he is the next generation in your family. How do children in families experience such large adjustments and what coping strategies do they use? David’s mother also withdrew from the research through the painful reliving of the experience. I observed similar responses of mothers when their children were admitted to ICU. I also observed there was a difference depending on the gender of their child, irrespective of age. How do mothers create and make sense of this lived experience? South Africa has many cultures and financial standing determines access to medical care. Public hospitals may provide a different experience in the rehabilitation process for patients and families. How would this compare to those receiving private treatment? Furthermore, how would their culture impact on the retelling and explanation of the experience? There are many stories waiting in the wings for their performance in front of an audience. What symphony will they perform?

This is my final chapter for this dissertation, Chapter 6. However, this is not your final chapter. I look forward to writing your Chapter 7 when you indicate you are ready- seven being the number of completion.

Until that time- goodbye for now,

Laurian

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APPENDIX A

DIAGNOSTIC CRITERIA FOR ADJUSTMENT DISORDERS

- A. The development of emotional or behavioural symptoms in response to an identifiable stressor(s) occurring within three months of the onset of the stressor(s).
- B. These symptoms or behaviours are clinically significant as evidenced by either of the following:
 - (1) marked distress that is in excess of what would be expected from exposure to the stressor
 - (2) significant impairment in social or occupational (academic) functioning
- C. The stress-related disturbance does not meet the criteria for another specific Axis I disorder and is not merely an exacerbation of a pre-existing Axis I or Axis II disorder.
- D. The symptoms do not represent bereavement.
- E. Once the stressor (or its consequences) has terminated, the symptoms do not persist for more than an additional 6 months.

Specify if:

Acute: if the disturbance lasts less than 6 months

Chronic: if the disturbance lasts for 6 months or longer

Adjustment disorders are coded based on the subtype, which is selected according to the predominant symptoms. The specific stressor(s) can be specified on Axis IV.

309.0 With depressed mood

309.24 With anxiety

309.28 With mixed anxiety and depressed mood

309.3 With disturbance of conduct

309.4 With mixed disturbance of emotions and conduct

309.9 Unspecified

(American Psychiatric Association, 2000, p. 683)

APPENDIX B

DIAGNOSTIC CRITERIA FOR 308.3 ACUTE STRESS DISORDER

- A. The person has been exposed to a traumatic event in which both of the following were present:
- (1) the person experienced, witnessed, or was confronted with an event or events that involved actual or threatened death or serious injury, or a threat to the physical integrity of self or others
 - (2) the person's response involved intense fear, helplessness, or horror
- B. Either while experiencing or after experiencing the distressing event, the individual has three (or more) of the following symptoms:
- (1) a subjective sense of numbing, detachment, or absence of emotional responsiveness
 - (2) a reduction in awareness of his or her surroundings (e.g., "being in a daze")
 - (3) derealisation
 - (4) depersonalisation
 - (5) dissociative amnesia (i.e., inability to recall an important aspect of the trauma)
- C. The traumatic event is persistently, re-experienced in at least one of the following ways: recurrent images, thoughts, dreams, illusions, flashback episodes, or a sense of reliving the experience or distress on exposure to reminders of the traumatic event.
- D. Marked avoidance of stimuli that arouse recollections of the trauma (e.g., thoughts, feelings, conversations, activities, places, people).
- E. Marked symptoms of anxiety or increased arousal (e.g., difficulty sleeping, irritability, poor concentration, hypervigilance, exaggerated startle response, motor restlessness).
- F. The disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning or impairs the individual's ability to pursue some necessary task, such as obtaining necessary assistance

or mobilizing personal resources by telling family members about the traumatic experience.

G. The disturbance lasts for a minimum of 2 days and a maximum of 4 weeks of the traumatic event.

H. The disturbance is not due to the direct physiological effects of a substance (e.g., a drug of abuse, a medication) or a general medical condition, is not better accounted for by Brief Psychotic Disorder, and is not merely an exacerbation of a pre-existing Axis I or Axis II disorder.

(American Psychiatric Association, 2000, p. 471-472)

APPENDIX C

DIAGNOSTIC CRITERIA FOR 309.81 POSTTRAUMATIC STRESS DISORDER

- A. The person has been exposed to a traumatic event in which both of the following were present:
- (1) the person experienced or witnessed, or was confronted with an event or events that involved actual or threatened death or serious injury, or a threat to the physical integrity of self or others
 - (2) the person's response involved intense fear, helplessness, or horror. **Note:** In children, this may be expressed instead by disorganized or agitated behaviour
- B. The traumatic event is persistently re-experienced in one (or more) of the following ways:
- (1) recurrent and intrusive distressing recollections of the event, including images, thoughts, or perceptions. **Note:** In young children repetitive play may occur in which themes or aspects of the trauma are expressed.
 - (2) recurrent distressing dreams of the event. **Note:** In children, there may be frightening dreams without recognizable content.
 - (3) Acting or feeling as if the traumatic event were recurring (includes a sense of reliving the experience, illusions, hallucinations, and dissociative flashback episodes, including those that occur on awakening or intoxicated). **Note:** In young children, trauma-specific re-enactment may occur.
 - (4) Intense psychological distress at exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event
 - (5) Physiological reactivity on exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event
- C. Persistent avoidance of stimuli associated with the trauma and numbing of general responsiveness (not present before the trauma) as indicated by three (or more) of the following:
- (1) Efforts to avoid thoughts, feelings, or conversations associated with the trauma
 - (2) Efforts to avoid activities, places, or people that arouse recollections of the

trauma

- (3) Inability to recall an important aspect of the trauma
- (4) Markedly diminished interest or participation in significant activities
- (5) Feeling of detachment or estrangement from others
- (6) Restricted range of affect (e.g. unable to have loving feelings)
- (7) Sense of a foreshortened future (e.g., does not expect to have a career, marriage, children, or a normal life span)

D. Persistent symptoms of increased arousal (not present before the trauma), as indicated by two (or more) of the following:

- (1) difficulty falling or staying asleep
- (2) irritability or outbursts of anger
- (3) difficulty concentrating
- (4) hypervigilance
- (5) exaggerated startle response

E. Duration of the disturbance (symptoms in Criteria B, C, and D) is more than one month.

F. The disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.

Specify if:

Acute: if duration of symptoms is less than 3 months

Chronic: if duration of symptoms is 3 months or more

Specify if:

With delayed onset: if onset is at least 6 months after the stressor.

(American Psychiatric Association, 2000, p. 467-468)

APPENDIX D

INFORMATION LETTER AND LETTER OF CONSENT

Informed Consent

Dear Participant

Research to be conducted by Laurian Ward through the Psychology Department, University of Pretoria

Title of the study: Family experiences of physical trauma.

Purpose of the study: To gain a narrative description from a family member/s of the experience of physical trauma of another family member.

Procedures: For this study you will be given a disposable camera and asked to take photographs of any items or symbols which could illustrate your experience of physical trauma. Once these have been developed you will be interviewed to tell your story of the experience. With your consent this interview will be taped, transcribed and then analysed. Once the data has been analysed the results of the analysis will be published as a mini-dissertation. The raw data will then be destroyed. The time needed for the photography will depend on what you chose to photograph, while the interview will take about one and a half hours.

Risks: The risk or discomfort of participating in this research may be that retelling the story may upset you.

Benefit: It may be of benefit that being able to illustrate and verbalise your experience may lead to an emotional healing. The sharing of your experience will also contribute to the understanding of this experience in the professional field and indirectly assist those in a similar predicament.

Participant's rights: Your participation in this study is voluntary. If at any stage during the process you feel uncomfortable and wish to withdraw you may do so without any consequences.

Confidentiality: All information obtained during this research will remain confidential. Should you choose to withdraw from the research your data will be destroyed and not included. The only persons with immediate access to your data will be my supervisor, Adri Prinsloo, Department of Psychology, University of Pretoria.

Right of access to the researcher: Should you have any questions regarding this research or your participation in it please do not hesitate to contact me at 072- 123 3632.

Yours faithfully

Laurian Ward (Miss)

Letter of Consent

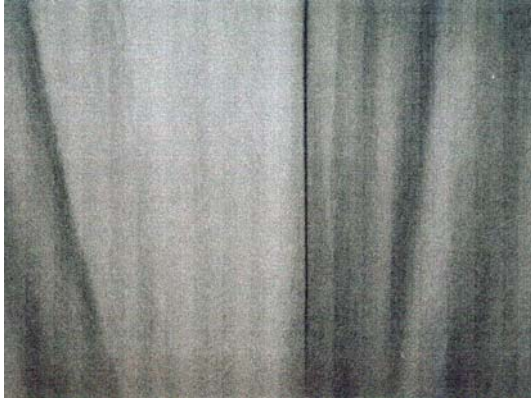
I, _____ hereby agree to be a participant in the research project as was discussed with me. I am aware of the purpose and planned programme of the research and am willing to participate in these events. I give my permission that all information gathered by the researcher during her research project may be used for the purpose of a research report, which will be presented to a supervising psychologist as well as an external evaluator, and may be published for academic purposes.

I also indemnify the University of Pretoria and the researcher of all claims that may occur during the course of the research.

This document was signed on this _____ day of _____ at _____ .

APPENDIX E

THE ORIGINAL PHOTOGRAPHS OF DAVID



Darkness representing David's blindness



The fist representing conflict



The screw representing David's prognosis



The pills representing suicide ideation



The knife representing suicide ideation



The Bible representing David's faith



Scrap metal representing David's life



The empty glass representing David's life



The light representing hope



Binoculars to see into the future



The walker representing David's mobility



The clock representing goal setting



The distribution board representing David's life



The flight of steps representing David's approach to life

APPENDIX F

THE ORIGINAL PHOTOGRAPHS OF ANNE



The ramp for David's wheelchair



David's pillbox for the week



Dough from occupational therapy



The drawer containing pills and plasters



The bulldog for David



Medical gloves



The house Anne and David are building



The red chair David sat in



The clock to teach David time



The front door David is designing