

# **Communication after mild traumatic brain injury: A spouse's perspective**

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**COMMUNICATION AFTER MILD TRAUMATIC  
BRAIN INJURY: A SPOUSE'S PERSPECTIVE**

by

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## ABSTRACT

Mild traumatic brain injury (MTBI) has gained increasing attention over recent years with much research directed at the nature of persisting symptoms experienced by individuals with MTBI. Owing to the subtle nature of cognitive-communicative difficulties after MTBI, as well as the lack of sensitivity of traditional assessment tools in identifying these difficulties, individuals with MTBI are seldom referred for speech-language therapy services. The need has therefore arisen for the communicative abilities of individuals with MTBI to be assessed in ways other than through the implementation of traditional assessment tools. This preliminary study, for which a qualitative approach with a multiple case study design was adopted, aimed to investigate communication following MTBI from the perspective of a spouse. The spouses of three individuals with MTBI were selected to participate in this study. Semi-structured interviews consisting of two open-ended questions were held with each spouse. The content obtained from the interviews was subjected to a discourse analysis (DA) and the themes that were identified were interpreted within the Model of Social Communication (Hartley, 1995). The results of this study revealed that each of the participants perceived changes in the communication of their spouses since the MTBI. When interpreted within the Model of Social Communication (Hartley, 1995), these communication difficulties were considered to be either the result of impaired internal processes (including impairments in executive control, stored knowledge, subcortical and limbic input or cognition) or the interaction between these impaired internal processes and the environment. The implications of these results regarding the role of the speech-language therapist in MTBI are highlighted. The potential value of the spouse, and the use of DA as both a methodological and clinical tool in the field of speech-language therapy are discussed. Recommendations for future research are made.

**KEY WORDS:** communication, discourse analysis, environment, executive control centre, the Model of Social Communication (Hartley, 1995), internal processes, mild traumatic brain injury, perceptions, post-concussion syndrome, spouse.

## SAMEVATTING

In die afgelope paar jaar is daar aansienlik meer aandag geskenk aan ligte traumatiese breinbesering (LTBB), en is heelwat navorsing gedoen oor volhardende simptome by individue met LTBB. Vanweë die subtiele patroon van kognitiewe kommunikasieprobleme na LTBB, asook die tekort aan sensitiewe tradisionele waardebepalende hulpmiddels om probleme van hierdie aard te identifiseer, word persone met LTBB selde na spraak-taalterapeute (STT'e) verwys. Daar het gevolglik 'n behoefte ontstaan om die kommunikasievermoëns van persone met LTBB op ander maniere as met behulp van die tradisionele metodes te evalueer. Met hierdie inleidende studie, wat van 'n kwalitatiewe benadering met 'n veelvoudige gevallestudie-ontwerp gebruik maak, beoog die navorser om kommunikasie ná LTBB vanuit die perspektief van 'n eggenoot te ondersoek. Die eggenote van drie persone met LTBB is gekies om aan hierdie studie deel te neem. Half gestruktureerde onderhoude wat uit twee oop vrae bestaan het, is met elk van die eggenotes gevoer. Die inligting wat uit die onderhoude verkry is, is aan 'n diskoersanalise (DA) onderwerp en die temas wat geïdentifiseer is, is aan die hand van die Model van Sosiale Kommunikasie (Hartley, 1995) geïnterpreteer. Uit die resultate van hierdie navorsing het dit geblyk dat al die deelnemers ná die MTBI veranderinge in die kommunikasie van hulle eggenote opgemerk het. Op grond van interpretasie volgens Hartley se Model van Sosiale Kommunikasie (1995) is die gevolgtrekking gemaak dat die geïdentifiseerde kommunikasieprobleme òf deur beskadigde interne prosesse (met inbegrip van gebreke ten opsigte van uitvoerende beheer, opgebergde kennis, subkortikale en limbiese toevoer of kognisie), òf deur die wisselwerking tussen hierdie beskadigde interne prosesse en die omgewing veroorsaak word. Die implikasies van hierdie resultate ten opsigte van die rol wat die STT in die behandeling van persone met LTBB kan speel, word uitgelig. Die potensiële waarde van insette deur die eggenoot, asook die gebruik van DA as beide 'n metodologiese en 'n kliniese instrument op die gebied van spraak-taaltherapie word bespreek. Ten slotte word aanbevelings met betrekking tot moontlike toekomstige navorsing gedoen.

**Slutelwoorde:** kommunikasie, diskoersanalise, omgewing, eksterne beheersentrum, Hartley se Model van Sosiale Kommunikasie (Hartley, 1995), interne prosesse, ligte traumatiese breinbesering, persepsies, postkonkussiesindroom, eggenoot

## LIST OF ABBREVIATIONS

<b>MTBI</b>	<b>Mild traumatic brain injury</b>
<b>PCS</b>	<b>Post-Concussion Syndrome</b>
<b>TBI</b>	<b>Traumatic brain injury</b>
<b>DA</b>	<b>Discourse analysis</b>
<b>SLT</b>	<b>Speech-language therapist</b>
<b>P1</b>	<b>Participant 1</b>
<b>P2</b>	<b>Participant 2</b>
<b>P3</b>	<b>Participant 3</b>
<b>NM</b>	<b>P1's spouse</b>
<b>NJ</b>	<b>P2's spouse</b>
<b>EM</b>	<b>P3's spouse</b>

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## CHAPTER ONE

### 1 INTRODUCTION

In this chapter, an orientation to the context of the study is given. The background to the study as well as the rationale is discussed. Terminology used in the text is then defined.

#### 1.1 ORIENTATION

Mild traumatic brain injury (hereafter MTBI), accounts for approximately 80% of all patients admitted to hospital with brain injuries (Culotta, Sementilli, Gerold & Watts, 1996; Kraus & Nourjah, 1989; Sinson, 2001). Although most individuals with MTBI show spontaneous and complete recovery from a few weeks to a few months post injury, approximately 15% complain of persisting symptoms long after their injury (Alexander, 1995; Bohnen, Wijnen, Twijnstra, van Zutphen & Jolles, 1995; King, 1997). Many individuals with MTBI typically experience difficulties in returning to work, unable to manage their previous demands (Barrow, Hough, Rastatter, Walker, Holbert & Rotondo, 2003). Ruff, Camenzuli and Mueller (1996:551) referred to this small percentage of individuals with MTBI experiencing difficulties beyond one year post injury, as the ‘miserable minority.’ The cluster of symptoms experienced long after MTBI, has been referred to as ‘Post-concussive Syndrome’ (hereafter PCS) (Alexander, 1995; Satz *et al.*, 1999). However, PCS has been described as ‘controversial’, since in the relevant literature different terms are used to refer to this cluster of symptoms occurring after MTBI (Evans, 1994). Controversy also exists around the presence of persisting cognitive-communicative versus emotional symptoms after MTBI, with many studies yielding differing results (Mathais & Coats, 1999) regarding these symptoms. Furthermore, the evaluation, diagnosis and management of MTBI in hospitals to date, has been characterised by a lack of uniformity (Blostein & Jones, 2003; De Kruijk, Twijnstra & Leffers, 2001a; De Kruijk, Twijnstra, Meerhoff & Leffers, 2001b; Ruff & Jurica, 1999). This lack of uniformity may be ascribed in part to the lack of sensitive assessment tools for MTBI. Diagnostic tools used by speech-language therapists (hereafter SLTs) have unfortunately been found to lack the sensitivity required to detect cognitive-communicative deficits typically associated with MTBI (Barrow *et al.*, 2003; Duff, Proctor & Haley, 2002). The fact that so many individuals with MTBI seem to ‘fall through the cracks’ (Sinson, 2001:425) may be the result of the lack in agreement within the literature regarding MTBI. The lack of sensitive tools for detecting MTBI and its

symptoms necessitates the investigation of cognitive-communicative deficits via alternative means.

Brain injury has been described as a ‘family affair’ (Lezak, 1988:111), and family members of individuals affected by traumatic brain injury (hereafter TBI) as an ‘untapped resource’ regarding perceptions of TBI (Snow, Douglas & Ponsford, 1995:367). It has been confirmed that the emotional impact of TBI is greater on *wives* than on other family members (Kreutzer, Gervasio & Camplair, 1994; Leathem, Heath & Woolley, 1996). Numerous studies have examined families’ perceptions of people with TBI (Koskinen, 1998; Leathem *et al.*, 1996; Martin, Viguiet, Deloche & Dellatolas, 2001). However, most of these studies have focused on *moderate* and *severe* injuries. In addition, most of the studies on families’ perceptions have adopted a quantitative approach, including the use of questionnaires, checklists, rating scales and structured interviews (Cavallo, Kay & Ezrachi, 1992; Koskinen, 1998; Leathem *et al.*, 1996; Machamar, Temkin & Dikmen 2002; Martin *et al.*, 2001; Nabors, Seacat & Rosenthal, 2002). In these methods, participants’ personal views are directly addressed, at times preventing valuable information from emerging. An alternative, qualitative means of eliciting information, referred to as discourse analysis (hereafter DA) has recently gained popularity within the field of speech-language therapy. This method of data collection focuses on the content rather than the structure of the discourse in a semi-structured interview. DA has proven to be a powerful tool for examining the content of discourse and for taking a closer look at the individual’s experience and interpretation of a chronic illness or injury.

This study aims to determine whether the spouse, through a DA, can provide valuable information regarding the communication of an individual who has sustained an MTBI. It is hoped that the results of the will shed light on the role of the SLT in the assessment and treatment of potential communication difficulties associated with MTBI.

## 1.2 DEFINITIONS OF TERMINOLOGY USED IN THE STUDY

- **Adynamia** in this study is referred to the lack of drive in an individual’s behaviour typically occurring after a TBI (Hartley, 1995).
- **Communication** in this study is a multi-faceted commodity encompassing both the verbal and nonverbal aspect of human social behaviour that involves the interaction of the individual with his/her environment (Hartley, 1995; New Penguin English Dictionary, 2001).

- **Discourse** in this study refers to the spoken interaction within a conversation.
- **Discourse analysis (DA)** refers to the qualitative, interpretive method of analysis used in this study. It examines the content of the conversation or discourse (Jaworski & Coupland, 1999) and leaves the reader with an interpretation of the discourse (Potter & Wetherell, 1987).
- **The Model of Social Communication (Hartley, 1995)** used in this study denotes the dynamic and ongoing nature of communicative interactions. It illustrates that communication is ‘a result of interaction between an individual’s environment and an individual’s internal functioning’ (Hartley 1995:25).

The following terms used in the study are taken from the Model of Social Communication (Hartley, 1995):

- **Cognitive processes** include an individual’s attention, perception, memory, visual-spatial processes and linguistic processes.
  - The **environment** indicates the external circumstances or conditions in which communication occurs.
  - The **executive control centre** is an area in the brain where integration of internal and external stimuli occurs, ensuring that communication is compatible with the environment as well as with the individual’s needs.
  - **Internal processes** are those processes that make up an individual’s internal functioning, namely stored knowledge, cognitive processes, subcortical and limbic input and the executive control centre.
  - **Products of communication** refer to the products or outcomes resulting from the interaction of an individual’s environment with his/her internal functioning.
  - **Stored knowledge** is made up of various cognitive structures called schemata and refers to how the individual’s world knowledge and past experiences guide conversation.
  - **Subcortical and limbic input** refers to an individual’s arousal, emotional status and motivation.
- **Mild traumatic brain injury (MTBI)** refers to a traumatically induced physiological disruption of brain function, manifested by at least one of the following: (1) loss of consciousness for up to 30 minutes; (2) any loss of memory regarding events immediately before or after the accident; (3) any alteration in mental state at the time of the accident, and (4) focal neurological deficit(s) that may or may not be transient. However, severity must not exceed the following:

after 30 minutes, an initial Glasgow Coma Scale of 13-15 and post-traumatic amnesia not greater than 24 hours (American Congress of Rehabilitation Medicine [ACRM], 1993).

- **Post-concussive syndrome (PCS)** refers to the cluster of symptoms that is present following an MTBI (Alexander, 1995; Satz *et al.*, 1999).

### 1.3 LAYOUT OF CHAPTERS

CHAPTER ONE: Introduction	In this chapter an orientation to the field of the study is provided. The background to the study and its rationale are explained. Terminology used in the text is then defined.
CHAPTER TWO: Literature study	This chapter aims to provide a comprehensive overview of existing theoretical knowledge and previous research in the field of MTBI. Concepts pertaining to DA are also discussed.
CHAPTER THREE: Research methodology	The empirical research is described in terms of the aim, research design, participant selection criteria and procedures, ethical aspects, materials used, data collection, data analysis procedures and, finally, trustworthiness and credibility.
CHAPTER FOUR: Presentation of results	In this chapter, the data collected from the semi-structured interviews is analysed into themes and categories and presented as results.
CHAPTER FIVE: Discussion	Interpretation of the above findings will be presented and discussed in this chapter. Identified themes within the text will be discussed and, where possible, correlations will be drawn between participants.
CHAPTER SIX: Conclusions	Relevant information from the study is used to draw conclusions in this chapter. Clinical and theoretical implications of the findings of this study to the field of speech-language therapy are highlighted. A critical evaluation of the study is also provided and any shortcomings within the study are described. Indications and recommendations for further research are also made

	within this chapter.
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#### **1.4 CONCLUSION TO CHAPTER ONE**

The purpose of this chapter was to orientate the reader to the field of MTBI and its possible communication difficulties. The problem statement, based on a theoretically grounded rationale, was presented. Definitions of terminology appearing throughout the dissertation as well as the layout of the chapter of the dissertation were provided.

## CHAPTER TWO

### 2 LITERATURE REVIEW

In this chapter concepts and terms that will be used in the course of this study are defined. A survey of existing theoretical knowledge and of previous research in the area of mild traumatic brain injury (MTBI) is presented. Concepts pertaining to discourse analysis (DA) are also included, with previous studies in this area being discussed.

#### 2.1 PREVIOUS RESEARCH IN MILD TRAUMATIC BRAIN INJURY

MTBI is said to account for the majority of patients admitted to hospital with brain injuries (Culotta *et al.*, 1996; Kraus & Nourjah, 1989; Sinson, 2001). The incidence of traumatic brain injury (TBI) among Johannesburg residents in 1986 was 316 per 100 000, with 87% considered to be MTBI (Brown, 1991). Despite these facts, the focus in research on TBI in the past has been on the diagnosis and management of *severe* TBI. However, in recent years more attention has been given to research on MTBI, with notable progress towards a common definition of this condition being made over the past 10 years (Blostein & Jones, 2003). Despite this increase in research, the diagnosis and management of MTBI remain poorly defined (Jagoda & Riggio, 2000), which has resulted in a lack of uniformity regarding both the diagnosis and the management of MTBI in hospitals (Blostein & Jones, 2003; De Kruijk *et al.*, 2001a; De Kruijk *et al.*, 2001b; Ruff & Jurica, 1999). The need remains for a clear definition of MTBI, and for research that will contribute to ensuring the effective management of this condition in affected individuals (De Kruijk *et al.*, 2001a). Since most of the MTBI-related research is conducted by researchers in the field of neuropsychology, a dearth exists in the area of speech-language therapy for affected individuals (Duff *et al.*, 2002).

MTBI has been defined as a traumatically induced physiological disruption of brain function, manifested by either loss of consciousness for up to 30 minutes; any loss of memory regarding events immediately before or after the accident; any alteration in mental state at the time of the accident, and focal neurological deficit(s) that may or may not be transient. However, severity after 30 minutes must not exceed an initial Glasgow Coma Scale of 13-15 and post-traumatic amnesia not greater than 24 hours (ACRM, 1993). Symptoms after an MTBI include emotional and behavioural changes (irritability, loss of temper, emotional lability), cognitive difficulties (impaired attention, perception, memory, speech/language or executive functions) and physical symptoms (nausea,



dizziness, headache, blurred vision, fatigue), which may occur in isolation or in combination (Green, Stevens & Wolfe, 1997; ACRM, 1993). An ongoing debate in relevant literature is concerned with the diagnosis, criteria, presenting symptoms and the outcomes of treatment of people who have suffered an MTBI. In order to obtain a uniform construct for MTBI, Ruff and Jurica (1999) propose three grades or levels of severity as the diagnostic criteria for MTBI. Type 1 includes the criteria aligned with ACRM. Type III is modelled by the criteria in the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV) (American Psychiatric Association, 1994) and Type II bridges the gap between the two.

Most individuals with MTBI show spontaneous and complete post-injury recovery within a few weeks to a few months. However, some may continue to present with symptoms after this time (Alexander 1995; King, 1997; Rosenthal, 1993). The cluster of symptoms that is present following an MTBI has been coined the 'Post-concussive Syndrome' (PCS) (Alexander, 1995; Satz *et al.*, 1999). PCS has been reported in up to 50% of individuals who have sustained an MTBI (Bazarian, Wong, Harris, Leahey, Mookerjee & Dombovy, 1999; Bohnen, Twijnstra & Jolles, 1992; Satz *et al.*, 1999). Recorded symptoms associated with PCS include headaches, fatigue, insomnia, dizziness, inability to concentrate, memory loss, irritability, depression, delayed information processing and intolerance to sensory stimuli and alcohol (Evans, 1994; Gualtieri, 1995; Rosenthal, 1993; Satz *et al.*, 1999). These symptoms may occur in isolation or in various combinations (Evans, 1994).

Evans (1994) states that, considering the many terms that have been used to describe the PCS following an MTBI, PCS can be best described as 'controversial'. Furthermore, King (1997) points out that the available literature still does not reflect full agreement regarding the description of the sequelae after MTBI as a *syndrome* (PCS). Kibby and Long (1996) state that post-concussion symptoms can occur in the absence of TBI, whilst Ruff (2001) claims that the term 'post-concussion disorder' is used primarily for individuals with MTBI. Further controversy exists regarding the duration of symptoms after an MTBI. A possible link has been established between complaints long after an MTBI, compensation claims and psychological factors (Binder, 1997). However, King (1997) reports that the emphasis on compensation claims in the recovery of individuals with MTBI is decreasing.

Despite the controversy surrounding PCS, approximately 15% of individuals with MTBI complain of disabling symptoms for as long as one year after sustaining their injury (Alexander, 1995; Bohnen *et al.*, 1995; Duff *et al.*, 2002; King, 1997; Tucker & Hanlon, 1998). Ruff *et al.* (1996:551) refer to this small yet significant proportion of individuals with MTBI who experience post-injury difficulties for longer than one year as the 'miserable minority'. Alexander (1995) calls this persisting condition 'Persistent Post Concussive Syndrome'. The confusion and debate surrounding the PCS, Persistent PCS and MTBI, have resulted in a need for further research in these areas.

Controversy in the literature regarding areas of deficits following MTBI may be partly accounted for by the lack of sensitive assessment tools. As far as the communication difficulties associated with MTBI are concerned, Tucker and Hanlon (1998) report that the difficulties experienced when documenting specific language problems in MTBI may be caused by the fact that traditional language tests often lack the sensitivity required to detect deficits of this specific nature. As a result, they found that little data was available on the effects of MTBI on language performance specifically.

The findings in the study by Tucker and Hanlon (1998) also indicate a need to investigate an alternative means of measuring and exposing communication deficits in persons with MTBI. Although tests may not be sensitive enough to detect subtle problems, one area where subtle cognitive and/or communicative difficulties may be detectable is within the context of a conversation. This study attempted to obtain information regarding the everyday conversation or communication abilities of an individual with MTBI within a natural setting as perceived by the spouse of an individual with MTBI.

## **2.2 COMMUNICATION DIFFICULTIES ASSOCIATED WITH MILD TRAUMATIC BRAIN INJURY**

MTBI has been associated with subtle language disorders (Mathais & Coats, 1999; Tucker & Hanlon, 1998). For example, performance on verbal fluency tasks has been found to be compromised in people with MTBI (Mathais & Coats, 1999). Verbal fluency performance is considered to be a sensitive indicator of the efficacy of an individual's communicative system (Penn, 1985). The communicative complaints of individuals with MTBI may also include word-finding problems and difficulties in clearly expressing their thoughts. An interesting finding reported in Tucker and Hanlon's study (1998) was that the performances of individuals with MTBI in narrative discourse tasks were found to be

similar to those of individuals with *moderate* TBI. Individuals with MTBI demonstrated difficulty in sequencing story pictures and, when these story pictures were ordered correctly, struggled to address the relevant details to produce an accurate story.

The individual with MTBI may also experience subtle yet significant cognitively based deficits, which affect communication. Cognitively based skills that are required for effective communication include the ability to sustain and alternate attention, adequate functional memory, word retrieval ability, the formulation of thoughts to express complex verbal and written communication, complex information processing for listening and reading, executive functioning, reasoning, problem solving and decision-making (Green *et al.*, 1997). Individuals with MTBI may experience difficulty in one or more of these skills (Green *et al.*, 1997; Mathais & Coats, 1999; Tucker & Hanlon, 1998).

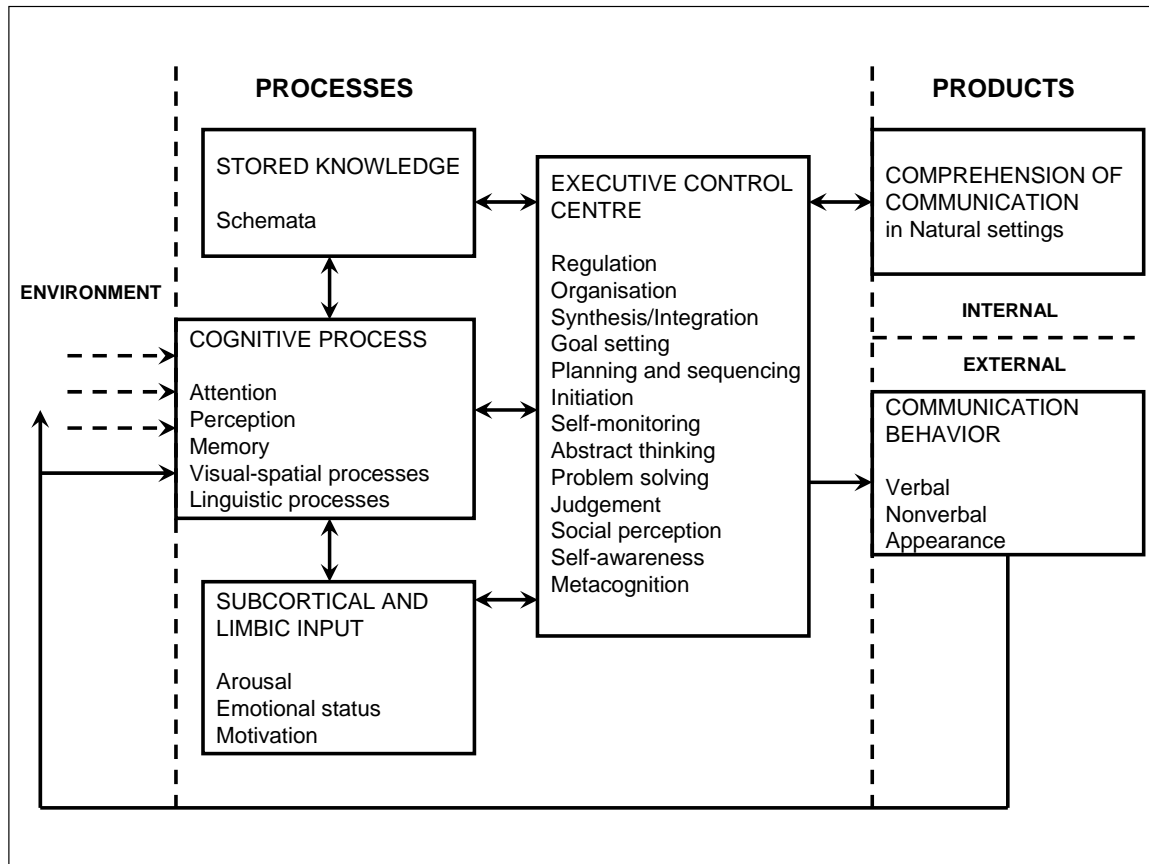
Diagnostic tools used by speech-language therapists (SLTs) have been found to lack the sensitivity required to detect cognitive-communicative deficits typically associated with MTBI (Barrow *et al.*, 2003; Duff *et al.*, 2002). For this reason, Barrow *et al.* (2003) recommend that evaluation procedures should more closely simulate real-world experiences, including, for example, reaction times measures, as such experiences are likely to be more valuable in identifying the subtle difficulties associated with MTBI that are seldom exposed by traditional tests.

According to Hartley (1995:21), 'functional communication consists of a complex repertoire of dynamic social behaviours that require the integration of one's knowledge of the world with cognitive, social, behavioural, psychological and linguistic processes.' Therefore, if any of these processes should be affected following an MTBI, communication will also be affected. Hartley (1995) defines communication as an aspect of human social behaviour that involves the interaction of the individual with his/her environment. It therefore involves more than simply the words, actions or gestures a person may use, it implies a complex interaction of one individual with another, as well as with the environment. A strong connection exists between communication and behaviour and they are dependent upon one another (Hartley, 1995; Ylvisaker & Feeney, 1998). A change in an individual's communication will therefore result in a change in his/her behaviour and vice versa.

### 2.2.1 The Model of Social Communication (Hartley, 1995)

Different fields of study view communication differently (Hartley, 1995). These differing views give rise to various models of communication. The researcher has chosen to adopt the Model of Social Communication (Hartley, 1995) as a foundation for addressing communication after MTBI. Hartley's model (1995) integrates social communication from a number of fields of study and relates it to communication after a TBI, thereby providing a theoretical basis for analysing such communication. The model (Hartley, 1995) can also be applied to the analysis of communication after an MTBI. Figure 1 provides an overview of The Model of Social Communication (Hartley, 1995).

The Model of Social Communication (Hartley, 1995) is both linear and circular and illustrates the dynamic and ongoing nature of communication. Communication develops over time as the communicative behaviour of one individual meets with that of another within a situation. The model depicts that comprehension of communication and communication behaviour are *products* of the interaction of the external environment with the individual's internal functioning, including the individual's knowledge and processing abilities. The model further outlines the *processes* that are involved in both the comprehension and production of communication behaviour (Hartley, 1995). In order to understand social behaviour, it is necessary to rapidly process verbal and nonverbal input from the environment and retain both this input and input that was received earlier in the interaction. Strategies for organising this verbal and nonverbal input, retrieving relevant knowledge, making inferences about meaning, making judgements and monitoring comprehension are applied by a control centre for information processing, called the executive control centre. Communicative behaviour is initiated and maintained by the overall goal formed by the executive control centre. A plan of what needs to occur, for example a communication response, is then formulated according to the individual's perceptions of a communication situation. The executive control centre must implement this plan, weighing up the appropriateness and effectiveness of each possibility before carrying it out. The plan is then executed and the control centre continually monitors and evaluates the chosen behaviour, making adjustments according to the external (the environment) and internal feedback (Hartley, 1995).



**Figure 1: Model of Social Communication (Hartley, 1995)**

Because human behaviour, including communication, does not occur in isolation, the person's environment becomes a major determinant in communicative behaviour (Hartley, 1995). Stemmer (1999) also states that an organism (the person) and the environment are in a state of constant interaction with one another. An individual's circumstances will thus influence the way in which communicative behaviour takes place. The home environment is viewed as a reliable context for examining communication behaviour, as this is where the individual is expected to be most comfortable. The spouse is assumed to be the member of the family who spends much time with the individual with MTBI, most often within the natural setting of the home environment. The spouse is expected therefore, to give a reliable representation of the communication environment of the individual with MTBI.

In summary, the Model of Social Communication (Hartley, 1995) provides an integrated communication framework based on findings from several different fields of study. Because this study comprises an investigation of the perceptions of spouses regarding *communication* by the individual with MTBI, the findings will be interpreted within the

framework of the Model of Social Communication (Hartley, 1995). Hartley's model (1995) will thus form the theoretical basis within which the results obtained will be interpreted. The spouse's view of the communication of the individual with MTBI is expected to include a description of the external *products* in Hartley's model (1995), or the behaviour that is *seen*, which includes verbal and nonverbal communication. When the results are interpreted, the interaction between the internal *processes* of the individual with MTBI and his/her *environment* will be investigated in an attempt to explain the communication behaviour described by the spouse.

### 2.2.2 The International Classification of Functioning, Disability and Health

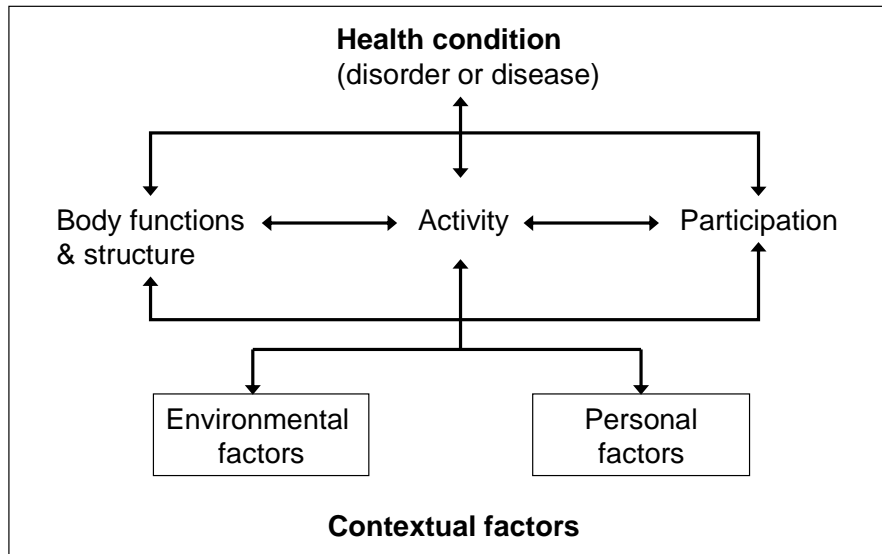
The International Classification of Functioning, Disability and Health (ICF) model has gained popularity as an aid to providing a better understanding of the impact of an illness on an individual. The ICF, developed and revised by the World Health Organisation (WHO, 2002) provides definitions for the terms *functioning* and *disability*, as well as a standardised framework for describing human functioning in society as an important component of health. The ICF (WHO, 2002) can therefore also be useful when trying to understand the impact of an MTBI on an individual's functioning at the social level. In the ICF (WHO, 2002), functioning and disability are used as umbrella terms to refer to three components: body structures and functions, activities and participation in society. The ICF (WHO, 2002) defines these terms as follows:

The *body* component includes both body structure and the physiological functions of body systems, including psychological and cognitive functions.

The *activity* component refers to the execution of a task performed by the individual.

The *participation* component refers to the areas of life where an individual is involved and has societal opportunities or barriers.

Figure 2 represents the model of disability that forms the basis for ICF (WHO, 2002). The diagram identifies the three levels of human functioning as classified by the ICF (WHO, 2002), namely: functioning at the level of the body or body structure, the whole person as an individual and the whole person within a social context.



**Figure 2: Interactions between the components of ICF (WHO, 2002)**

Disability and functioning are viewed as outcomes of the interactions between health conditions and contextual factors. A few similarities can be drawn between the ICF model (WHO, 2002) and the Model of Social Communication (Hartley, 1995). The ICF model (WHO, 2002) also recognises that contextual factors can interact within the model, with *body functions*, *activity* and *participation*. The *contextual factors* include *environmental factors*, which refer to the immediate environment, and *personal factors*, such as gender, age, education and personality. These *contextual factors* within the ICF model (WHO, 2002) can be compared with the *environment* mentioned in the Model of Social Communication (Hartley, 1995). *Body functions and structures* in the ICF model (WHO, 2002) are comparable to the *processes* described in the Model of Social Communication (1995), as the body functions include the internal cognitive processes that may be affected after an illness. *Products* in the Model of Social Communication (Hartley, 1995) could be compared to *participation* in the ICF model (WHO, 2002), where the individual is involved at a societal level with others, and may perform a variety of communication behaviours in different settings.

The cyclical nature of both the ICF model (WHO, 2002) and the Model of Social Communication (Hartley, 1995) is evident when they are compared. This means that when one component of the model is affected, it inevitably affects another. Although the ICF model (WHO, 2002) and the Model of Social Communication (Hartley, 1995) are similar, the Model of Social Communication (Hartley, 1995) focuses on *communication*,

and was therefore preferred as the framework within which to interpret the results obtained in this study.

As stated in Hartley's model (1995), the environment plays an important role in an individual's communicative behaviour. The family is an example of the environment in which communication takes place.

### **2.3 FAMILY ADAPTATION AFTER MILD TRAUMATIC BRAIN INJURY**

Lezak (1988:111) refers to TBI as a 'family affair'. It is likely that family members of individuals with TBI will be affected to a similar extent by this condition as is the individual who has sustained the injury. A TBI not only compromises the quality of life of the injured individual, but also that of his/her family members (Lezak, 1988). We can therefore assume that, to some degree, an MTBI similarly affects the family unit.

Numerous researchers have investigated family members' perceptions of individuals with TBI (Brooks & McKinlay, 1983; Brooks, Campsie, Symington, Beattie & McKinlay 1986; Cavallo *et al.*, 1992; Hendryx, 1989; Koskinen, 1998; Leach, Frank, Bowman & Farmer, 1994; Leathem *et al.*, 1996; Martin *et al.*, 2001; Willer, Allen, Liss & Zicht, 1991). The valued perceptions of families and individuals affected by TBI are still seen as an 'untapped resource' (Snow, Douglas & Ponsford, 1995:367), which is an indication that further research involving the family of individuals with TBI should be conducted.

Various studies have investigated the amount of burden and stress that TBI can place on family members. For example, the communication difficulties experienced by parents with TBI have been found to negatively affect their adolescents' perceptions of their own quality of life (Sedgwick, 2000). In a study by Machamer *et al.* (2002), the level of burden and depression among significant others (parents and spouses) of individuals with severe TBI was found to be high. However, the same study revealed an overall positive experience of family members caring for the individual with a moderate to severe TBI. A large majority of the caregivers included in the study reported that they were pleased to be able to care for the individual with a TBI and felt good about their ability as caregivers at least some of the time. Cavallo *et al.* (1992) attempted to group families on the basis of their differing perceptions of the changes in the person with a TBI. The results indicated that it was not possible to generalise about how families reacted after a TBI, as perceptions of problematic areas differed within and between families. The findings of Cavallo *et al.*



(1992) emphasise the value of investigating the views and perceptions of individual family members (such as spouses) of persons recovering from MTBI.

Few studies have investigated the impact of TBI on the adjustment of the unaffected *spouse* (of the individual with TBI). Kreutzer *et al.* (1994) examined the prevalence of stress and unhealthy family functioning in primary caregivers (in this case, spouses *and* parents) of adults with TBI. *Spouses* reported a higher degree of unhealthy family functioning and higher depression scores than the parents of individuals with TBI. Similar research by Leatham *et al.* (1996) found that *spouses* of individuals with TBI reported significantly greater need for role changing and more stress than the parents of individuals with TBI. The reason for this may be that spouses (wives in particular) are compelled to cope with daily tasks and responsibilities without the benefit of having a partner capable of advising them and helping them shoulder the burden of responsibility (Florian, Katz & Lahav, 1989). In another study that compared the marital adjustment in people with TBI and with spinal cord injuries, the wives of persons with severe TBI reported higher marital dysfunction than the wives of persons with moderate TBI and spinal cord injuries (Peters, Stambrook, Moore, Zubek, Dubo & Blumenschein, 1992). In a similar study during which Peters, Stambrook, Moore and Esses (1990) assessed the marital adjustment of individuals with mild, moderate and severe TBI, the wives of individuals with severe TBI experienced higher marital dysfunction than the wives of individuals with mild and moderate TBI. These studies highlighted the fact that spouses of individuals with TBI are invariably affected due to the TBI.

These studies of the perceptions of spouses regarding their partners suffering the consequences of TBI were focused on either a heterogenous TBI population, or on individuals with predominantly severe TBI - possibly because of the assumption that spouses have a greater need for support after their significant other has sustained a severe TBI. We can, however, assume that the spouses of individuals with MTBI also need to make certain adjustments with regard to their relationship with their partners. With the exception of Hendryx (1989), who included persons with good to moderate recovery after TBI in his research, few researchers have focused solely on the perceptions of individuals with *mild* TBI. Although the symptoms after MTBI are not as severe, the impact of the injury may be great. It is therefore necessary to investigate the perceptions of spouses of individuals with *MTBI* specifically. A study of spouses' perceptions of their partners' communication may provide valuable insights into the nature of the possible

communication difficulties experienced after an MTBI. Their perceptions may also contribute to the evaluation and treatment of the individual with MTBI. Traditional tests in formal settings may not reveal communication difficulties of these individuals. The spouse, who interacts with the individual with MTBI in his/her natural environment, could provide valuable information with regard to his/her communication in a natural setting. Since therapy cannot always take place within the individual's natural environment, the generalisation of therapy to the natural environment may be facilitated and promoted if the spouse is included in the evaluation and management of the potential communication difficulties following MTBI. The family undeniably has a vital role to play in the recovery of the individual after both TBI and MTBI (Lezak, 1988; Dell Orto & Power, 2000). O'Keefe (1996:234) states: 'Nobody knows the individual better than family ... .' The spouse is likely to be the family member who spends the most time with the individual and provides support after the MTBI. When rehabilitation *is* necessary, rehabilitation programmes for individuals with TBI or MTBI tend to be patient centred, with little focus on the spouse's contributions or involvement. This is ironic, since once patients have been discharged, their spouses become responsible for continuing their rehabilitation (Peters *et al.*, 1990).

#### **2.4 THE VALUE OF DISCOURSE ANALYSIS IN INVESTIGATING THE COMMUNICATION DIFFICULTIES ASSOCIATED WITH MILD TRAUMATIC BRAIN INJURY**

In most of the studies that have looked at how individuals with TBI are perceived by their family members, a quantitative approach was taken. Researchers have requested family members to complete questionnaires (Brooks & McKinlay 1983; Hendryx 1989; Koskinen, 1989; Leathem *et al.*, 1996; Martin *et al.*, 2001; Nabors, Seacat & Rosenthal, 2002), checklists (Cavallo *et al.*, 1992) and rating scales (Koskinen, 1998) and have conducted structured interviews with them (Brooks & McKinlay, 1983; Cavallo *et al.*, 1992; Leathem *et al.*, 1996; Machamar *et al.*, 2002; Nabors *et al.*, 2002). These methods, all substantiated with regard to their validity, outline prescribed areas and issues to which participants are expected to respond. In the structured interview, for example, the traditional goal is to measure consistency in participants' responses, thus finding genuine phenomena and unbiased responses (Potter & Wetherell, 1987). This method, like the others, leans more strongly towards quantitative analysis. Structured questions like those asked in interviews, questionnaires and rating scales may be limiting as the participants' personal issues and views are directly addressed, rather than being carefully elicited. This

can prevent unexpected and possibly valuable information from being disclosed. As an alternative, Wedcliffe (1999) suggests making use of a semi-structured interview rather than a self-administered questionnaire in an attempt to elicit additional data from the participant. Wedcliffe (1999) investigated the psychosocial effects of TBI on the quality of life of a group of spouses by using a questionnaire. Her results indicate a need for the implementation of an approach to data collection that does not directly influence the participants' views.

DA is another technique that could possibly be used for eliciting additional information regarding an individual's view of how his/her spouse's ability to communicate has been affected by an MTBI. Speech-language therapy studies investigating the discourse behaviours of persons after TBI have usually focused on the deficit-based investigation of the structure of discourse (Vyncke, 2000). Many of these studies have taken a close look at linguistic and non-linguistic aspects and measures within discourse and conversation (Armstrong, 2002; Coelho, Youse & Le, 2002; Ehrlich & Barry, 1989; Garcia, Metthé, Paradis & Joannette, 2001; Mentis & Prutting, 1987; Snow *et al.*, 1995; Snow, Douglas & Ponsford, 1998). However, we are currently witnessing a trend towards examining the *content* of the discourse, rather than its structure, and the DA method has recently gained some popularity in speech-language therapy. DA has been found to be a valuable tool for examining the content of individuals' discourse and for taking a closer look at the individual's experience and interpretation of a chronic illness or injury.

DA, as defined by Willig (1999:2), is concerned with, amongst other things, the 'ways in which language constructs experiences, including ... a sense of self.' People use their discourse to *construct* versions of their social world (Potter & Wetherell, 1987). We can therefore assume that the 'talk' or the discourse constructs the individual's reality. Willig (1999) notes that something can always be described in more than one way and our choice of how to use words to convey perceptions and experiences gives rise to individual versions of reality. In the light of this, we can therefore say that language constructs reality (Willig, 1999). It should be obvious that the way in which the spouses selected for this study experience their partners' communication is likely to differ from how it is experienced by the therapist. DA will be used to construct all the individual spouses' 'realities' regarding the way they perceive their partners' communication after the MTBI.

DA also encourages reflexivity in its approach to the study of language in use. Reflexivity deals with the researcher and the meaningful interaction of the research with the context. The researcher plays a central and visible role in the study, attempting to understand how his/her presence, actions, interests and personal views influence the context and create meaning. In DA, reflexivity implies it is impossible for the researcher to detach him/herself from the research (Wetherell, Taylor & Yates, 2001). The researcher thus has a vital role to play in understanding the ‘world reality’ of the person being examined.

DA has been used effectively as a measuring tool for investigating an individual’s perception of an illness (Vyncke, 2000). Studies conducted in the medical field have been employing DA approaches for many years to bring about a new understanding of patients’ perspectives to treatments and illnesses. In South Africa, DA studies have recently gained popularity in the area of speech-language therapy, where they have aided the examination of individuals’ perceptions of their injuries or illnesses. Many of these studies examined the effect of illness or injury on affected individuals’ quality of life. Nel (2002) used DA to examine how people affected by dysphagia resulting from oral cancer perceived their quality of life. She recommended that DA be applied to other populations as well. Freeman (2000), also by means of DA, investigated the quality of life of individuals with TBI, and Sedgwick (2000) discussed how adolescents perceive their own quality of life after a caregiver has sustained a TBI. However, few studies using DA have focused specifically on the ability of individuals to *communicate* subsequent to an injury or illness. This led to the identification of need for a study focusing only on communication as perceived by spouses of individuals with MTBI.

This study will use DA to examine how the spouses of persons affected by MTBI perceive their partners’ communication. MTBI, being a classification of TBI, merits study so as to determine how it affects the injured individual’s communication. Information on the spouses’ perceptions may provide valuable additional insight for clinicians with regard to the management and referral of the individual with MTBI, and perhaps even preventing persisting symptoms from occurring. To this end, the spouses’ perceptions may even prevent individuals with MTBI from ‘falling through the cracks’ (Sinson, 2001:425).

## **CHAPTER THREE**

### **3 METHODOLOGY**

In this chapter, the research method adopted for this study is described.

#### **3.1 MAIN AIM**

The main aim of this study is to describe how spouses of individuals with mild traumatic brain injury (MTBI) perceive their significant others' communication.

#### **3.2 RESEARCH DESIGN**

A multiple case study design was used to conduct this research within the framework of qualitative research. Relevant literature indicates that when used appropriately, case study research can yield important information and promote greater understanding of a particular phenomenon (Graziano & Raulin, 2000; Leedy & Ormrod, 2001). Case studies aim to analyse a situation precisely and in detail in order to provide insight into the phenomenon being investigated (Titscher, Meyer, Wodak & Vetter, 2000). In case study research, fewer constraints are placed on the procedures, which implies that little control is imposed on the behaviour of the participants (Graziano & Raulin, 2000). These lowered constraints allow the researcher to be able to observe the natural flow of the participants' behaviour, revealing information that can be valuable to the data being collected. A lowered constraint approach can also be a source of ideas and hypotheses, enabling the researcher to become familiar with a fairly new research area. Case studies are particularly valuable when an area of limited understanding and information is being investigated (Graziano & Raulin, 2000; Leedy & Ormrod, 2001). However, the single case study does carry the disadvantage of poor representativeness, therefore generalisations should be made with extreme caution (Graziano & Raulin, 2000). In addition, since the observations in this study occurred within the natural setting of a conversation, where few constraints were imposed on the participants' behaviour, replication of the research becomes difficult (Graziano & Raulin, 2000).

For the purpose of this study, the researcher has selected a multiple single-case study design, despite the generalisation concerns, as the data will be obtained by way of interviews and analysed by means of discourse analysis (DA). The very nature of DA suggests that an in-depth study is required. A further reason for choosing multiple case

studies, rather than a single case study, was to increase the possibility of proposing generalisations, thus promoting understanding in similar situations (Leedy & Ormrod, 2001).

### **3.3 PARTICIPANTS**

Three participants were selected for the study. This small number is due to the labour-intensive nature of the analysis of the DA of the participants' conversations with the researcher (Wetherell *et al.*, 2001).

#### **3.3.1 Selection criteria**

##### **3.3.1.1 *Criteria for the selection of the participants***

The participants had to be *spouses* of individuals who had sustained MTBIs. No selection criteria were prescribed for the spouses in terms of gender, age or education. The participants were, however, to be proficient in either English or Afrikaans, as these were the languages in which the interviews were to be held. Participants were also to be living with their spouses for a minimum period of one year prior to the MTBI. This would ensure that the participants were familiar with their spouses' pre-morbid and post-morbid communication abilities. Spouses, specifically, were selected since the literature reveals that they are affected to a greater extent than, for example, parents (Kreutzer *et al.*, 1994; Leatham *et al.*, 1996) after a traumatic brain injury (TBI). For easier reading, Participants 1, 2 and 3 will be referred to as P1, P2 and P3.

##### **3.3.1.2 *Criteria for the selection of the individuals with MTBI***

The individuals with MTBI were selected according to the following prescribed criteria:

- *Classification of TBI*: Each of the individuals was to have had sustained an MTBI. The definition of an MTBI used for this study was taken from a publication by the MTBI Committee of the Head Injury Interdisciplinary specialist group of the ACRM (1993), which includes the following:
  - Glasgow Coma Scale (GSC) score of 13-15, 30 minutes after the injury was sustained
  - Post-traumatic amnesia not greater than 24 hours
  - Loss of consciousness for approximately 30 minutes or less
- *Time since injury*: The individuals with MTBI were to have a post-injury interval of more than six months. The reason for this criterion was to ensure that the spouse had adapted, or was adapting to the effects of the injury. Adaptation is

viewed as the last stage in the five stages of emotional reaction associated with chronic conditions as explained by LaPointe (1997). It was assumed that if adjustment had indeed occurred, it would prevent the initial stages, such as denial, from influencing the results of the study. In addition to emotional adjustment, most individuals with MTBI show spontaneous and complete recovery from neurological symptoms within three months post-injury (Alexander, 1995). Those individuals with MTBI included in this study whose spouses describe their communication difficulties will therefore be likely to be presenting with persisting symptoms associated with the MTBI.

- *Place of residence:* The individuals with MTBI were to have been living at home with their spouses since the injury. This would ensure that the spouses would be familiar with the communication styles developed by the individuals with MTBI after their injuries.
- *Age and gender:* Age and gender were not selection criteria.

### **3.3.2 Selection procedures**

The Research Proposal and Ethics Committee of the Faculty of Humanities of the University of Pretoria was approached for ethical clearance. Once ethical clearance had been granted (Appendix A), the participants were selected by means of convenience sampling, referring to participants being those who were most easily available (de Vos, Strydom, Fouché & Delport, 2002). The selection procedure was as follows:

- A letter explaining the purpose and nature of the study and requesting assistance with the identification of past patients with MTBI who answered to the prescribed criteria was addressed to a local hospital and to a neuropsychologist. Permission was asked to contact past patients with MTBI for the purpose of this study (Appendix B).
- The names of P1 and P3 were obtained from the hospital records, and P2 was recommended for participation in the study by the neuropsychologist.
- The researcher contacted the spouses and the persons with MTBI who fulfilled the criteria telephonically. The purpose and nature of the study was explained and they were asked whether they would be willing to participate in the study.
- Participants and spouses with MTBI who agreed to take part in the study were provided with a letter of information regarding the study as well as a letter of informed consent, which they were requested to sign to confirm their willingness to participate (Appendix C).

### 3.3.3 Ethical aspects

- The Research Proposal and Ethics Committee of the Faculty of Humanities of the University of Pretoria granted ethical clearance for the study to be carried out (Appendix A).
- The individuals with MTBI and their spouses were provided with a verbal and written explanation of the nature and purpose of the study and written consent was obtained from them.
- Those who agreed to participate were assured of confidentiality at all times during the study.
- Participants were free to withdraw from the study at any time.

### 3.3.4 Description of participants

Three participants (*spouses* of individuals with MTBI) took part in this study. Table 1 contains a description of each of the participants included in this study.

**Table 1: Description of participants**

	<b>P1</b>	<b>P2</b>	<b>P3</b>
Gender	Female	Female	Male
Primary language	Afrikaans	Afrikaans	Northern Sotho
Number of years of education	14 years	14 years	11 years
Current occupation	Technologist	Landscaper	Driver, but currently unemployed
Occupation at time of spouse's MTBI	Technologist	Landscaper	Driver



### 3.3.5 Description of individuals with MTBI

Table 2 contains a description of each of the individuals with MTBI. The individuals with MTBI are referred to as NM, NJ and EM respectively and are the spouses of P1, P2 and P3.

**Table 2: Description of individuals with MTBI**

	NM	NJ	EM
Date of injury	27-09-2003	24-02-2001	25-07-2003
Time since injury at time of first interview	Six months	Three years	Nine months
Glasgow Coma Scale (GCS)	14	13	12
Period of loss of consciousness (LOC)	Altered consciousness over a period of a few days	Altered consciousness for less than an hour	Unknown, no record in file (sedated for a few days)
Number of years married to/living together with spouse	Five and a half years	Four years	Ten years
Number of years of education	12	12	12
Occupation prior to MTBI	Unemployed (previously a supervisor in a retail business)	Landscaper	Unemployed (previously a 'casual' worker in a retail business)
Employed at the time of interview?	No	Yes	No
Number of children	Three	None	Three

Although EM obtained a GCS score of 12, this was regarded as the upper classing of moderate TBI and seen as a borderline MTBI. Furthermore, EM was not referred for a cognitive or communicative assessment or therapy by the neurosurgeon, which indicates that, in his opinion, EM's cognitive and communicative abilities were of an acceptable standard. After the injury, EM was able to resume her normal household duties. This was the reason for her inclusion in the study. Although LOC was not indicated on the hospital records, an estimation thereof was obtained from each spouse. P1 stated that NM had experienced altered consciousness and had been confused and disoriented for several days. NM had also experienced a brain

haemorrhage in the frontal lobe due to the injury. Although this indicates additional neurological fallout, NM's GCS score remained within the limits posited for the classification of MTBI. Information regarding site of lesion for NJ and EM was not indicated on their medical records. According to P2, NJ had experienced an altered state of consciousness and had remained confused and disoriented for less than an hour. P3 stated that EM had experienced confusion for a length of time (a few days). She had, however, been sedated during this time, which contributed towards her confusion and disorientation. It was therefore not possible to establish the exact duration of LOC for any of the individuals with MTBI included in this study.

### **3.4 EQUIPMENT AND MATERIAL FOR DATA COLLECTION**

In order to obtain the required data, a semi-structured interview was held. The traditional interview places a high value on consistency in participants' responses in order to reflect reality beyond the interview situation. Consistency in DA, however, has a different meaning. The researcher desires to identify the frequent (or consistent) patterns in the language use of the participant (Potter & Wetherell, 1987). The term 'conversational encounter' is used, rather than an interview, as the researcher's questions become just as much a part of the analysis as the interviewee's responses.

The researcher guided the participants through a semi-structured interview, using two open-ended questions to provide a framework for additional questions or issues that may have arisen. Although the actual focus of the interview was communication, the interviewer attempted to follow the participant's lead. Opportunities for clarification when information was not clearly understood were also created within the discourse. The following two questions were presented as the leading questions within the interview:

#### **Question 1: 'What do you think communication entails?'**

The rationale behind this question was to obtain an idea of the participants' perceptions of communication. Communication is seen as a multi-faceted commodity, involving the exchanging of ideas, information, thoughts or opinions through a system of symbols, signs or behaviour. Communication is a verbal or written message (New Penguin English Dictionary, 2001). Obtaining information from the participants regarding their views on what communication entails would provide valuable insights into the components of communication possibly affected after MTBI highlighted in their response to the second request.

**Question 2: ‘Tell me about your spouse’s communication.’**

By making a ‘request’, rather than asking a question, participants were encouraged to report on those components of their spouses’ communication (e.g. verbal or nonverbal) of greatest relevance to them. Since no time frame (before/after the injury) was mentioned in the request, the participants could supply the information that was most important to them at the time of the interview. By allowing the participants to freely describe their spouses’ communication within the context of what they (the participants) viewed communication to entail, it was hoped that information would be obtained regarding the possible impact of MTBI on communication.

This conversation was recorded using a tape cassette recorder (AIWA TP-510) and an audio-visual cassette recorder (HITACHI VM E53E) for later analysis. High-quality cassettes (a TDK B-60 tape cassette and a SONY DX E-180 audio-visual cassette) were used to ensure recordings of good quality.

### **3.5 PILOT STUDY**

#### **3.5.1 Aim**

A pilot study, using the same procedure as for the main study, was conducted in order to determine the clarity of the questions to be posed. Any necessary changes to interview questions or the overall organisation of the study could then be made, according to the results obtained (Potter & Wetherell, 1987). The feasibility of the study could thus be determined (Leedy & Ormond, 2001).

#### **3.5.2 Participant for pilot study**

One participant was selected according to the same criteria as those used for the main study. This participant will be referred to as PP1. A description of PP1 is presented in Table 3.

**Table 3: Description of participant**

	<b>PP1</b>
Gender	Female
Primary language	Afrikaans
Number of years of education	15 years
Current occupation	Housewife
Occupation at time of spouse's MTBI	Housewife

### 3.5.3 Description of individual with MTBI

A description of PP1's spouse with MTBI is included in Table 4. PP1's spouse is referred to JR.

**Table 4: Description of individual with MTBI**

	<b>JR</b>
Date of injury	21-12-2002
Time since injury at time of first interview	14 months
Glasgow Coma Scale score	15
Period of loss of consciousness	Altered consciousness reported
Number of years married/living together with spouse	15 years
Number of years of education	15 years
Occupation prior to accident	Internal auditor at SAPS
Employed at time of first interview	Yes
Number of children	Two

### 3.5.4 Equipment and material used for data collection during pilot study

The same equipment as specified in the main study was implemented in the pilot study.

### 3.5.5 Results of pilot study

(see Appendix D)

The pilot study was conducted to determine the clarity of the proposed questions, the adequacy of the recording equipment and the time it would take to set up and conduct the interview. The two questions posed to the participant were found to be understood by the

participant. No changes to the questions or data collection and analysis procedures were therefore necessary.

### **3.6 DATA COLLECTION, RECORDING AND ANALYSIS PROCEDURES**

#### **3.6.1 Data collection procedures**

The following procedures were followed to gather the required data:

- Once individuals with MTBI who met the selection criteria had been identified, their and their spouses' agreement to participate in the study was obtained.
- A letter of consent was handed to the individuals with MTBI and their spouses (see Appendix C). This letter was compiled according to the guidelines suggested by Silverman (2001).
- The individuals who had agreed to participate in the study were contacted telephonically to make an appointment for data collection.
- The data collection took place in the participants' homes or other locations where they felt comfortable.
- The procedures to be followed were again explained to the participants on the day of data collection.
- Recording equipment was set up as unobtrusively as possible.
- The researcher began the data collection by presenting the two open-ended questions to the participant.
- The individual with MTBI was not present during the recording.
- The researcher analysed the discourse into themes according to the guidelines provided in Potter and Wetherell (1987) and Wetherell *et al.* (2001).
- The data collected were analysed and interpreted and four weeks after the initial interviews the participants were re-interviewed by the researcher to ensure that the data collected during the interviews had been interpreted correctly. The participants were thus given an opportunity to comment on the researcher's interpretations. In this way, trustworthiness of the results was ensured.

#### **3.6.2 Data recording procedures**

The data (discourse) from the tape and audio-visual cassettes was transcribed in Standard orthography in the relevant language so that the discourse could be easily analysed.

### 3.6.3 Data analysis procedures

In order to obtain a qualitative description of the participants' perceptions of their spouses' communication, a DA was implemented. Recently the use of DA has become increasingly popular in the interpretation of how an illness is experienced by an individual (Vyncke, 2000). DA examines the content of the conversation, rather than aspects of structural organisational, such as the use of pauses, turn-taking and adjacency pairs (Jaworski & Coupland, 1999). In other words, it examines and interprets the meaning behind what is being said in the conversation. Discourse is seen as interaction, and the focus is on what happens within the interaction (Wetherell *et al.*, 2001). The 'talk' in the conversation therefore constitutes the data.

In this study the researcher adopted the DA approach, as opposed to content analysis. Conventional content analysis involves simply coding data into categories and calculating the frequency of the occurrences, leaving the reader with a numerical or quantitative summary rather than a qualitative interpretation of the text (Potter & Wetherell 1987). DA in contrast leaves the reader with the *interpretation* of a text in order for meaning to be conveyed. The interpretive nature of DA implies that the researcher 'does not seek to exhaust categories, but to *generate* them by way of identifying how people use language' (Phillips & Hardy, 2002: 74). The analysis does not end because the researcher cannot finding anything new, but rather because the data obtained is sufficient to provide answers to the questions and issues addressed in the study (Wood & Kroger, 2000).

The transcription of the interview marks the start of the analysis process. This was done using Standard English or Afrikaans orthography. The discourse was read carefully by the researcher, as well as by a second professional with sufficient knowledge of DA to make a valuable contribution. This was done to warrant confirmability and trustworthiness. The transcribed discourse was read repeatedly and carefully over a period of time in order for the researcher to become familiar with and 'make sense' of the text.

After reading the transcript repeatedly, the researcher recorded recurring images, words and issues next to the text in the first draft. An example of how the analysis was done is shown below:

Participant 1: “...as hy alkohol in het, dan raak hy kwaad, wat nie rêrig was voor die ongeluk nie.”  
(‘...if he has any alcohol in him then he gets angry, which wasn’t really the case before the accident.’)

Alcohol causes him to lose his temper.

Participant 1: “... want hy’t nie so baie gedrink toe hy werk gehad het nie. Hy drink meer. Ek weet nie; dis seker maar om die stres te vergeet.”  
(‘... because he never drank so much when he had a job. He drinks more. I don’t know; it’s probably to forget about the stress.’)

Unemployment contributes to his drinking problem.

Participant 1: “... hulle [die kinders] is net ‘n uur of twee hier, dan sal hy byvoorbeeld op een van hulle afgaan ...”  
(‘... they [the children] are here for just an hour or two and then he will “go off” at one of them ...’)

The children aggravate his temper.

Participant 1: “... hy lewe nou natuurlik, omtrent op hoofpynpille, omdat die hoofpyn is konstant ...”  
(‘... he lives of course now on headache pills because the headache is constant ...’)

Headaches are common.

Participant 1: “dis sodra hulle [die kinders] inkom ... dan gaan drink hy twee pynpille ...”  
(‘... it’s the moment they [the children] come in ... then he drinks two pain pills...’)

Children contribute to headaches.

These notes were then listed as follows:

Alcohol causes him to lose his temper.

Unemployment contributes to his drinking problem.

The children aggravate his temper.

Headaches are common.

Children contribute to headaches.

The notes were not arranged in any specific order. The words and images used in the discourse were carefully studied and placed into categories based on similarities between them. Themes were then identified within these categories, according to the frequency at which they occurred, the information that followed regarding those themes, and the amount of discourse that was linked to each particular theme. In the example given above, the theme ‘Loss of temper and its impact on communication’ was identified. As in the above example, patterns that occurred within themes were identified. These were viewed

as sub-themes within the main theme. Patterns that occurred within the main theme were listed as ‘Alcohol as a trigger to loss of temper’; ‘Family circumstances as a trigger to loss of temper’ and ‘Physiological factors as a trigger to loss of temper’. These patterns were then discussed individually. The information obtained was interpreted within the framework of Hartley’s model (1995).

#### **3.6.4 Trustworthiness and credibility**

Lincoln and Guba (1985:290) refer to the ‘truth value’ of qualitative studies. The following four constructs (Lincoln & Guba, 1985) were adhered to in the present study:

*(i.) Credibility:*

The aim of credibility is to conduct the study in a way that will ensure that participants are accurately represented and described. The study needs to provide an in-depth description of the setting or pattern of interaction being studied, showing all the complexities of the interaction process. In order to adhere to this construct, participants and their spouses with MTBI in the present study were selected according to the selection criteria and were carefully described. The data collection procedure was carefully outlined and described.

*(ii.) Transferability:*

This involves making one set of findings applicable to another context or group of people. Traditionalists usually see the transferability (or generalisability) to other populations or settings as a weak area in qualitative research. To counter these challenges, the researcher can refer to a theoretical framework to demonstrate how data collection and analysis will be guided by already established concepts. In the current study, a comprehensive literature review was conducted to ensure strong theoretical grounds for the study, based upon the latest research. The data obtained was interpreted using a theoretical framework (Hartley, 1995).

*(iii.) Dependability:*

This refers to the researcher’s accounting for changes of conditions in the phenomenon chosen for the study, as well as changes in design as the context becomes increasingly understood and refined. The conventional paradigm of reliability supposes an unchanging world where a study can be replicated. The qualitative assumption, however, is that the social world is being constantly constructed, thus making



replication in itself problematic. In the present study, a pilot study was conducted to identify and eliminate possible shortcomings in the study and thus adhere to the construct of dependability.

(iv.) *Confirmability:*

This area emphasises the importance of the findings reflecting the questions posed by the study and the participants' responses, rather than the researcher's biases or prejudices. It addresses the need to ask whether further research is likely to confirm the findings of the study. In the present study, a second interview was arranged with each participant to confirm whether the initial conversation had been correctly interpreted and analysed by the researcher. During the process of analysis, the researcher may incorrectly assume a specific interpretation of the talk (Wetherell *et al.*, 2001). This second interview would thus attempt to prevent incorrect interpretation as well as any biases. A further attempt to strengthen confirmability in this study was made by employing a second observer to interpret the DA. This second observer was a professional in the field of speech-language therapy with sufficient expertise in DA to make a valuable contribution. The second observer first studied the transcribed data on her own. This was followed by a session with the researcher during which all the interpretations were discussed. Because of the extensive range of DA techniques and the multiplicity of the phenomena under investigation, the form that analysis takes on varies from study to study (Phillips & Hardy, 2002). It is thus important to elaborate on the particular approach to DA adopted by the researcher for this study. The analysis took place within the framework of DA and in accordance with the guidelines provided in Potter and Wetherell (1987) and Wetherell *et al.* (2001).

### **3.7 SUMMARY OF METHOD**

In this chapter, the method followed in this study was presented. The study made use of a multiple-case study approach. A conversation was initiated using two open-ended questions, presented to three participants whose spouses with MTBI met the selection criteria. Once data had been collected, DA was used to identify themes in the discourse.

## CHAPTER FOUR

### 4 PRESENTATION OF RESULTS

The purpose of this study was to ascertain how spouses of individuals with mild traumatic brain injury (MTBI) perceive their significant others' communication

During an unstructured interview, two open-ended questions were used to obtain information from the spouse concerning the communication of the individual with MTBI. To aid clarity during reading, the affected *spouse* of Participant 1 will be referred to as NM. NM's MTBI occurred six months prior to the initial interview. The spouse of Participant 2 will be referred to as NJ. NJ's MTBI occurred three years prior to the initial interview. The spouse of Participant 3 will be referred to as EM. EM's MTBI occurred nine months prior to the initial interview. The transcribed interviews between the researcher and the participants are included as Appendices E, F and G.

In this chapter, the results obtained from the discourse analysis (DA) of each of the participants are presented. Participant 1 is referred to as P1.

#### 4.1 PARTICIPANT 1

(Appendix E)

##### 4.1.1 Participant 1's view of communication

As discussed under Method (Chapter Three), the participants' understanding of the term 'communication' will determine their interpretation of the second request in the interview, namely 'Describe your spouse's communication'. When P1 was asked what communication means to her, she responded as follows:

“... om jouself te ‘express’...”

(‘... to express yourself ...’)

“... om by iemand te sê hoe jy voel ...”

(‘... to tell someone how you're feeling ...’)

In her definition of communication, P1 placed emphasis on spoken communication and, in particular, on the verbal expression of emotions. After being prompted by the researcher to provide additional information, she further recognised nonverbal components such as body language and facial expressions as being part of communication. She stated:

“... soos hulle sê ‘body language’. Soos hoe jou lyf kan praat en jou gesigsuitdrukkinge kan ook maar kommunikasie wees ...”

(‘... like they say body language. Like how your body can talk and your facial expressions can also be part of communication ...’)

When P1 was asked what was *important* to her regarding communication, she once again emphasised the *verbal* component by stating the following:

“Seker maar hoe jy jouself kan uitdruk. Ek dink dis vreeslik moeilik as jy nie kan kommunikeer nie ... met iemand.”

(‘Probably how you can express yourself. I think it is terribly difficult if you cannot communicate ... with someone.’)

It became evident that P1 viewed communication as something that takes place within the context of a relationship. The following quotes support a relationship being present within the context of communication:

“... jy wil met **iemand**\* kommunikeer...”

(‘... you want to communicate with **someone** ...’)

“... as jy nie kan kommunikeer ... met **iemand**\*”

(‘... if you cannot communicate ... with **someone**.’)

“... om by **iemand**\* te sê hoe jy voel ...”

(‘... to tell **someone** how you’re feeling ...’)

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\* Emphasis added by the researcher, thus not P1’s own

The above phrases indicate another individual being involved in the communication process, therefore inferring that a relationship of some type is present between the speaker and the listener.

When asked to define communication and describe NM's communication, P1 was thus expected to provide information regarding NM's ability to communicate both verbally and nonverbally.

#### **4.1.2 Participant 1's description of NM's communication**

The second request made to P1 was: 'Describe your spouse's communication.'

During the analysis of the discourse following the second request, four themes were identified. These themes were not necessarily *directly* related to the spouse's communication, but were considered by P1 to have an impact on NM's communication. The following four primary themes were identified:

**4.1.2.1**        *Loss of temper*

**4.1.2.2**        *Memory loss*

**4.1.2.3**        *Word-finding difficulties*

**4.1.2.4**        *Role change*

These themes, as well as any patterns that occur within them, will be discussed individually in the following section.

##### **4.1.2.1 Loss of temper**

In reply to the researcher's second question, namely 'Describe NM's communication', P1 responded almost immediately by voicing her concern regarding NM's tendency to easily lose his temper. Her immediate response was:

*"Nee, hy kan goed kommunikeer. Hy kan net, sy humeur is net partykeer bietjie kort met die kinders ..."*

('No, he can communicate well. He can just, he is sometimes a bit short-tempered with the children ...')

When considering P1's definition of communication, loss of temper can, in fact, be linked to her perception of communication. She views communication to be an expression of how you *feel*. This implies that for *her* communication is a means or outlet for expressing emotions. In this case, loss of temper, although a negative response, is a way for NM to vent his feelings. She therefore infers that NM's temper impacts on his communication.

During both the initial and the follow-up interview, P1 repeatedly emphasised her desire to see a change with regard to NM's loss of temper. The following quotations demonstrate this concern:

R\*: "So dis die ding [humeur] wat jou die meeste pla."

(R: 'So that's the thing [temper] that bothers you the most.')

P1: "Ja, ja. Nee, verder is hy heel 'oraait'."

(P1: 'Yes, yes. No, otherwise he's quite okay.')

"Ja, al wat ek agterkom is soos sy humeur."

('Yes, all that I notice is his temper.')

According to P1, NM was equally concerned about his loss of temper. She reported:

"Hy weet daarvan [die humeur], ja. Hy sê ook dis al wat hy rêrig agterkom wat aan hom anders is. En hy sê ook hy wil nie so wees nie."

('He knows about it [the temper], yes. He says that is all he can really notice that is different about him. And he says he doesn't want to be like that.')

P1 later referred to NM's behaviour as 'aggression'. She did mention, however, that this occurs mainly when he has had too much to drink.

"... as hy nou bietjie meer gedrink het, mens kan sien hy bietjie, dan sal hy bietjie aggressief [begin raak]..."

('... if he drinks a bit more, one can see, then he will [become more] aggressive ...')

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\* R refers to researcher

In summary, although P1 feels that NM's *communication per se* does not constitute a problem, his loss of temper and occasional aggression clearly impacts on his ability to communicate and interact effectively with his family.

#### 4.1.2.1.1 *Patterns occurring within the theme: 'Loss of temper'*

A few prominent patterns were observed to occur within the theme 'loss of temper'. P1 regularly referred to the presence of stress factors or 'triggers' in NM's life, which were observed as being triggers to his loss of temper. These were:

- 4.1.2.1.1.1 Alcohol as a trigger to loss of temper
- 4.1.2.1.1.2 Family as a trigger to loss of temper
- 4.1.2.1.1.3 Physiological factors as a trigger to loss of temper

These patterns will be discussed individually.

##### 4.1.2.1.1.1 Alcohol as a trigger to loss of temper

A factor that seems to influence NM's loss temper greatly is the use of alcohol. P1 described situations where NM's temper was exacerbated by the intake of alcohol. This is reflected by the following statement:

*"... as hy enigsins enige alkohol drink, dan raak hy ook baie aggressief."*  
(*'... if he drinks any alcohol at all, he also becomes very aggressive.'*)

This behaviour only became apparent after NM's MTBI, as illustrated by the following quote:

*"... as hy alkohol in het dan raak hy kwaad, wat nie rêrig was voor die ongeluk nie."*  
(*'... if he has any alcohol in him then he gets angry, which wasn't really the case before the accident.'*)

During the follow-up interview, P1 clearly stated disapproval of NM's use of alcohol. In fact, she mentioned NM's use of alcohol more frequently during the follow-up interview than the initial interview. This could indicate NM's increased use of alcohol in the period between the two interviews, causing it to be a greater problem than initially indicated. While discussing adjustments that she has had to make, alcohol is mentioned again as an example, illustrated by the following quote:

*"... of drink, byvoorbeeld, soos as ek sê ek raak nou vir hom kwaad, as hy net een bier drink, waar voorheen het dit my nie gepla nie, want voorheen was dit net een dan bly dit by een."*

(‘... or drinking for example, as I say I now get angry with him if he drinks just one beer, whereas before it wouldn't have bothered me because before it was one and it stayed at one.’)

P1 mentioned that the fact that he was unemployed possibly contributed to NM's increased drinking following the MTBI. This is supported by the following statement:

*"... want hy't nie so baie gedrink toe hy werk gehad het nie. Hy drink meer. Ek weet nie; dis seker maar om die stres te vergeet."*

(‘... because he never drank so much when he had a job. He drinks more. I don't know; it's probably to forget about the stress.’)

The ‘stress’ mentioned in the above quote seemed to refer to the family's financial difficulties at the time. P1 confirmed during the follow-up interview that financial difficulties definitely increased NM's stress.

Furthermore, NM's unemployment, according to P1, had led to feelings of depression, as evident from P1's following statement:

*"... want dis meer soos 'n depressie asof hy voel hy beteken niks ..."*

(‘... because it's more like a depression, as if he feels he has no worth ...’)

P1 mentioned that she believed that NM's depression and drinking would improve as soon as he found a job. The following statement attests to this:

*“Ek weet dit gaan tien maal verbeter as hy net werk kry, dat hy weer kan ‘sort of’ voel hy sorg nou weer vir ons.”*

(‘I know it will be ten times better if he gets a job, that he can again sort of feel he can take care of us again.’)

This positive outlook for the future is one of the few positive statements made by P1 during the follow-up interview.

According to P1, alcohol in the home had become a contentious issue between her and NM. She clearly witnessed the effects of alcohol on NM’s behaviour and temper and therefore wanted him to refrain from taking alcohol altogether. The couple’s relationship, and therefore their communication, is thus negatively affected by NM’s use of alcohol.

#### 4.1.2.1.1.2 Family as a trigger to loss of temper

The children, according to P1, seem to be another major stress factor that aggravates NM’s temper. The moment the children arrive home, he needs to take a headache tablet. His lack of patience with the children is demonstrated by the following quote:

*“... hulle [die kinders] is net ‘n uur of twee hier, dan sal hy byvoorbeeld op een van hulle afgaan ...”*

(‘... they [the children] are here for just an hour or two and then he will ‘go off’ at one of them ...’)

P1 mentioned that NM’s loss of temper was frequently unwarranted. She stated that he often responded to the children’s behaviour unreasonably, indicating the impact of his temper upon his role as a father. This unwarranted loss of temper is evident in P1’s statement:

*“... dan sal hy haar nou ‘n harder pak gee as wat hy eintlik, of oor iets ‘stupid’, wat nie eintlik regtig ‘n pak regverdig nie.”*

(‘... then he will give her a harder hiding than what he ought to, or about something silly, which doesn’t actually justify a hiding.’)



According to P1, this negative behaviour later results in NM experiencing feelings of regret and remorse, as illustrated by P1's statement later in the conversation:

*“Hy [NM] sê baie keer hy voel ook dadelik jammer ... dan sal hy vreeslik sê jammer, en dan voel hy baie sleg daaroor.”*

(‘He [NM] says he often feels sorry right away ... then he will say sorry and then he feels very bad about it.’)

P1 reports that NM is particularly prone to losing his temper with one of the three children. This is illustrated by the following remark:

*“... Veral met BM\* nogal, want CM\* is sy oogappel so hy sal nie met haar so erg raak nie. Maar BM ... die kleinste dingetjie irriteer hom vreeslik.”*

(‘... Especially with BM, because CM is the apple of his eye so he won't become so bad with her. But BM ... the smallest thing irritates him terribly.’)

During the follow-up interview with P1, however, she indicated that a change had already become evident in respect of his irritability towards one daughter. She commented that the relationship between father and daughter was showing signs of improvement.

NM's irritability was manifested mostly towards his family, including his wife, and was generally not a problem amongst friends in a social setting. P1 illustrated NM's irritability towards her in the following statement:

*“... hy sal ook nie met ander mense somer aggressief raak nie. Dis meer met my, dis asof ek, omdat ek nader aan hom is ...”*

(‘... he will also not really become aggressive with other people. It's more with me, it's as if I, because I'm closer to him ...’)

Although P1 initially maintained that NM's communication had not been affected by the MTBI, it became clear from her later comments that his temper affected interaction within the family. When P1 was asked to define *communication*, she indicated *relationships* as being an integral part of communication. Interaction inevitably takes place within family

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\* BM and CM refer to P1 and NM's children

relationships, therefore any change or problem that affects interaction will also affect these relationships, and *vice versa*. Since NM's bad temper had a negative effect on his interaction with family members, it had far-reaching negative consequences for communication within the family.

#### 4.1.2.1.1.3 Physiological factors as a trigger to loss of temper

Physiological factors can be viewed as internal triggers over which, compared with the other apparent external or circumstantial triggers, NM has little control. At the end of the initial interview, NM was clearly still experiencing the effects of the MTBI. According to P1, he still experienced headaches, an internal physiological symptom, as demonstrated by the following quote:

“... *hy lewe nou natuurlik op, omtrent op hoofpynpille, omdat die hoofpyn is konstant ...*”  
(‘... he lives of course now on headache pills because the headache is constant ...’)

These headaches occurred particularly when circumstances at home became stressful, as the following quote suggests:

“... *dis sodra hulle inkom ... dan gaan drink hy twee pynpille ...*”  
(‘... it's the moment they come in ... then he takes two pain pills ...’)

As soon as the children came home, NM had to take two headache tablets. The children were too stressful for NM to deal with independently and he required additional means to be able to cope with these circumstances.

A second physiological factor that influenced NM's behaviour directly after the MTBI was fatigue. According to P1, NM was permanently tired and slept a great deal during the first month after the MTBI. This has since, however, improved.

During the follow-up interview P1 stated that the symptoms of headaches and fatigue were no longer a problem. In summary, headaches and fatigue as physiological factors can therefore be viewed as transient symptoms, as they no longer occurred at the time of the follow-up interview.

#### **4.1.2.2 Memory loss**

Memory loss was a further theme that emerged from the DA of P1. However, this theme was not as prominent as P1's concern regarding NM's loss of temper. P1 did not seem particularly concerned about NM's memory and was of the opinion, at the time of the initial interview, that his memory for new events and newly acquired information was not affected. However, she admitted that NM's short-term memory had been affected directly after the MTBI. When comparing NM's good memory at the time of the interviews to his limited memory directly after the MTBI, P1 stated:

*"... hy't dit [sy geheue] mos vir 'n ruk verloor. Na die ongeluk was hy vir 'n hele ruk, net 'n paar dae het hy nie omtrent 'n geheue gehad nie."*

(‘... he lost it [his memory] for a while. After the accident for a while he was, he practically didn't have a memory for a few days.’)

These comments refer to the transient nature of NM's short-term memory problems. These transient memory problems seem to be the only memory problems that occurred since NM's MTBI, implying that at the time of the interviews, his short-term memory was no longer affected. However, his memory problems directly after the injury must have been significant, seeing that P1 mentioned them during the interview.

In summary, according to P1, NM's memory difficulties, although present directly after the MTBI, did not affect his communication at the time of the interviews.

#### **4.1.2.3 Word-finding difficulties**

When asked to describe NM's communication, P1 was quick to report that no problems were present, as confirmed by the following quote:

*"Nee, hy kan goed kommunikeer ..."*

(‘No, he can communicate well ...’)

Difficulties relating to word-finding problems were, however, reported by P1 later on in the conversation. Word-finding is directly related to her definition of communication,

considering that she views communication as being predominantly the *verbal* expression of how one feels. Despite this, P1 did not consider NM's communication as a cause for concern. This is an interesting observation, seeing that she placed such emphasis upon verbal expression in communication in her definition of communication. She mentioned NM's word-finding difficulties in the following statement:

“... *en hy vergeet sekere woorde, soos as mens oud raak ...*”

(‘... and he forgets certain words, like when someone gets old ...’)

P1 stated that NM's word-finding difficulties also extended to recalling the names of friends or family. Although P1 referred to NM's poor recall of names as poor *memory*, this difficulty in recalling names appeared to be related more to word-finding difficulties than to memory difficulties. She also acknowledged his occasional frustration during conversations when he is unable to recall a particular word, as illustrated by the following remarks:

“... *hy word kwaad vir homself ... hy kan dit nie hanteer nie ...*”

(‘... he gets angry with himself ... he can't handle it ...’)

“... *ek meen hy word basies kwaad as mens nie vir hom dadelik weet waarvan hy praat nie.*”

(‘... I mean he basically gets angry if someone doesn't immediately know what he is talking about.’)

These quotes inferred that word-finding difficulties not only affected his communication, but also influenced and aggravated his loss of temper. These word-finding difficulties occurred fairly routinely and, according to P1, were everyday occurrences.

In the follow-up interview, P1 implied that these word-finding problems, similar to memory, seemed to be transient rather than persistent problems. At the time of the follow-up interview, these word-finding difficulties had become less problematic, according to P1

who, for example, stated that NM's word-finding abilities had shown improvement since the initial conversation:

“... *Ek moet sê ek dink dit [woordvinding] raak beter, met tyd.*”

(‘... I must say I think it [word-finding] is getting better with time.’)

In summary, P1 did not view NM's word-finding problems as a *main* area of concern following the MTBI. In the follow-up interview, she emphasised NM's improvement in his word-finding abilities. P1 described verbal expression as an important component of communication. Although NM experienced word-finding difficulties at the time of the interviews, P1 described NM's verbal communication to be fairly intact.

#### **4.1.2.4 Role change**

The theme of role change emerged prominently during the follow-up interview with P1 and can therefore not be ignored. On the topic of adjustments regarding their relationship, P1 reported that these were still ongoing. Referring to the change in her role that had taken place since NM's MTBI, she responded as follows:

“... *dis nog besig om te gebeur [aanpassing], maar ek dink ek het baie, soos na die ongeluk het ek baie van, soos 'n ouer-rol gevat. Soos wat hy amper soos een van die kinders was.*”

(‘... it's still busy happening [adjustment], but I think after the accident I took the role of being a parent. Like he was almost like one of the children.’)

P1 stated that adjustments in their relationship since the accident were still occurring. She had previously emphasised the presence and importance of a relationship within her definition of communication. Her role change, which had resulted in a change in her relationship with NM, also affected their communication, since NM was no longer seen as an ‘equal’. According to P1, she had to change her role to being a ‘parent’, rather than a wife, to NM. Consequently, she also had to assume more of the responsibilities in the

household after NM's MTBI. A sense of resentment was detected when she reported this role change, as demonstrated in the following exchange:

*P1:* "... *Ek kon nie altyd die een wees wat na iemand kyk nie. Ek wil hê iemand moet 'n bietjie na my ook kyk nog.*"

(‘... I can’t always be the one who looks after someone else. I want someone to still look after me a bit.’)

*R\*:* “*Dis amper 'n man se rol, né?*”

(‘That’s almost a husband’s role, right?’)

*P1:* “*Presies, ja.*”

(‘Exactly, yes.’)

*R:* “*Ja.*”

(‘Yes.’)

*P1:* “*So hy’t nou basies amper sy rol verloor.*”

(‘So basically he’s now almost lost his role.’)

P1 seemed to be discussing NM’s role as the financial provider for his family. The above statements by P1 also indicate a sense of loss, as she pointed out that NM has, in her opinion, basically ‘lost his role’. She stated that she believed that NM felt the same way about this change in roles and that this had affected his feeling of self-worth. P1 further stated that NM had started taking on more responsibility by looking after the children during the day. This is viewed as a positive step in the adjustment process. She mentioned that previously, just after the MTBI, NM had been unwilling, or unable, to take responsibility for looking after the children or taking care of finances. This had become her role. According to P1, looking after the children has given him a sense of responsibility, as demonstrated in the following quote:

“... *nou vat hy die verantwoordelikheid om na die kinders te kyk deur die dag ...*”

(‘... now he takes responsibility for looking after the children during the day ...’)

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\* R refers to researcher

P1 was hopeful that NM would resume his role of financial provider once he found a job. She also felt that his feeling of self-worth would improve as he would feel that he was able to provide for his family again. The following quote illustrates this:

*“Ek weet dit gaan tien maal verbeter as hy net werk kry, dat hy weet hy weer kan ‘sort of’ voel hy sorg nou vir ons.”*

(‘I know it will be ten times better when he gets a job that he can know he can now take care of us again.’)

The change in roles evidently had a great impact on P1 and had, as she reported, affected their relationship. Here it should be noted again that in her description of communication, communication was placed within the context of a relationship. The change in roles has therefore affected P1 and NM’s communication.

To summarise, P1 placed emphasis on both the verbal and the nonverbal components of communication. She also viewed communication as taking place within a relationship. In the DA, P1 emphasised her concern regarding NM’s loss of temper, which had implications for his communication with others, particularly within the family. Alcohol, family, and physiological factors were identified as factors that triggered NM’s loss of temper. Memory loss and word-finding difficulties were further identified as themes within P1’s DA. However, these themes were not as prominent as the theme of NM’s loss of temper, despite their contribution to the changes that had occurred in his communication since the MTBI. P1 also identified the role change that both NM and she had experienced since the MTBI. This role change impacted on their relationship, and consequently on their communication.

## 4.2 PARTICIPANT 2

(Appendix F)

The spouse of Participant 2 will be referred to as NJ. NJ's MTBI occurred three years prior to the initial interview.

In this section, Participant 2's response to the first question in the interview is presented. This is followed by a discussion of themes identified in the DA in the course of the conversation emanating from Question 2. Participant 2 is referred to as P2.

### 4.2.1 Participant 2's view of communication

It is likely that P2's understanding of the term communication determined the manner in which the subsequent question was answered, namely 'Describe your spouse's communication.'

Communication, according to P2, is vital within any relationship. She stated the following:

*“Jy moet goeie kommunikasie hê om 'n goeie verhouding op te bou ... jy moet al jou dinge kan uitsorteer en uitredeneer ...”*

(‘You must have good communication to build up a good relationship ... you must be able to sort out and reason through all your issues ...’)

*“... vir my staan praat bo alles ...”*

(‘... for me, talking stands above everything ...’)

P2 clearly feels that talking, or the verbal component, is fundamental to communication. During the interview she further reported that a person's actions, attitude and personality are also integral to communication, as implied by the following statement:

*“... seker maar jou houding van hoe jy optree en wat jy uitstraal as persoon ...”*

(‘... probably your attitude of how you behave and what you radiate as a person ...’)



The above statement also indicates that P2 views behaviour as a component of communication. Verbal communication and behaviour are therefore most likely to be addressed by P2 in the course of the conversation relating to NJ's communication.

#### **4.2.2 Participant 2's description of NJ's communication**

The researcher's second request to P2 was: 'Describe your spouse's communication.'

During the analysis of the discourse following the second request, three themes were identified. These themes were not necessarily *directly* related to NJ's communication, but were seen by P2 to impact on his communication. The three themes identified were:

##### **4.2.2.1 Adynamia**

##### **4.2.2.2 Memory loss**

##### **4.2.2.3 Social withdrawal**

These themes will be discussed individually in the following section.

##### **4.2.2.1 Adynamia**

P2 described communication as 'how you behave and what you radiate as a person'. Lack of motivation, as described by the term *adynamia* (Hartley, 1995), affects the way one behaves. The change that had occurred in NJ's drive since the MTBI has thus had a negative effect on P2's perception of NJ's communication.

The emerging pattern of NJ's lack of drive or motivation since the MTBI was summed up by P2 in the following statement:

*"... daai vlammetjie wat daar moet wees is nie meer daar nie ..."*

(... that "spark" that should be there is no longer there ...)

The 'spark' that P2 referred to is interpreted as NJ's drive and motivation prior to the MTBI, which has been diminished since the incident. P2 introduced NJ's lack of drive by referring to the fact that, since the MTBI, NJ finds it difficult to complete tasks. P2 stated that although NJ's lack of motivation to complete a task had been more evident shortly after the MTBI, there were still times where he seemed to show that same behaviour:

“... dan los hy dit ... en ek dink van dit het hy nog ‘n bietjie oorgehou ...”  
(‘... then he gives up ... and I think he still has some of that left behind ...’)

Whereas, according to P2, NJ used to be a ‘go-getter’, he had become reluctant to take on new tasks at times. The following statement illustrates this change:

“... hy het nie meer daai lus vir dinge nie en hy het nie meer daai ... motivering om ‘n ding aan te pak en hom klaar te maak partykeer ...”  
(‘... he does not have that desire for things any more and he doesn’t have that ... motivation to start a thing and to finish it sometimes ...’)

However, this adynamia appears to be inconsistent, as P2 mentioned that when NJ *actively* decides to do something, he is in fact able to bring it to completion. In the initial interview, P2 indicated that NJ’s inability to start and finish a project was of minimal concern, and that his lack of motivation was reasonably under control:

“... hy kry maar nog dae waar hy bietjie laks is, maar dis eintlik minimum, maar dit is maar nog daarso ...”  
(‘... he still gets days where he’s a bit lax, but that’s actually minimal, but it is still there ...’)

During the follow-up interview, P2’s increased concern regarding NJ’s adynamia became apparent. She felt that although improvement in this area was evident, NJ’s drive was not what it had been prior to the MTBI. The following statement made during the follow-up interview supports this:

“... die dryfkrag is weg, hy kom met rukke terug, maar hy’s nie daar waar dit moet wees nie. En dis nogal ‘n groot leemte eintlik.”  
(‘... the drive is gone ... it comes back at times, but it’s not there where it should be. And it’s a large gap actually.’)

In the follow-up interview, as illustrated by the above statement, P2 revealed that NJ had experienced a certain ‘sense of loss’ since the accident. During the initial interview, P2 did not describe NJ’s lack of drive as a *loss*, as she did during the follow-up interview.

We can speculate that P2 perhaps had more time to ponder on NJ's lack of drive during the period between the initial and follow-up interview, which possibly led her to realise that NJ's behaviour was actually a greater cause for concern than she had initially thought. Although NJ has returned to work and three years had passed since the accident, P2 maintained that NJ lacks the drive he had exhibited before the MTBI, thus indicating a change in his *behaviour*. She further stated that he is no longer the *person* he used to be:

“... *hy's nou bietjie, ja, hy's anders. Hy's nie wat hy moet wees nie.*”  
(‘... he's now a little, yes, he's different. He's not what he should be.’)

In the above statement, P2 *alludes* to a change in NJ's personality. Personality and behaviour are closely related, continually affecting each other, as personality often determines an individual's behaviour (Pervin, 1993). It is thus difficult to separate personality from behaviour, as behaviour comprises an integral part of an individual's personality (N. Cassimjee, personal communication, 21 April, 2006). P2 elaborated further on NJ's ‘spark’ that had disappeared by describing how he became more introverted and withdrawn directly after the MTBI, reluctant to take part in conversation and share his feelings. This behaviour was contrary to NJ's communication before the accident, when he was open about his feelings and opinions.

During the initial interview, P2 described that on a few occasions in the course of the past eighteen months, she had witnessed NJ ‘becoming his old self again’. Clarification was needed on this point, as earlier during the initial interview P2 had referred to NJ as being ‘back to his old self’. When clarified during the follow-up interview, P2 explained that NJ was rather ‘becoming his old self’ than being ‘back to his old self’. The following statement illustrates P2's clarification:

“*Ek sou sê hy's meer besig om sy ou self te raak.*”  
(‘I would say he's more busy becoming his old self again.’)

It is interesting to note that P2 shared that NJ was becoming his old self again, rather than stating that he was his old self. Thus, although the accident happened three years earlier,

P2 maintained that the process of adapting to the MTBI and its consequences was still ongoing, as indicated in the following statement:

*“... Ek dink dis [adaptasie] nog in die proses. Ek dink dis nie regtig aangepas nie ... dis maar ‘n ding wat bly en ek dink jy moet op een of ander stadium ... verby hom kom, maar [ons het] nog nie heeltemaal [aangepas] nie.”*

(‘... I think it’s [adaptation] still in the process. I think we haven’t really adjusted yet ... it’s a thing that stays and I think at some or other stage you must get past it, but [we] haven’t completely [adjusted].’)

Although complete adaptation does not seem to have taken place, the past eighteen months have required less adjustment than the first eighteen months. P2 described this positive change in NJ’s adjustment over the past eighteen months in the following quote:

*“... nou die laaste jaar en ‘n half het hy meer begin gesels en meer oopmaak weer.”*

(‘... now the last year and a half he has been starting to talk more and open up more again.’)

Despite the fact that the changes in NJ’s communication in the first eighteen months frustrated them both at times, they remained open and honest in their communication. During this period, they continued to deal with these changes by speaking about them, thus practically applying P2’s view of the verbal component of communication as being vital to the success of a relationship. The following statement illustrates this point:

*“... ons het daaroor gesels en hy’t net gesê, ‘Ag, ons moet tyd gee en kyk, dalk verander dit’ ...”*

(‘... we spoke about it and he just said, “Ag, we must give it time and see, maybe it will change” ...’)

According to P2, talking through the difficult times made it easier for them to deal with the changes in NJ, as illustrated by the following statement:

*“... jy’s bewus van hoe die ander een voel en wat hy dink en wat hy beleef ... dit maak dit makliker ... as wat jy stilbly en weet nie wat dink die ou ...”*

(‘... you’re aware of how the other feels and what he thinks and what he experiences ... it makes it easier ... than keeping quiet and not knowing what the other is thinking ...’)

In summary, when reflecting on the change that occurred in NJ’s drive as well as in his social functioning since the MTBI, very little is now left of the ‘go-getter’ he used to be. The change in NJ’s drive as reported by P2 thus also alludes to a change in his personality. If we relate this change to P2’s perception of communication, which includes ‘how you behave’ and ‘what you radiate as a person’, the change in NJ’s drive has therefore affected his communication.

#### **4.2.2.2 Memory loss**

P2 reported a change in NJ’s memory since the MTBI and mentioned that he tends to be a little forgetful at times, struggling to recall details of past events or conversations. The following statement illustrates his forgetfulness:

*“... hy’t ‘genuine’ ‘n geheue soos ‘n olifant gehad ... deesdae kan jy vir hom ‘n ding sê en hy sal ... sweer jy het dit nie vir hom gesê nie ...”*

(‘... he really had a memory like an elephant ... these days you can tell him something and he will ... swear that you did not tell him ...’)

Although P2 mentioned that NJ’s short-term memory had been affected since the MTBI, she felt that his long-term memory difficulties were more problematic than his short-term memory. Occasional difficulties with his long-term memory were illustrated by the following statement:

*“... die laaste vyf, ses jaar, is daar sekere goed wat hy nou nie kan lekker onthou nie.”*

(‘... the last five, six years, there are certain things that he cannot remember very well.’)

During the follow-up interview, P2 confirmed that she was more concerned about NJ’s long-term memory than she was about his short-term memory. She stated that it had

become more difficult for NJ to recall certain events that had occurred before his MTBI. This is an interesting observation, since short-term recall difficulties are generally more prominent after TBI, with long-term recall abilities usually remaining intact (Kay & Lezak, 1990). Nevertheless, according to P2, these difficulties, despite being infrequent, continue to impact on NJ's communication in conversations with others.

P2 mentioned that although short-term memory difficulties are occasionally evident, they occur less frequently. Although occasional difficulties in this area do not seem to bother NJ, there are times when P2 notices that they do worry him. The following quotation confirms this:

“... *ek sal nie sê dit pla hom regtig nie, maar partykeer dan kan ek sien hy twyfel nou ...*”  
(‘... I won't say it really bothers him, but sometimes I can see he doubts ...’)

It would therefore appear that NJ's memory difficulties do not impact on his communication only, but also *cause him to question his own capability to recall information accurately*. According to P2, long-term and short-term recall difficulties cause NJ to question his own capability and therefore undermine his self-confidence, as evident from the above statement.

In summary, P2's description of communication emphasised the verbal element as well as an individual's attitude. She felt that NJ's memory difficulties, despite being in the 'minority', influenced his self-confidence during communication at times. Memory difficulties have thus influenced NJ's communication since the MTBI.

#### ***4.2.2.3 Social Withdrawal***

Although seemingly unrelated to communication after MTBI, the physical problems experienced by NJ after his accident, specifically his backache, appeared to indirectly affect his communication. In P2's description of communication, she mentioned that communication gives an indication of the type of person you are, in other words, alluding to personality:

“*Jou hele houding straal uit hoe jy as persoon seker maar is ...*”  
(‘Your whole attitude radiates how you are as a person ...’)

According to P2, their physical activities have changed since the accident, as NJ is unable to take part in physical events, such as sports, which they previously enjoyed doing together. In view of P2's above description of communication, we can therefore say that the MTBI, and more specifically NJ's back problem, has prevented him from continuing with the activities in his life. In the following quotations, P2 gives an indication of how their participation in physical activities, together with friends, has changed:

*“... soos fisiese dinge doen saam met vriende, en so hy sal baie keer ‘uitchicken’ sekere goeters wat hy vroeër sal gedoen het ...”*

(‘... like doing physical things with friends, and so he will often ‘chicken out’ of certain things that he would have done before ...’)

*“... as hy wil sosiaal verkeer dan kan hy nie altyd nie, so hy moet homself distansiëer van sekere dinge ...”*

(‘... if he wants to socialise, he is not always able to, so he has to distance himself from certain things ...’)

These statements also reflect the element of relationships that P2 emphasised in her description of communication. She felt that communication was essential for any relationship to be successful. If NJ avoided activities that he used to participate in with friends before the MTBI, his relationship with these friends would also have been affected. Communication is essential in any relationship, therefore, if communication is affected, a relationship will be affected too.

P2 also briefly mentioned NJ's persistent headaches for the first two years after the MTBI. She did not, however, report these headaches as having had a negative impact on his functioning. At the time of the follow-up interview, he was not experiencing any headaches.

In summary, P2 mentioned the presence of NJ's physical difficulties after the MTBI and described how his physical activities have been limited since the MTBI. The ramifications

of these physical difficulties appear to have affected more than just his physical activities: he has distanced himself from friends, which has affected his relationships with them. As discussed, P2 regards good, open communication as essential for building any relationship. Decreased sporting activities since the MTBI have therefore indirectly affected NJ's communication with his friends and have resulted in social withdrawal.

Adynamia, memory loss and social withdrawal are themes that emerged from the DA of the conversation with P1 regarding her husband's communication. According to P2, these difficulties and their subsequent impact on communication were not present before NJ's MTBI. It would therefore appear that NJ's adynamia, memory loss and social withdrawal are associated with his MTBI.



### 4.3 PARTICIPANT 3

(Appendix G)

Participant 3's spouse is referred to as EM. EM's MTBI occurred nine months prior to the initial interview.

In this section, Participant 3's response to the first question in the interview is presented. This is followed by a discussion of themes identified in the DA in the course of the conversation emanating from Question 2. Participant 3 is referred to as P3.

English is P3's second language. The researcher attempted, as far as possible, to clarify information in the conversation with P3 so that misunderstandings could be avoided. However, a few incongruencies in the DA seem to have occurred when P3 did not understand the researcher's question adequately. P3 also provided contradictory and ambiguous information at times. Although these incongruencies caused some degree of confusion, none detracted from, nor contradicted the main themes that emerged. These incongruencies are discussed as they occurred under the headings and themes below.

#### 4.3.1 Participant 3's view of communication

It is likely that P3's understanding of the term *communication* determined the manner in which the subsequent request was answered, namely 'Describe your spouse's communication.'

P3 began explaining communication by placing it within the context of a relationship. In doing this, he referred to his relationship with his wife. Throughout the discourse, P3 often used situations or provided examples when explaining his answer, seemingly in an attempt to further illustrate his point. He described communication by referring to the communication between him and his wife in the following way:

*'If I've done something wrong ... my wife ... say, "I don't like this" ... I say, "Sorry I've done this wrong, forgive me" ... that's good communication.'* (Brings two index fingers side by side)

P3 implied that the relationship between him and his wife was characteristically an honest relationship. He further mentioned the importance of the nonverbal component of communication. He viewed body language and eye contact during conversation as crucial to effective communication. These nonverbal components were highlighted in the following phrases:

*'...when you talk you don't throw hands like this.'* (Flings hands in the air)

*'If you fold your hands it means that you don't listen.'* (Folds arms high up against chest)

*'You must look the person straight to the eyes.'* (Points to researcher's eyes)

Honesty was emphasised in the following statement referring to the influence of body language on communication:

*'If I'm talking lies, you'll see me from the face and the body language.'*

The nonverbal component of communication was clearly an area of significance to P3. He believed that the integrity of the conversation partner's message could be noticed from the body language that he or she used. It could therefore be predicted that P3 would report on both verbal and nonverbal components when referring to EM's communication at the time of the interviews.

Because English is P3's second language, careful interpretation of the discourse was necessary. The following section discusses incongruencies in the DA concerning P3's definition of communication.

- ***Incongruencies found within Participant 3's view of communication***

In the initial interview, P3 discussed the role of body language in communication in detail. He proceeded to illustrate this role further by relating a rather confusing, lengthy episode which included other peoples' comments. The following quotation is an example of his speech:

*'... you sit like this (sits with back against chair and puts on a high-pitched voice): "Ah, SM\*, it was raining, I went to my mother-in-law's place, it was so raining"... after tears ... you drink beer ... to not cry any more ... you must forget that person ....'*

When this information was clarified, P3 simply confirmed his emphasis on body language during communication. He did not clarify or explain the episode he had just discussed.

During the conversation, P3 often used comparative examples when explaining himself. These examples seemed to be used when he could not find adequate words in English to describe what he wanted to say. The following statement describing his view of good communication illustrates this:

*'I don't like chicken, I like fish, my wife, she cook fish nicely, the way I like it.'*

This example is interpreted as a 'mutual understanding' that exists between P3 and EM. This same 'understanding' was described again when EM's body language was discussed. He described her body language as follows:

*'We don't talk, we just look at each other and find out the TV it's on, and just look at the TV, then we turn, we look each other ... we don't answer each other, but the way we sitting like this (looks purposefully into researcher's eyes), we talk.'*

The importance of body language was confirmed in the follow-up interview, although similar confusing statements seemed to be apparent. This confusion was demonstrated in the following statement:

*'It's like yourself and your husband. Sometimes you just, you don't talk, you just look at each other, but ... you talking, but you don't talk like the way I talk now, just look at each other.'*

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\* SM refers to P3

Although the details of this message were unclear, the main message of the importance of body language within conversation was conveyed, clarified and confirmed.

### **4.3.2 Participant 3's description of EM's communication**

The second request made to P3 was: 'Describe your spouse's communication.'

During the analysis of the discourse following the second request, two themes were identified. These themes were not necessarily *directly* related to the spouse's communication, but were seen by P3 to impact on EM's communication at the time of the conversation. The two themes identified were:

#### ***4.3.2.1 Delayed processing***

#### ***4.3.2.2 EM's effective communication***

These themes will be discussed individually in the following section.

#### ***4.3.2.1 Delayed processing***

When first asked to comment on EM's communication, P3 immediately responded positively by saying that he '*liked*' the way EM communicates. He described EM's communication as being important in their relationship and did not initially mention any changes that had taken place in her communication since the MTBI. He felt that the understanding between him and his wife was very good, which, in the light of his description on communication above, was viewed by P3 as good communication.

When asked to discuss EM's communication since the accident, P3 referred mainly to the changes that *he* has had to make to accommodate the change. Before EM's MTBI, he spoke quickly, but had since learnt to reduce his speech rate when talking to her. He mentioned this change in the following statements:

*'... before the accident I used to talk fast ...'*

*'... when I talk to my wife, I don't talk faster, ... slowly (shows hands motioning from fast to slow) and then she understands.'*

Although P3 initially highlighted EM's good communication, he later implied that her understanding or processing seemed to have been affected by the MTBI. EM's delayed processing was clarified in the initial interview, during which P3 stated that EM did not *hear* him when he spoke rapidly. Clarification of the difference between *hearing* and *processing* was necessary here. The following exchange with P3 clarifies his understanding of the two terms:

R\* : '... is it that she doesn't **hear** you, or is it that it is slower for her to **process** (points with hand to head to show 'understanding') what you've said?'

P3: 'No, she hear, she hear, but to **process**, it's just because, the accident, ja, the accident, so that's why ... (screws up face to show confused look)'

P3 confirmed here that EM's *processing*, rather than her hearing, was affected since the MTBI. The quotation also implied that P3 felt that the accident had been the cause of EM's diminished ability to process information. The medical doctors who treated EM after the accident had advised P3 on how he should behave towards her and communicate with her after the accident, and were still playing a role in this regard. The doctor who had treated EM in the hospital advised P3 to reduce his speech rate when addressing her. P3 confirmed that from that time onward, he had been more aware of the way he spoke to EM. The following statement illustrates the adjustment suggested by the doctor:

'... the doctor he has said to me, "If you talk to your wife, don't talk faster, slowly" ...'

P3 placed great value on the doctor's advice. He therefore remembered and respected the doctor's words even after EM's discharge from the hospital. During the follow-up interview, P3 confirmed that the doctor had played an important role in their lives immediately after the MTBI and was continuing to do so. A few months after the MTBI, P3 still regarded the doctor's words of advice as being as important as they had been at the time of the accident. He emphasised the doctor's role and his high regard for the doctor's advice regarding communication in the following statements:

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\* R refers to the researcher

*‘... and he [the doctor] says, “No, it will take quite a while, but speak slowly so she can understand.” ’*

*‘So even now I’m still doing what the doctor said.’*

P3 confirmed that the doctor’s advice was still influencing his communication with EM, even though nine months had passed since the accident.

P3 later reiterated that when he talks at a reduced rate, EM’s comprehension is good. It is also probable that by repeating the information to EM, he facilitates improved understanding. During the follow-up interview, P3 agreed that EM occasionally took longer to understand. The following exchange demonstrates this:

*R\* : ‘When you ... ask her maybe a bit of a complicated question, does she take a little bit longer?’*

*P3: ‘Ja, a little bit longer to answer, sometimes. But it’s not so often.’*

His answer suggested that although processing may be delayed, he does not experience it as problematic.

P3 mentioned the change that he has had to make in his speech rate on numerous occasions during the initial and follow-up interviews. He reported that when he slows down his speech, EM’s understanding improves. P3 thus seemed to view EM’s ability to understand as being related to his speech rate. That is, the quicker he speaks, the less likely it is that she will understand. He also admitted that he still forgets to reduce his speech at times and that EM must regularly remind him to speak slowly. This implies that, at the time of the interview, P3 was still in the process of adjusting to reducing his speech rate when conversing with EM. In P3’s definition of communication, the verbal component of communication was emphasised, which explains why it was so important to P3 to adjust his speech so that EM would be able to understand him.

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\* R refers to researcher

The following section deals with incongruencies in the DA concerning P3's view on delayed processing:

- *Incongruencies found within the theme of 'delayed processing'*

Incongruencies in the DA of the follow-up interview became apparent when EM's understanding of P3's speech was discussed. The conclusion drawn by the researcher on the basis of the initial interview was posed to P3, namely that EM's comprehension was affected at times:

R\*: '*... she maybe struggles a little bit more in her understanding ...?*'

P3: '*Yes, yes.*'

During the follow-up interview P3 seemed to agree with the finding that EM's comprehension had been affected. However, he later clarified that EM only struggled to understand when he spoke too *rapidly*, as the following statement suggests:

*'No, no, no. When I'm talking slowly she understands quickly, when I'm talking fast she goes, "Huh, huh? I don't understand," you see.'*

EM's ability to understand is diminished in a demanding listening situation, such as rapid speech. Before the accident, EM was able to understand P3 despite his rapid speech, as illustrated in the following exchange:

P3: '*... before the accident I used to talk fast ...*'

R: '*And she could understand you then?*'

P3: '*Yes, before, but ...*'

The above exchange confirms that EM's communication was in fact affected by the MTBI.

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\* R refers to researcher

#### **4.3.2.2 EM's effective communication**

As mentioned before, P3 is satisfied with his wife's communication and has high regard for the way in which she communicates. The following statement captures P3's satisfaction with the communication that existed between them at the time of the interview:

*'There's a good communication with me and my wife, I like it.'*

P3 regarded EM's ability to communicate after the MTBI as being superior to his own. This opinion conveyed his positive attitude towards EM, which was, in fact, evident throughout the interview. The following statement conveyed his high regard for his wife's communication at the time of the interviews:

*'... she answer me slowly, nicely, nicely and sometimes actually how can I put it, she's better than mine ...'*

This statement emphasises the *verbal* component of communication which, according to his description of communication, is of great importance.

P3 showed great admiration for the resilience with which EM handled her own condition following the MTBI. He discussed her resilience during the difficult time when EM's mother passed away soon after the MTBI. According to P3, EM also provided the family with good advice. He implied that her good communication extended beyond their relationship. EM also comforted P3 during difficult times and she clearly provided a strong support for him by way of verbal expression. P3 elaborates on EM's encouragement in the following statement:

*'... she says to me, "Don't panic, you get a job, don't panic."'*



P3 also emphasised the understanding that existed between him and EM. He mentioned that they often did not even need to use words because they understood one another. This is demonstrated by the following statement:

*'... we don't talk, we just look at each other and find out the TV it's on ... we don't answer each other ... but the way we sitting ... we talk.'*

Upon clarification, it was determined that in this instance P3 was referring to the understanding that exists between him and his wife without the need for words. Therefore, according to P3, the nonverbal communication that exists between them is good. This nonverbal component is also described in his definition of communication as being very important to him.

The following section discusses incongruencies in the DA concerning P3's view on EM's effective communication:

- ***Incongruencies found within the theme of 'EM's effective communication'***

Even though the information pertaining to the theme of 'effective communication' was clarified in the follow-up interview, it cannot be stated with certainty that P3 understood all of the researcher's statements and questions in this section. The following quotations provide evidence of inadequate understanding:

R\*: *'... You said that your wife's communication to you now ... is better than before the accident.'*

P3: *'Exactly.'*

R: *'Why do you think that is so?'*

P3: *'Before, when I talk to her ... I used to talk a little bit faster ... then after the accident then I think that ... his mind ... his brain was damaged, so I must talk slowly ....'*

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\* R refers to researcher

It is not possible to make the deduction from the above statements that EM's communication, at the time of the interview, is better than it was *before* the accident, as P3 suggested. The researcher again questioned P3 as to whether, at the time of the interview, EM's communication was better than before the MTBI:

R\* : 'Compared to before? Even *before* the accident?'

P3: 'Yes.'

It appeared that P3 did not understand the researcher's questions here, which resulted in unclear responses given. However, P3's responses in the previous interaction seemed to indicate that her processing was affected by the accident but that there had been improvement *since* the accident.

To summarise, EM appears to exhibit delayed processing since the MTBI, requiring people to reduce their speech rate when speaking to her. Despite this change, P3 considers EM to be a competent communicator and is pleased with the communication between them as well as between EM and other family members. No further themes emerged from the DA of the interview with P3.

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\* R refers to researcher

## CHAPTER FIVE

### 5 DISCUSSION

The main aim of this study was to describe how spouses of individuals with mild traumatic brain injury (MTBI) perceive their significant others' communication. The data was collected by making use of semi-structured interviews and the information was then analysed by means of a discourse analysis (DA).

In this chapter the results obtained are interpreted. Each participant's perceptions of his or her spouse's communication are discussed separately, with comparisons and similarities drawn where possible. The Model of Social Communication (Hartley, 1995) will form the conceptual framework within which the themes obtained from each participant's DA will be interpreted.

#### 5.1 PARTICIPANT 1

##### 5.1.1 Participant 1's view of communication

By asking Participant 1 (P1) to describe the communication of her spouse, NM, the researcher hoped to obtain a description of what Hartley (1995) would refer to as the *products* of communication, namely NM's verbal and nonverbal communication behaviour. P1 first mentioned the verbal component of communication as important to her, and only later mentioned the role of nonverbal behaviour in communication. The presence of a relationship within communication addressed by P1 may be applied to all parts of the Model of Social Communication (Hartley, 1995) and is seen to be the result of the interaction between the different processes, products and the environment. The model denotes the 'dynamic, ongoing and cyclical nature of communication interactions' (Hartley, 1995:22), which implies that relationships as communication interactions are ongoing and continue to change as time passes.

In summary, P2's view of communication involved both verbal and nonverbal components of communication within the context of a relationship. An examination of P2's description of NM's communication, led us to predict that she would comment on his verbal and nonverbal behaviour within their, and perhaps other, relationships.

## 5.1.2 P1's description of NM's communication

The themes that emerged from the DA of P1's discourse regarding NM's communication are interpreted within the context of the Model of Social Communication (Hartley, 1995).

### 5.1.2.1 *Loss of temper: a product of the interaction between the internal process of subcortical and limbic input with the environment*

A theme that emerged strongly from P1's description of NM's communication was that of loss of temper. P1 emphasised that NM's tendency to lose his temper was the change in his behaviour that was of most concern to her. This seemed to affect his communication with his family.

Irritability, often leading to loss of temper, is known to be one of the common sequelae in the first three months after an MTBI. It is usually known to disappear in most individuals after three months of the MTBI (ACRM, 1993; Alexander, 1995; Binder, Rohling & Larabee, 1997; Rosenthal, 1993). NM, however, at the time of the interviews, was six months post-injury. In a small minority of individuals, irritability has been found to be a possible persisting symptom (Alexander 1995). Hoon Kim, Manes, Kosier, Baruah and Robinson (1999) conducted a study on individuals with traumatic brain injury (TBI) over a period of one year, examining factors associated with irritability. Of these individuals, 39% had MTBI. Individuals were evaluated at one month post-injury, with follow-up evaluations at three, six, nine and 12 months. Altogether 18.2% of all the individuals met the irritability criteria during the initial evaluation, and 15.1% met the criteria at three, six, nine and 12 months. The study interestingly showed that individuals *without* irritability had a greater TBI severity than individuals with irritability. The reason for this was possibly because irritability requires more intact cognitive processes, and that individuals with MTBI experience the most frustration, which is acted out as irritability.

NM's irritability and associated loss of temper has persisted beyond three months post-injury. When viewed within the Model of Social Communication (Hartley, 1995), NM's loss of temper may be the product of the interaction between his possibly impaired internal process of subcortical and limbic input with his environment.

The brain's subcortical regions and limbic systems influence an individual's processing

and behaviour (Hartley, 1995). Adequate and efficient emotional control is thus dependent on a certain level of arousal from the limbic system. This level of arousal from the limbic system is, in turn, determined by the reticular activating system. The reticular activating system is particularly sensitive to axonal damage, often associated with TBI. It is possible that NM sustained diffuse axonal injury, resulting in decreased cortical activation required for successful information processing and behaviour control (Hartley, 1995). The potential result of this decreased cortical activation is the irritability, poor frustration tolerance and increased anger (loss of temper) which, according to P1, are characteristic of NM's communication.

Hartley (1995) states that communication behaviour is the product of the interaction between internal processes and the *environment*. Bohnen *et al.* (1992) speculate that emotional complaints after MTBI are related to an individual's inability to cope with environmental pressures. It is clear from the DA of the interview with P1 that numerous factors are indeed present in NM's *environment*, and that they interact with his possibly impaired internal processes of information processing and behaviour control to further trigger his loss of temper. One such factor is represented by NM's children. According to P1, NM easily loses his temper with the children after they arrive home. To prevent him from losing his temper, he takes headache tablets upon their arrival. Another possible environmental factor is NM's unemployment. NM was unemployed before the MTBI. These two factors (namely the presence of children and NM's unemployment) are therefore not new. P1 did not mention that NM had been in the habit of losing his temper before the MTBI. We can therefore assume that his loss of temper is associated with the MTBI and his resulting inability to deal with his environmental pressures. NM's reduced ability to cope with these stressful environmental factors corresponds with results in a study conducted by Gouvier, Cubic, Jones, Brantley and Cutlip (1992). Their results revealed that an increase in symptoms after MTBI is likely to occur during stressful periods, as appears to be the case with NM. Hanna-Pladdy, Berry, Bennett, Phillips and Gouvier (2001) also examined the effect of stress factors in complicating the recovery process for individuals with MTBI. Hanna-Pladdy *et al.* (2001) found that 'Post-concussive Syndrome' increased when individuals with MTBI were placed under highly stressful conditions. NM's loss of temper, a symptom of Post-concussive Syndrome, increases when he is confronted with the environmental factors of children and unemployment. Since these factors were present before the accident, his loss of temper is

thus likely to be associated with his MTBI and not with new environmental stress.

In summary, it would appear that in the case of NM, MTBI has impacted on his communication. While the speech-language therapist (SLT) has a role to play in improving NM's communication interaction, a team approach is advocated to manage NM's loss of temper as he may require psychological or medical intervention.

A reduction in the arousal state of the individual with MTBI is also caused by alcohol (Hartley, 1995). P1 frequently mentioned NM's drinking habits, implying the presence of an alcohol problem since the MTBI. Corrigan, Lamb-Hart and Rust (1995) went as far as to state that, should any use of alcohol be causing a problem, it is referred to as abuse. According to P1, NM's aggression and irritability worsen with the intake of alcohol. Ito, Miller and Pollock (1996) also found that alcohol can exacerbate aggression. Some individuals with *mild* TBI have reported increased sensitivity to modest alcohol use (Alexander, 1995). According to P1, NM's unemployed status has resulted in an increase in his intake of alcohol since the MTBI. Once again it appears as if the MTBI has been the catalyst in the change in NM's drinking habits, and has caused increased irritability with subsequent loss of temper.

A large amount of research exists on the pre-morbid history of the use of alcohol as a factor affecting outcome after TBI (Cherner, Temkin, Machamer & Dikmen, 2001; Corrigan, 1995; Kelly, 1995; Sander, Witol & Kreutzer, 1997). However, the literature reports fewer studies regarding *post-injury* drinking behaviour related to TBI, indicating a need for further investigation in this area (Corrigan, 1995; Kreutzer, Marwitz & Witol, 1995; Sander *et al.*, 1997). One such study investigating post-injury drinking behaviour in individuals with TBI (not specific to the severity of TBI) compared the drinking behaviour of individuals with spinal cord injury to that of individuals with TBI (Kolakowsky-Hayner, Gourley, Kreutzer, Marwitz, Meade & Cifu, 2002). The researchers found that persons with TBI and spinal cord injury either chose to abstain completely from alcohol, or to drink frequently. They proposed that the latter could be a method of coping with the stress and depression that frequently occur after a TBI and a spinal cord injury. P1 supports the proposal that NM's increased alcohol intake could be the method he has chosen to cope with his unemployment and resultant feelings of worthlessness. According

to P1, NM's increased use of alcohol has seemed to exacerbate his loss of temper and has thus impacted on his interaction and communication with others.

#### ***5.1.2.2 Loss of temper: a product of impaired executive control***

A further explanation for NM's loss of temper when viewed within the context of the Model of Social Communication (Hartley, 1995) may be that his executive control centre is impaired. In the Model of Social Communication (Hartley, 1995), the point of integration of internal and external stimuli, including stressful circumstances, is the executive control centre. This centre ensures that the individual's communication behaviour is compatible with the *environment* and the individual's needs. The executive control centre also regulates the expression of an individual's *internal processes* so that the *environment* is considered when behaviour is executed. The frontal lobes, and particularly the prefrontal region, are together referred to as the executive control centre. Executive functions within this centre carry out planned, organised, self-monitored and goal-directed behaviour (Kay & Lezak, 1990). Executive functions are similarly defined by Ylvisaker and Feeney (1998), who state that they *control* deliberate cognitive, social, academic, vocational and communicative behaviours. The executive control centre continuously monitors the individual's communicative behaviour or *products* of communication, making adjustments based on environmental and internal feedback (Hartley, 1995). As stated in the Method, NM sustained a haemorrhage in his frontal lobe area. Damage to the frontal lobes may make it difficult for an individual to control his/her anger and emotions (Kay & Lezak, 1990). The possibility exists that, owing to his brain injury, NM's executive control centre struggles to adequately carry out, regulate and control his behaviour and emotions. The affected executive control centre has resulted in the disinhibition and excessive display of emotions, evident in NM's loss of temper. This may explain why NM struggles to anticipate the consequences of his behavioural responses, often acting impulsively. It is interesting to note that, according to P1, NM does not seem to lose his temper with his friends. This is a possible indication that NM is, to a certain extent and in certain contexts, indeed able to control his temper. According to P1, NM is also remorseful once he has lost his temper with one of his children. This indicates a level of awareness of his behaviour, which an individual with a moderate to severe TBI may not have.

In summary, NM's loss of temper, when viewed within the Model of Social

Communication (Hartley, 1995) may be interpreted as the result of the interaction between his impaired internal processes of information processing and behaviour control with the environment, or as a result of impaired executive control. Of significance is that this product of communication was not considered problematic by P1 prior to the MTBI. NM's loss of temper and subsequent communication difficulties therefore seem to be associated with his MTBI.

### ***5.1.2.3 Memory loss and word-finding difficulties: Products of impaired internal processes of cognition and stored knowledge***

P1 also referred to NM's loss of memory, although transient, and word-finding difficulties. When viewed within the Model of Social Communication (Hartley, 1995), these difficulties may be the result of impaired internal processes of cognition and stored knowledge.

Information from the environment is continuously received, processed and monitored during normal communication by an individual's cognitive processes. These cognitive processes include attention, perception, visual-spatial processes, linguistic processes and memory. They are necessary for the perception and comprehension of linguistic and non-linguistic output (Hartley, 1995).

Memory is a basic skill required to support the perception and comprehension of both verbal and nonverbal inputs. It involves retaining these inputs for sufficient time to process and store information, and is therefore necessary for maintaining a conversation with another (Hartley, 1995). Memory loss was a transient symptom according to P1's reports of NM's recovery after the MTBI. Although NM's short-term memory did not concern P1 at the time of the interviews, it was problematic for a short time after the MTBI, making conversation and communication difficult. This finding corresponds with the literature where short-term memory loss is reported to be a common symptom after MTBI, resolving typically after three months (Levin, 1989). NM was six months post-injury at the time of the interviews. NM's home environment has not seemed to influence his memory. However, P1's view of NM's short-term memory functioning may have been slightly different had NM been in a demanding working environment. Individuals with MTBI often do not 'appear' impaired to staff and family once they are discharged from hospital. However, these individuals experience great difficulty when resuming



sometimes stressful responsibilities at work, school or home (Dittmar, 1997). NM's unemployed status may thus conceal possible memory-related difficulties that might have occurred had he been in a demanding work environment.

Although memory difficulties seemed to be transient according to P1, word-finding difficulties were still problematic at the time of the interview. When interpreted within the context of the Model of Social Communication (Hartley, 1995), word-finding difficulties can be classed under NM's internal processes of stored knowledge. Semantic memory includes an individual's knowledge of the internal and external world and is built up over time. NM's word-finding difficulties were expected to be highlighted by P1, especially since she viewed expression of feelings as central to communication. However, in P1's opinion, NM's occasional word-finding difficulties did not seem to negatively affect his ability to communicate.

In summary, NM appears to have exhibited memory and word-finding difficulties since the MTBI. When interpreted within the Model of Social Communication (Hartley, 1995), these are considered to be the result of impaired internal processes of cognition and stored knowledge.

#### ***5.1.2.4 Role change: a consequence of the continued interaction between the products of loss of temper, loss of memory and word-finding difficulties with the environment***

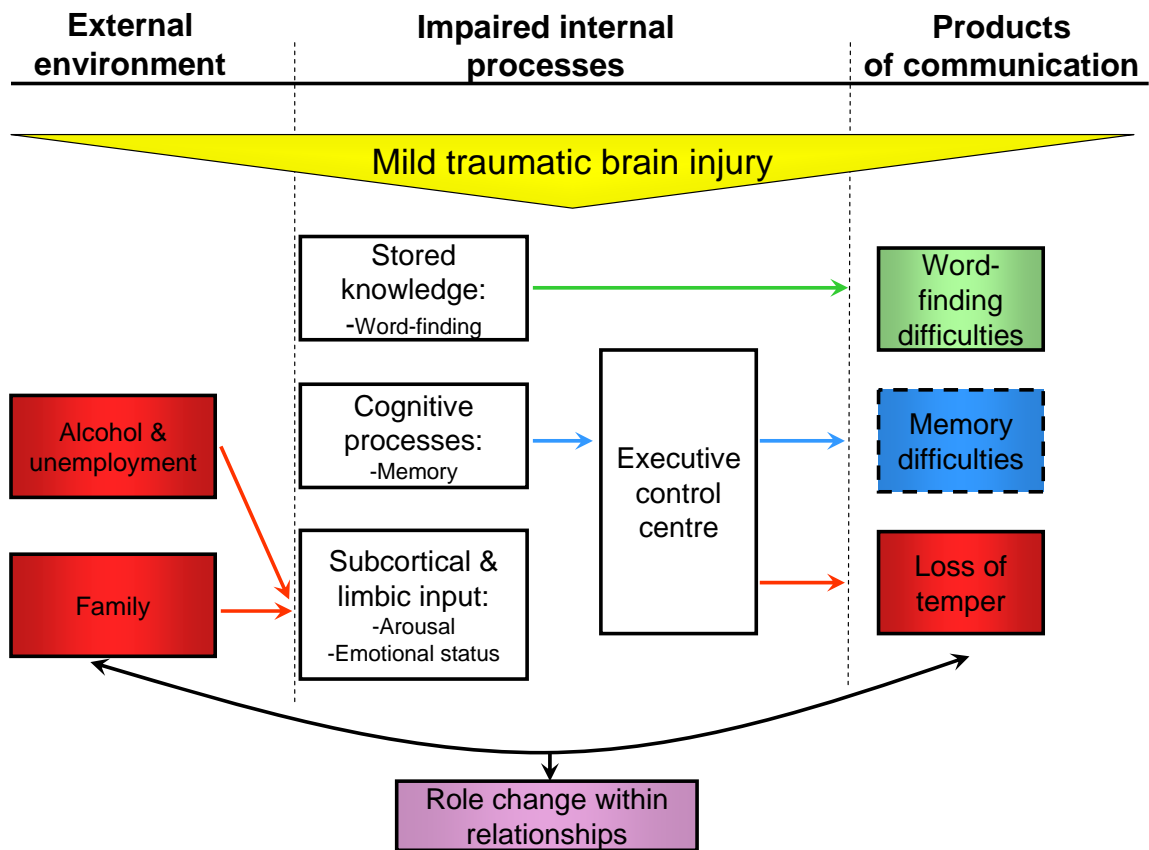
NM is no longer able to fulfill his previous role in the home as the provider for his family and support for his wife. The reason for this is possibly his inability to control his temper, his loss of memory and word-finding problems in interaction with environmental demands, as mentioned earlier. Potential long-term consequences of an MTBI exist because of this interaction. The Model of Social Communication (Hartley, 1995) illustrates that because communication is ongoing and cyclical, communication interactions, or relationships, evolve over time. Since NM's MTBI, his relationship with P1 has changed and evolved.

The dramatic change of roles experienced within the family (Dell Orto & Power, 2000) is frequently a major stressor after TBI, regardless of the severity of the TBI. The most difficult adjustment that P1 has had to make regarding her relationship with NM since the

MTBI is the parental role that she has had to assume. Since the MTBI, P1 has become NM's support, rather than his equal, as she has become the sole breadwinner responsible for the financial welfare of the family. Because currently her relationship towards him is more like that of a 'parent', she finds it difficult to view him as her partner or 'equal'. Leatham *et al.* (1996) examined this role-change experience reported by parents and partners of individuals with TBI. The partners in Leatham *et al.*'s study (1996) reported the change of role in their *relationship* with the individual with TBI to be the greatest role change for them. These results correspond with P1's experience regarding NM, therefore the same may be applied to individuals with MTBI. Kreutzer *et al.* (1994) reported that the spouse of an individual with TBI, and similarly with MTBI, is often forced to adopt a parental role, which again ties in with P1's experience.

In her definition of communication, P1 implied that communication was important in a relationship. Therefore, if the relationship between P1 and NM had been negatively affected by the change in roles, it would thus be likely that their communication behaviour would also have been affected.

As the evidence suggests, it would appear that the MTBI has indeed impacted on NM's communication according to P1. Individuals with MTBI therefore require the services of a SLT. However, each individual would need to be treated and managed multidisciplinary team seeing that factors such as alcohol and unemployment play a role in aggravating his loss of temper.



**Figure 3: Adaptation of the Model of Social Communication (Hartley, 1995) depicting NM’s loss of temper, memory and word-finding difficulties and subsequent role change as products of the interaction between his external environment and impaired internal process**

Figure 3 represents a summary of interpreted themes from P1’s DA which emerged from her description of her spouse, NM’s communication. Within the context of the model (Hartley, 1995), NM’s loss of temper, memory difficulties (viewed as transient) and word-finding difficulties are regarded as the products of the interaction between his environment (alcohol, unemployment and family) and his impaired internal processes of stored knowledge, cognition and subcortical and limbic input. Within the context of the model (Hartley, 1995) NM’s loss of temper is regarded as a product of the interaction of NM’s environment with his reduction in arousal and inadequate emotional control. Loss of temper was also a product of the possibly impaired executive control centre. Word-finding and memory difficulties are interpreted as products of possible damage to stored knowledge and cognitive processes respectively. Role change within NM and P1’s relationship is viewed as a consequence of the ongoing interaction between the products and the environment. It would appear that the products of NM’s communication, as described by P1, are related to the MTBI.

## 5.2 PARTICIPANT 2

### 5.2.1 Participant 2's view of communication

By asking Participant 2 (P2) to describe her spouse NJ's communication, the researcher hoped to obtain a description of what Hartley (1995) would refer to as the *products* of NJ's communication, namely NJ's verbal and nonverbal communication behaviour. P2 emphasised that speech, or the verbal component, is fundamental to communication. This is similar to the definition given by P1, who viewed 'expressing yourself' as the most important component of communication. However, P2 further reported that *behaviour* is also a contributor to communication. When we examine the definitions of communication and behaviour, a definite link between the terms becomes apparent. Communication has been defined as the exchanging of ideas, information, thoughts or opinions through a system of symbols, signs or *behaviour* (New Penguin English Dictionary, 2001). Behaviour is thus a vehicle via which communication takes place.

P2 further mentioned that one's 'attitude and what you radiate as a person' contributes to communication. This statement seems to allude to an individual's personality (N. Cassimjee, personal communication, 21 April 2006). Personality is defined as the sum total of the behavioural and mental characteristics by means of which an individual is recognised as being unique (Collins Concise Dictionary, 2001). Personality and communication both include behaviour as a component in their definitions. A change in personality may thus affect an individual's communication. Conversely, a change in communication may be perceived as a change in an individual's personality.

In summary, P2 regards communication as involving more than simply communicating verbally. She stated that the entire person, including his attitude and behaviour, is involved in communication. The close relationship between communication, behaviour and personality is thus apparent in her definition. Therefore, when studying P2's description of NJ's communication, we predict that she will include a description of how his personality and behaviour influences his communication.

### 5.2.2 Participant 2's description of NJ's communication

The themes that emerged from the DA of P2's discourse regarding NJ's communication are interpreted within the context of the Model of Social Communication (Hartley, 1995).

### 5.2.2.1 *Adynamia: a product of impaired subcortical and limbic input*

A theme that strongly emerged from P2's description of NJ's communication was his reduced motivation following the MTBI. She described this change with phrases such as: 'that spark that should be there is no longer there', 'he doesn't have that motivation' and 'the driving power is gone'. These phrases allude to 'adynamia'. Adynamia is the lack of drive or motivation that often occurs in individuals who have been affected by TBI (Hartley, 1995). P2 also reported that NJ became withdrawn in the eighteen months following the MTBI. This was probably as a result of NJ's adynamia and his lack of motivation to become involved in social interactions.

NJ's adynamia and subsequent social withdrawal seem to have resulted in P2's perception of the change in his personality. Personality comprises the patterns of emotional and motivational responses that develop over the life of an organism (Prigatano, 1987). Prigatano's (1987) inclusion of motivational responses in his definition of personality possibly explains why P2 experienced NJ to be withdrawn after the MTBI. P2 referred to NJ as '*almost* back to his old self' in the eighteen months preceding the interview, implying that the process of change since the MTBI is still taking place.

In an MTBI, emotional difficulties should typically improve after approximately three months (Alexander, 1995). According to P2, although NJ's motivational and emotional responses have improved over the past three years, his motivation has not returned to its pre-morbid level. Emotional and personality sequelae after TBI have been less understood and have received less attention than cognitive consequences after TBI (Mathais & Coats, 1999). NJ's reduced motivation has affected his social interaction to a degree as, according to P2, he became more withdrawn in the eighteen months following the MTBI. This observation is similar to the finding by Parker (1996), who reported that reduced motivation after TBI can impair efforts of social interest with other individuals.

According to Prigatano (1987) motivation refers to complex emotional states that parallel hierarchical goal-setting behaviour. Motivation influences an individual's attentional processes and thereby affects social interaction by either dampening or stimulating efforts at processing or formulating appropriate responses. NJ's social withdrawal since the MTBI, as perceived by P2, could therefore possibly be attributed to the change in NJ's motivation since the MTBI. Since personality is comprised of motivational and emotional

responses (Prigatano, 1987), it therefore falls within the process of subcortical and limbic input within the Social Communication Model (Hartley, 1995). The basal ganglia and their connections to the limbic system (in particular the hypothalamus) are regions in the brain that are involved in motivation. Because of the likelihood of damage to the anterior and mesial temporal lobe (part of the limbic system) and to the basal ganglia, changes in motivation and emotional responses within subcortical and limbic input, as seen in NJ, are common after TBI (Hartley, 1995). A common sequelae to this possible damage is adynamia. Personality, which includes motivational and emotional responses, is thus modified by, and modifies an individual's cognitive abilities, as well as the executive control centre, as the Social Communication Model (Hartley, 1995) suggests.

Bohnen, Jolles, Twijnstra, Mellink and Wijnen (1995) found that consequences of MTBI are manifested differently in different individuals. This finding is true when we compare P1 and P2's perceptions of their spouses' communication. For example, P1 often mentioned her husband, NM's loss of temper. When interpreted within the context of the Social Communication Model (Hartley, 1995), this was seen, as with NJ, to reflect impaired subcortical and limbic input. However, in the case of NM, impaired subcortical and limbic input was seen to interact with environmental factors, termed as 'triggers'. In contrast to this, P2 did not describe anything in NJ's environment that appeared to contribute to his lack of drive or motivation (that is, his adynamia). These differences between NM and NJ highlight the importance of the SLT to conduct in-depth, individual assessments within this population.

Despite the fact that NJ became withdrawn in the first eighteen months following the MTBI, P2 maintained that communication remained a priority in their relationship. This finding is in contrast to that of NM's relationship with P1. P1 felt that her role within her relationship with NM had changed as she had become a parental figure rather than a partner. P2's comments also implied that NJ's relationship with others had been affected, since he had withdrawn from social opportunities. He also became more withdrawn compared to the open, talkative person he had been before the MTBI. NM's relationship with others had, on the other hand, not changed according to P1. P1 maintained that it was only NM's behaviour towards his family that had changed since the MTBI. These contrasts between NM and NJ again confirm the importance of in-depth, individual assessments with this population.

To summarise, when reviewing P2's view of communication, she emphasised that in addition to verbal expression, behaviour also contributes towards an individual's communication. NJ's social withdrawal after the MTBI implied a direct effect on his verbal communication. NJ's adynamia seemed to affect his behaviour, demonstrated by social withdrawal. Since adynamia and social withdrawal were not present before the MTBI, we can ascribe these changes to NJ's MTBI. At the time of the interviews, P2 reported that NJ was becoming his 'old self' again. However, he was not yet the same as before the MTBI. P2's view of the change that had taken place in NJ's personality since the MTBI was similar to a case discussed in an editorial written by Sinson (2001:425), in which she referred to an individual after MTBI, stating that 'he was never quite himself after the accident'. Thus, when considered within P2's perception of communication, it could be stated that NJ's communication had changed since the MTBI.

#### ***5.2.2.2 Adynamia: a product of impaired executive control***

When viewed within the context of the Social Communication Model (Hartley, 1995), a further explanation for NJ's adynamia could possibly be that it was a result of damage to the executive control centre. The frontal lobes, responsible for executive functions, play an important role in goal-orientated behaviour initiation – a skill which, according to P2, was affected. Since his MTBI, NJ occasionally struggles to approach a new task. The limbic system, vital in motivation within the individual, is connected to the frontal lobes (Hartley, 1995). NJ's adynamia may thus be viewed as a product of impaired subcortical and limbic input, as well as executive control.

Problems in the executive control centre are common after TBI because of the high frequency of frontal lobe and diffuse axonal damage. Individuals who have sustained dorsolateral damage usually lack the ability to formulate and initiate goal-directed behaviour and as a result demonstrate diminished drive (Auerbach, 1986). This behaviour seems indicative of NJ's adynamia. His adynamia is in contrast to P1's description of NM, who seems to be more typical of individuals with orbitofrontal damage who exhibit poor control over their internal drives and, as a result, become irritable (Hartley, 1995). This contrast again confirms that consequences of MTBI are manifested differently in different individuals (Bohnen *et al.*, 1995) and highlights the importance of in-depth, individual assessments with this population.

### 5.2.2.3 *Memory loss: a product of impaired cognitive processes*

P2 reported a change in NJ's memory since the MTBI. According to her, he struggles to recall *details* of past events or conversations. This is in contrast to his memory prior to the MTBI, when she claimed that he had a 'memory like an elephant'. P2's observation differs from that of P1 with regard to memory loss. P1 stated that NM's memory problems lasted only a few days after his MTBI, and were thus viewed as transient. P2, however, reported that NJ still experiences memory difficulties, although not pronounced. Memory processes have known to be affected after MTBI (ACRM, 1993; Green *et al.*, 1997; Zappalá & Trexler, 1992). Although residual memory problems typically resolve after three months in an MTBI, impairment in retention can persist (Levin, 1990). NJ's accident was three years ago. In a study by Rimel, Giordani, Barth, Boll and Jane (1981), over 70% of individuals with MTBI displayed problems with memory.

At the time of the interviews, P2 strongly felt that NJ's memory for past events, or long-term memory, as she referred to it, was *more* problematic than his short-term memory. This is an interesting observation, as short-term recall problems or impairments of storing and retrieving new information are more prominent after TBI than older and deeply ingrained information (Kay & Lezak, 1990), which usually remains intact. However, in contrast with this finding, early work by Brooks (1975) on memory after TBI suggests that *short-term* memory processes following TBI may remain intact and that deficits may be found in *long-term* memory. Brooks (1975) suggests that deficits in short-term memory could possibly lead to storage and retrieval problems in long-term memory. He proposed that the slower rate and decreased efficiency of working memory impaired the manipulation of information in preparation for storage and retrieval from long-term stores. Brooks' findings (1975) provide a possible explanation for P2's report regarding NJ's long-term memory deficit. NJ's memory difficulties are seen to impact negatively on his communication as memory involves retaining verbal and nonverbal inputs and is vital for maintaining a conversation with another (Hartley, 1995). NJ may experience difficulty in retaining these inputs during a conversation as both his short-term and his long-term memory storage has, according to P2, been affected to some extent.

Gronwall and Wrightson (1981) examined the relationship between information processing capacity, post-traumatic amnesia (PTA) and deficits of memory after TBI. They found that TBI seems to have various effects on memory. One such effect involves a



deficit in the ability to retrieve information from memory once it has been placed into long-term memory store. This occurred in 25% of cases of TBI, regardless of the severity of the injury. This implies that individuals with MTBI may also suffer from long-term memory loss. NJ may be included in this 25%, since P2 claims that NJ's long-term memory storage has been impaired.

Although P2 reported predominantly long-term memory retrieval deficits for NJ, she still reported the occurrence of minor short-term memory difficulties. In her opinion, both long-term and short-term memory difficulties affected NJ's self-confidence at times. Impaired self-confidence may have further contributed to NJ's reduced internal drive or motivation resulting in social withdrawal.

Dikmen, Temkin, McLean, Wyler and Machamer (1987) examined the effects of injury severity, time from injury to testing, and the type of task on memory performance following TBI. Individuals with TBI were studied one month after, and again 12 months after injury. Results showed that memory problems were present at one and at 12 months after injury, but that after 12 months an improvement in memory was evident. The memory functions of approximately one third of the group within each classification of TBI were significantly impaired at 12 months post-injury. Although the extent of these memory problems is not indicated in this research, one can assume that one third of individuals with MTBI would also experience memory difficulties one year after having sustained the injury. NJ, for example, still experiences subtle memory difficulties despite the fact that three years have passed since the MTBI.

In summary, P2 placed the verbal component as paramount in her view of communication. NJ's subtle memory difficulties impact on his verbal communication, for example, when he converses with others. P2 acknowledged that NJ's memory deficits impacted on his self-confidence, thus possibly contributing to his adynamia and resulting in social withdrawal.

#### ***5.2.2.4 Social withdrawal: a consequence of NJ's adynamia***

P2 described that NJ had become withdrawn in the eighteen months following the MTBI, participating less in social interactions. As discussed in 5.2.2.1, this behaviour appeared to be as a consequence of NJ's lack of motivation or adynamia. NJ's social withdrawal as a

consequence of adynamia is similar to Parker's finding (1996), who reported that reduced motivation after TBI can impair efforts at social interest within individuals.

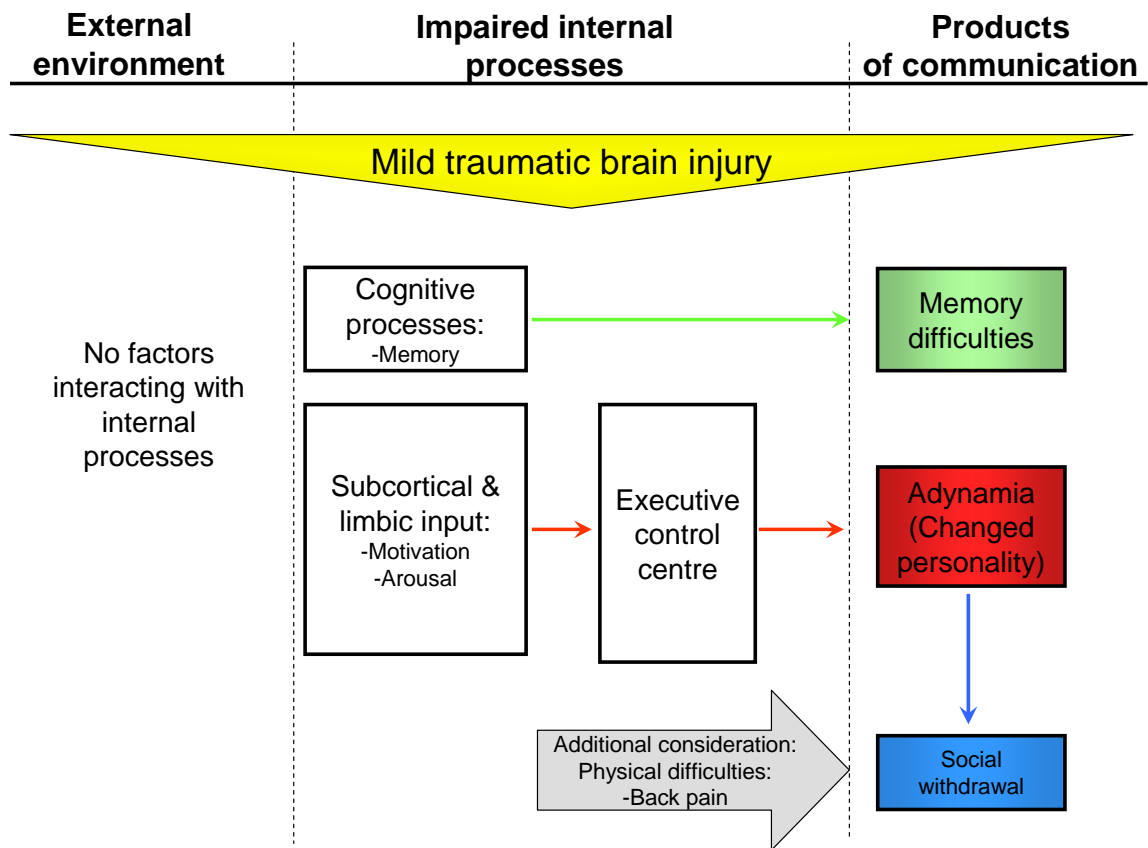
#### ***5.2.2.5 Social withdrawal: a product of NJ's physical difficulties***

The physical difficulties experienced by NJ after his accident, specifically his backache, did not seem to have had an effect on his communication when initially investigated. However, since P2 reported that NJ's backache affected his functioning, further investigation was necessary.

NJ's back pain was not caused by the MTBI, but appears to be associated with the event that also caused the MTBI. According to the relevant literature, back pain is not regarded as a typical symptom after MTBI. However, other system injuries, for example orthopaedic injuries, could add significantly to the disruption of psychosocial functions, including the performance of leisure activities (Dikmen, McLean & Temkin, 1986). NJ's back pain was a physical result from the accident that lasted for a period of two years and disrupted his general functioning, particularly his leisure activities.

Hartley (1995) mentions disturbances in motor skills as an additional factor which could occur after TBI, but which is not included in her Model of Social Communication. Physical difficulties could possibly hamper skilled social behaviour (Hartley, 1995). Although NJ's physical difficulties, namely his back pain, do not stem directly from the MTBI, they do impact on his social interaction. According to P2, NJ avoids social gatherings that include sporting activities with friends. Although NJ's back problems have improved since the accident, they still affect his social functioning. Since NJ does not participate in social activities as readily as he did before the MTBI, his back pain is seen as a motor skill difficulty that has resulted in social withdrawal.

In summary, Hartley (1995) did not include physical difficulties in her model and she views these as considerations additional to her model of Social Communication (Hartley, 1995). When NJ withdraws from social gatherings as mentioned by P2, he is in fact also withdrawing from relationships with others. Therefore NJ's physical difficulties have contributed to his social withdrawal.



**Figure 4: Adaptation of the Model of Social Communication (Hartley, 1995) depicting NJ’s memory difficulties, adynamia and social withdrawal as products of his impaired internal processes of cognition, subcortical and limbic input and executive control and physical difficulties.**

Figure 4 represents a summary of interpreted themes from P2’s DA which emerged from the description of her spouse, NJ’s communication. Arousal levels within the internal process of subcortical and limbic input were possibly affected due to the MTBI, resulting in decreased motivation and emotional responses which have led to NJ’s adynamia. Since it is difficult to separate an individual’s motivation levels and resultant behaviour from his personality, P2 inferred a change in NJ’s personality. Within the context of the Model of Social Communication (Hartley, 1995), NJ’s adynamia and inferred changed personality are regarded as the products of impairment in his subcortical and limbic input associated with his MTBI. NJ’s adynamia is also viewed as a product of possible damage to the executive control centre due to the MTBI. Further, social withdrawal is viewed as a consequence of NJ’s adynamia. NJ’s memory difficulties are interpreted within the context of the model as the product of NJ’s possibly impaired internal cognitive process of memory. From the information that was acquired from the DA, no factors appear to have been present in NJ’s environment that could have interacted with his impaired internal cognitive processes to further affect his communication. NJ’s physical difficulties of back

pain are seen as an additional consideration to the model as they appear to contribute to NJ's withdrawal from social activities. It would therefore appear that NJ's memory difficulties, adynamia and social withdrawal are associated with his MTBI.

## 5.3 PARTICIPANT 3

### 5.3.1 Participant 3's view of communication

By asking Participant 3 (P3) to describe his spouse EM's communication, the researcher hoped to obtain a description of what Hartley (1995) would refer to as EM's *products* of communication, namely her verbal and nonverbal communication behaviour. P3 immediately referred to his relationship with his wife when describing his perception of communication, thus viewing relationships as fundamental to communication. Similarly, P1 and P2 emphasised the importance of communication in relationships. P2 regarded communication as essential for a relationship to function effectively. When referring to communication, P3 seemed to place both verbal and nonverbal components thereof within the context of a relationship - either with his wife or with others. The Model of Social Communication (Hartley, 1995) is representative of relationships and depicts the ongoing, dynamic nature of these communicative interactions as a result of the interaction between the various *internal processes*, the *products* and the *environment* of the individual.

Upon investigation of the conversation with P3, it was evident that he viewed the content of the *verbal* component of the message conveyed as an essential factor for communication. P3 included honesty as being important when a message is conveyed either or nonverbally. He also considered body language to be significant when communicating with others. This was similar to the observation by P1, who also viewed the nonverbal component as a factor to be considered within communication.

In summary, P3 regarded relationships as fundamental to communication. He viewed the *content* (verbal component) of a message as well as the *manner* (nonverbal component) in which it is conveyed to be essential components of communication. Therefore, when studying P3's description of EM's communication, it can be predicted that he may elaborate on their relationship and the *way* in which they communicate with each other.

### 5.3.2 Participant 3's description of EM's communication

The themes that emerged from the DA of P3's discourse regarding EM's communication are interpreted within the context of the Model of Social Communication (Hartley, 1995).

#### 5.3.2.1 *Delayed processing: a product of impaired cognitive process of attention*

The theme that prominently emerged from P3's description of EM's communication was the change that had taken place in EM's processing since the MTBI. To start with, P3

explained that *he* had changed his communication since the MTBI by adjusting his speech rate when communicating with EM. The adjustment of his speech rate prompted the researcher to establish why this was necessary. Although P3 did not initially state that EM found it difficult to process information, it became apparent later in the conversation that EM indeed experienced a processing problem. According to P3, it was necessary at times to repeat auditory information in his conversations with EM. P3 reduced his speech rate when repeating information to EM as he recalled that the doctor at the time of the MTBI had told him that his wife ‘understood better’ when he reduced his speech rate. This corresponds with Hartley’s (1995) statement that a reduction in processing speed may mean that an individual will be unable to keep up with a normal conversation rate. Although P3 did not seem to regard EM’s delayed processing as serious, her delayed processing was still viewed as a *change* that had taken place following the MTBI.

Information from the environment is continuously monitored, received and processed during communication interactions through cognitive processes. This implies that in order to adequately process auditory information during communication, the listener needs to give attention to the message. Attention is a necessary cognitive skill that supports the perception, comprehension and processing of verbal and nonverbal information within the environment (Hartley, 1995). Delayed processing is one of the most frequently reported and persisting cognitive changes after a TBI (Ponsford & Kinsella, 1992). A study conducted by Cicerone (1996) found that attention deficits were apparent in the processing speed of individuals with MTBI, but not in their accuracy during dual task demands. This finding may explain why P3 felt that EM’s communication following the MTBI did not really constitute a problem, despite her delayed processing speed. That is, she was able to accurately understand the content of P3’s communication message although it took longer and he had to repeat it at times.

Ponsford and Kinsella (1992) suggest that there could be a trade-off between speed and accuracy in performance following TBI, where quality of performance could improve by slowing down the pace at which material is presented. Madigan, DeLuca, Diamond, Tramontano and Averill (2000) assessed information processing speed in individuals with moderate to severe TBI by using both a visual and an auditory test. The results of this study revealed a slower information processing speed when *auditory* information was presented. Although EM’s TBI was not classified as moderate, but rather as an *upper* classification of moderate and a borderline MTBI, the results of Madigan *et al.*’s study

(2000) are similar to P3's experience of EM's processing. Furthermore, Madigan *et al.*'s study (2000) found that when individuals with TBI were provided with adequate time to control the pace of the task presented to them, their performance accuracy did not differ from that of individuals without TBIs. Similarly, when P3 adjusted his speech rate so that the pace of the message presented to EM was slower, she was able to understand P3 accurately.

Despite EM's delayed processing, P3 implied that he and EM, owing to their good relationship, understand each other well. This relates to P3's emphasis of the nonverbal component in his description of communication. According to P3, it is not always necessary to communicate verbally. Thus, according to P3, EM is able to process *nonverbal* information. However, the possibility does exist that EM's processing of verbal or auditory information in *other* relationships and within *other* settings may be hampered. As she is currently unemployed, P3 is unable to determine how EM would process complex information within a demanding situation with time constraints, as would be encountered within a working environment. Individuals with MTBI have been found to be less efficient in the processing of information under time pressures and within demanding situations, such as a work environment (Ponsford, 1990).

In the light of the Model of Social Communication (Hartley, 1995), no factors were present in EM's environment that contributed to or exacerbated her delayed processing. This observation is unlike P1 where NM's environment appeared to contribute to his loss of temper. However, the findings regarding EM are similar to those for P2's spouse, NJ, in whose case the environment was also not considered to be a factor that contributed to his adynamia. While there is nothing in EM's environment that exacerbates her communication difficulties, it emerged strongly from the DA of P3's interview that he has adjusted his communication, and thus EM's environment, to accommodate her delayed processing. Such environmental modifications to assist the individual with MTBI did not appear as strongly in the DA of the interviews with P1 and P2.

In summary, P3's description of EM's communication depicted a change in her communication, and specifically in her processing speed, since the MTBI. Despite this change, P3 described EM's communication as good. Since before the MTBI, EM was able to understand P3 without it being necessary for him to alter his speech rate, we can assume that her delayed processing of P3's speech may have been caused by the MTBI.

According to the Model of Social Communication (Hartley, 1995), we may assume that EM's delayed processing may have been caused by her possibly impaired internal cognitive processing.

### ***5.3.2.2 Delayed processing: a product of impaired executive control***

In addition to being ascribed to an impairment of the cognitive process of attention, delayed processing may also be interpreted within the Model of Social Communication (Hartley, 1995) as being the product of impaired executive control. The executive control centre controls cognitive processing and therefore also plays a role in information processing (Hartley, 1995). The possibility therefore exists that EM's cognitive processing difficulties are associated with impaired executive control.

The frontal lobe system, which houses the executive control centre, activates the arousal system when increased mental effort or divided attention is required. It has already been established that attention is a vital cognitive skill for processing information from the environment (Hartley, 1995). The frontal system helps to maintain attention and concentration, controlling the focus and the shifting thereof as required. The frontal lobes influence attentional processes through connections with the reticular activating system. The reticular activating system is sensitive to axonal damage, typically associated with TBI. Like P1, EM may have sustained axonal damage, resulting in decreased cortical activation, which is required for successful information processing (Hartley, 1995). This may explain why EM struggles to follow P3's conversation at times, needing repetition of information at a reduced speech rate.

As stated before, a study by Madigan *et al.* (2000), which assessed the processing speed of individuals with moderate to severe TBI compared to that of healthy individuals by using one auditory and one visual test, revealed that speed of information processing in the TBI group was slower on the *auditory* task relative to the visual task. Madigan *et al.* (2000) explain this result by pointing out that, following a TBI, an individual's auditory system is more susceptible to damage than the visual system. In TBI, temporal cortical regions together with frontal regions are particularly sensitive to damage. The role of the temporal regions in auditory functions may account for the more significantly reduced speed observed in the TBI group on the auditory task (Madigan *et al.*, 2000). Similarly, this result may explain EM's delayed processing for *auditory* information during her conversations with EM.



The communication difficulties experienced by NM and NJ, as described by P1 and P2 respectively, were also ascribed to possible impairment in the executive control centre. According to P1, NM's tendency to lose his temper worsened after the MTBI, P2 reported a lack of motivation in NJ, and P3 stated that EM's processing of information had been affected since the MTBI. In each of the three cases the problem could possibly be the result of damage sustained to the executive control centre. The role of the executive control centre in communication difficulties must thus be taken into account by the SLT.

In summary, EM's delayed processing of information during conversation as reported by P3, was not present before the MTBI. Delayed processing is thus seen as a product of communication following the MTBI, possibly as a result of damage to EM's executive control centre, or as a result of impaired attention.

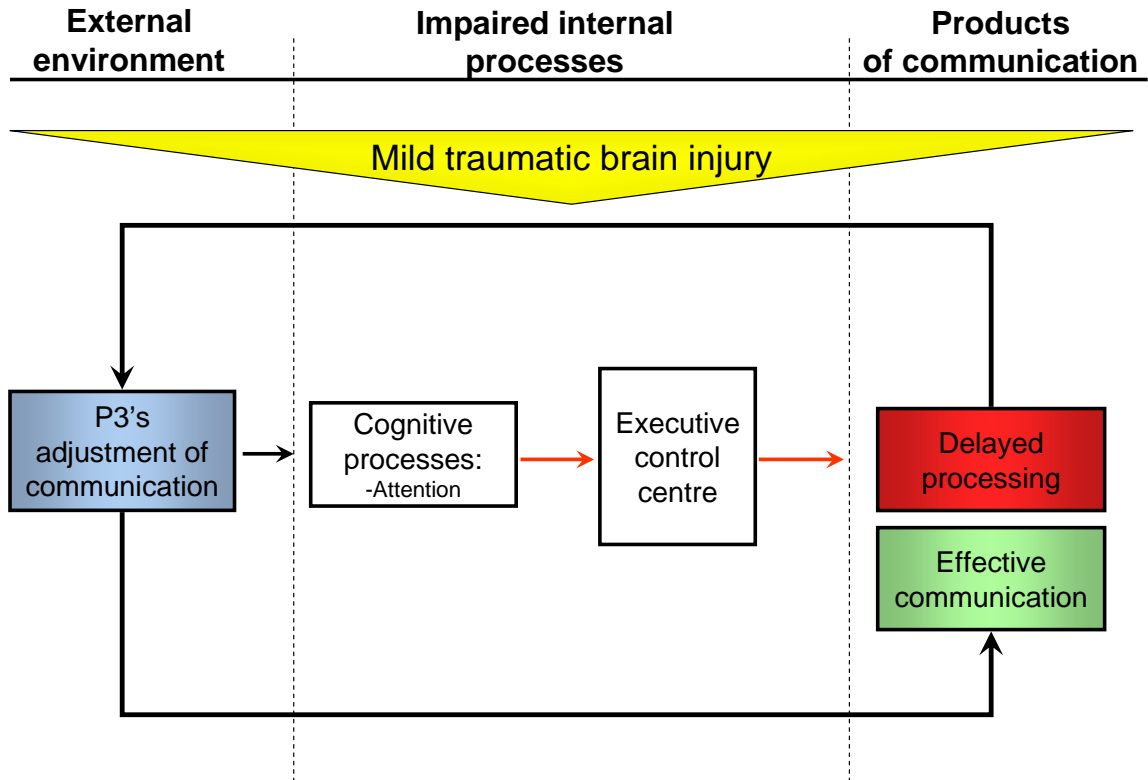
### ***5.3.2.3 Effective communication: a product of the interaction between EM and her environment***

A further theme that emerged from the DA of the interview with P3 concerning his description of EM's communication relates to the effective communication that she has maintained despite her MTBI. P3 commented on EM's effective communication within their relationship as well as in her relationship with others.

When considering the Model of Social Communication (Hartley, 1995), a possible change in EM's environment has been a reduction in P3's speech rate to accommodate her processing difficulties. However, at the time of the interviews no factors that could have exacerbated her apparent internal processing difficulties, for example work stress, were present in EM's environment. It is for this reason that P3 may perceive EM to have maintained effective communication with those around her. However, this scenario may have been different had EM been employed at the time of the interview with P3. Work demands bring additional stress for an individual and it is not possible to predict how the MTBI might have affected EM's functioning within a working environment. The findings of research conducted by Park, Moscovitch and Robertson (1999) on investigating attention impairments in individuals with TBI, indicate that performance in individuals with TBI was impaired during non-routine tasks requiring a high degree of processing – as found within a work situation. However, when these individuals with TBI carried out routine tasks that could be performed automatically, their performance was unimpaired.

In EM's situation these routine tasks may be her activities in the home. Although the study of Park *et al.* (1999) involved individuals with severe TBI, other research has shown that individuals with MTBI also experience information processing difficulties when placed in demanding situations with time constraints, which inevitably accompany most types of employment (Ponsford, 1990). We can thus expect EM's functioning within a work environment to be less effective than it is in her home environment.

In summary, at the time of the interviews P3 described EM's communication after the MTBI as being effective and praiseworthy. If one considers P3's perception of communication, it appears as if he regards his relationship with his wife as the most important consideration in his definition. The assumption can therefore be made that since P3 is satisfied with his *relationship* with EM, he is also satisfied with her *communication*, as he seems to equate the two. In the light of the Model of Social Communication (Hartley, 1995), P3's reduced speech rate may be considered to be a factor within the environment that facilitates EM's communication. EM's *environment*, that is being at home, did not exacerbate her delayed processing. This might have been different had she been in a working environment.



**Figure 5: An adaptation of Hartley’s Model of Social Communication (1995) depicting EM’s delayed processing as a product of her impaired internal cognitive process of attention or executive control. EM’s effective communication is depicted as a product of P3’s adjustment of his speech rate to accommodate her delayed processing speed.**

Figure 5 represents a summary of interpreted themes from P3’s DA which emerged from his description of his spouse, EM’s communication. When interpreted within the model, EM’s delayed processing is regarded as a product of her impaired internal *cognitive process* of attention. Possible damage to the executive control centre may also have resulted in EM’s delayed processing as the executive control centre controls the cognitive processes. P3 has adjusted his communication to accommodate EM’s delayed processing. This adjustment is regarded as a support within EM’s environment that interacts with her impaired internal processes to produce, in P3’s opinion, effective communication. It is possible that P3 perceives EM’s communication as being effective only because of the absence of environmental factors that could interact negatively with her internal processes. According to the information given by P3, EM’s MTBI appears to have produced only delayed information processing.

### **Impaired executive control centre: a commonality in P1, P2 and P3**

It is interesting to note that, in the context of the Model of Social Communication (Hartley, 1995), the affected spouses of all three participants in this study exhibited possible impairments to their executive control centres. This finding confirms the presence of impairment in executive functions in individuals affected by MTBI (Green *et al.*, 1997; ACRM, 1993). Furthermore, it highlights the importance of addressing executive control functions and their effect on communication in the treatment of the individual with MTBI.

In conclusion, when the DA of the interviews with P1, P2 and P3 is applied to the Model of Social Communication (Hartley, 1995), it becomes apparent that the communication of all three spouses with MTBI was affected as a result of the interaction of their environments with their impaired internal functioning, or as a result of their impaired internal functioning as such, possibly due to the MTBI.

## CHAPTER SIX

### 6 CONCLUSIONS AND IMPLICATIONS

#### 6.1 INTRODUCTION

In this chapter, the theoretical and clinical implications of the results of this study will be discussed. Also included in this chapter is a critical evaluation of the research conducted in this study. This is followed by recommendations for further, related research.

#### 6.2 CONCLUSIONS: THEORETICAL AND CLINICAL IMPLICATIONS

The results obtained in this study have numerous potential theoretical and clinical implications.

- Various studies involving individuals with traumatic brain injury (TBI) have involved the **spouse**: Wedcliffe (1999) used information provided by spouses to investigate the psychosocial effects of TBI on their quality of life; Kreutzer *et al.* (1994) consulted with spouses (and parents) of adults with TBI to examine the prevalence of stress and unhealthy family functioning; research by Leatham *et al.* (1996) used information from spouses to determine their perceptions of role change, social support and stress after TBI; and Peters *et al.* (1990) involved the spouses of individuals with mild, moderate and severe TBI to assess marital adjustment after TBI. In the current study, spouses were relied upon to provide information on communication after mild traumatic brain injury (MTBI). Each spouse was found to perceive communication as a unique concept, with their respective definitions emphasising the various components of communication that they considered to be important. As a result of their differing views regarding communication, the discourse analysis (DA) of the interviews with the respective spouses of persons affected by MTBI highlighted changes that they had noticed in their partner's communication in accordance with their (the spouses') definition of communication. An implication of involving the spouse in the management of an individual with MTBI is that he/she is able to provide valuable information regarding the affected individual's communication within his/her own natural environment. In this way needs that are relevant to both the client and his/her partner will be identified, which will assist the speech-language therapist (SLT) in the identification of relevant communication goals. Such information is not likely

to be obtained as readily by way of a formal assessment of the individual with MTBI using traditional tests. Spouses are often responsible for continuing the rehabilitation of their partners with MTBI once discharged from hospital (Peters *et al.*, 1990). For this reason, spouses should be included in the rehabilitation team during the evaluation and management of the individual with MTBI. This will facilitate the generalisation of therapy to the natural environment of the individual with MTBI. This study thus highlights the valuable role that the spouse can play in the assessment and management of communication difficulties following MTBI.

- One of the most important implications emerging from this study is the **role of the SLT** in the MTBI population. Individuals with MTBI are not often referred to SLTs because of their lack of obvious communication symptoms. SLTs have been ill-equipped to address and evaluate subtle communication difficulties of individuals with MTBI (Duff *et al.*, 2002). As the evidence from the DA in the current study suggests, the symptoms exhibited by the individuals with MTBI do affect their communication in some way, which confirms that SLTs have a role to play in this population. From the results obtained in this study, it appears that the SLT's role in the treatment of MTBI is primarily to address the effect of impaired executive control on social interaction in these individuals. Furthermore, the SLT has a role to play in educating and informing hospital staff, family members and the individuals with MTBI themselves regarding possible consequences of MTBI that may result in communication problems. The value of providing information and counselling has been documented as reducing the number and frequency of post-concussion sequelae (Duff *et al.*, 2002). The results of this study further highlight the need for the SLT to function within a team in the treatment of individuals with MTBI. As the results of this study indicate, and as the literature confirms (Green *et al.*, 1997), the possibility exists that multiple symptoms may occur after an MTBI. This implies that various professionals should be involved in the treatment of individuals with MTBI. The SLT dealing with MTBI should acknowledge when the needs of the individual fall beyond her area of expertise and refer when necessary. In the current study, P1 was concerned about the frequent loss of temper displayed by her spouse, NM, and by his increased use of alcohol. Since loss of temper and alcohol problems fall beyond the SLT's area of expertise, referral to an appropriate professional who is able to address these problems, would be necessary. Lastly, the SLT should offer support to the spouse to effectively manage his/her significant other affected by MTBI. This support may

take the form of early education of the spouse concerning the possible deficits that could occur after MTBI so that future problems may be dealt with adequately, or it may involve referral to other professionals who can assist the spouse in the appropriate way.

- In this study, data was collected by means of a **semi-structured interview**. The data obtained from the interview was then subjected to a **discourse analysis (DA)**. Only a few previous speech-language therapy studies have made use of a DA to investigate an individual's perception of an illness, since DA has just recently gained popularity in the area of speech-language therapy. Nel (2002) used a semi-structured interview with DA to examine the perceptions of people affected by dysphagia from oral cancer. Freeman (2000) investigated the quality of life of individuals with differing degrees of TBI, making use of a semi-structured interview and DA. Similarly, Sedgwick (2000) used a semi-structured interview and DA to discuss how adolescents perceive their own quality of life following a caregiver sustaining a TBI. In the current study, a semi-structured interview and DA were found to be valuable in obtaining information regarding communication after MTBI. Since communication difficulties associated with MTBI are subtle in nature, they are often not detected when traditional tests are used (Duff *et al.*, 2002). By using the qualitative method of DA, the researcher in this study was able to make use of the participants' personal views to bring additional insights into the phenomenon of MTBI. DA, unlike quantitative methods such as questionnaires, structured interviews and rating scales, does not adhere to a rigid formula for analysis (Vyncke, 2000). Although these quantitative methods are important for corroborating findings in research, they are viewed as prescriptive and may prevent possibly helpful information from being divulged. The in-depth nature of DA relies on individual analysis to identify and add to information that may have been overlooked by the use of these quantitative methods (Vyncke, 2000). The personal views and opinions that were yielded by the participants in this study through the use of the semi-structured interview and subsequent DA were found to add value to the identification of communication difficulties in the phenomenon of MTBI. A further advantage of the use of semi-structured interviews and DA noted by the researcher in this study was that incongruencies and misunderstandings could be easily identified and clarified. For example, P3 was not a first language English speaker. During the DA of the first interview held with this participant, certain contradictory statements, and questions that P3

possibly did not understand, were identified. These incongruencies could be clarified during the follow-up interview. Had P3 been given a questionnaire or rating scale to complete, difficulties that he may have experienced in understanding certain questions may not have been identified as easily. By making use of semi-structured interviews and DA as part of the assessment in MTBI, the SLT can deliver improved services to this population by focusing on highlighted issues emerging from the DA. Although DA, for the purpose of this study, was used to examine how spouses of individuals with MTBI perceive their significant others' communication, it may also be valuable in investigating the perceptions of other family members or even of the individual with MTBI him/herself. Furthermore, DA may be applied to other disorders or injuries such as neurogenic speech disorders, so as to investigate individuals' perceptions regarding their experiences and to provide further insight into these phenomena.

- The current study revealed that the **Model of Social Communication (Hartley, 1995)** can be applied to the identification, management and research of individuals with communication difficulties. Hartley (1995) states that social communication is a product of the interaction between an individual's environment and his internal functioning. Therefore, this model has value in the clinical application of a variety of communication disorders. As suggested by the results of this study, the Model of Social Communication (Hartley, 1995) also has value within MTBI. When the Model of Social Communication (Hartley, 1995) is applied to the management of an individual with MTBI, the affected products of communication can be established and addressed. Identification of the impaired internal processes in interaction with possible factors in the environment of the individual with MTBI may further assist the SLT in establishing a treatment plan for the individual with MTBI. When the Model of Social Communication (Hartley, 1995) was applied to the participants in the current study, it was found that all three participants experienced possible damage to their executive control centres. This finding confirms the presence of executive function difficulties after MTBI (Green *et al.*, 1997; ACRM, 1993) as well as their contribution to communication difficulties after MTBI. It is therefore important to address executive functions within the treatment of the individual with MTBI. Further, by applying the Model of Social Communication (Hartley, 1995) to MTBI, modifications within the individual's environment can be made in conjunction with the SLT and the spouse, in order to effectively assist in the communication of the individual with MTBI.



### 6.3 CRITICAL EVALUATION OF THE CURRENT STUDY

While the current study brought insight and understanding to how spouses of individuals with MTBI perceive their significant others' communication, a few limitations must be mentioned.

- The limited number of participants in this study makes it difficult to generalise the results to other individuals with MTBI. However, this study was limited to three participants due to the labour intensive nature of the DA of the interviews with each participant. Further, since discourse constructs individuals' realities (Potter & Wetherell, 1987) and since the purpose of this study was to determine individuals' perceptions, DA used within a greater number of participants would have been likely to reduce the significance of each individual's insights into the phenomenon of MTBI. Each individual case that makes use of DA is different and should therefore be examined and interpreted individually (Wood & Kroger, 2000).
- A further limitation to this study is related to the fact that English was Participant 3's second language. Participant 3 (P3) had difficulty understanding certain questions and a few of his responses were contradictory. However, South Africa is characterized by multilingualism and the researcher did not want to exclude this participant from the study based on the fact that English was not his first language. SLTs in this country are urged to find a way of providing speech-language therapy services to all language and cultural groups. A semi-structured interview and DA in P3's case were in fact helpful in understanding what P3 intended to say. Therefore, while incongruencies and misunderstandings did occur, these were better clarified by means of a semi-structured interview and DA than if P3 had completed for example, a questionnaire.
- The fact that NM, the spouse of Participant 1, had also suffered a haemorrhage in addition to sustaining an MTBI, may have interfered with the results obtained. However, it was decided to include Participant 1 (P1) in this study as, with the exception of NM's brain haemorrhage, he matched all of the other specified selection criteria.
- A further possible limitation to this study was that no additional data collection methods, for example rating scales or questionnaires, were used to supplement the information obtained from the DA. This would have facilitated triangulation of the data as the multiple sources of data may have converged to support the results

obtained (Leedy & Ormrod, 2005). In this study, the participants' perceptions *alone* were relied upon to obtain information regarding their affected spouses' communication. DA was exclusively chosen as a measuring tool on account of both its in-depth nature in attaining perceptions and its labour-intensive analysis (Wetherell *et al.*, 2001). The purpose of the study was rather to determine how spouses perceived their partners' communication after MTBI, than to establish the deficits within individuals with MTBI. Further, to aid in the trustworthiness of the interpretation of the discourse, a follow-up interview was conducted with each participant.

- The use of only two questions in the semi-structured interview may be viewed as a limitation to the current study. Should more questions have been included in the interview, more specific information regarding the communication of the individual with MTBI since the accident might have been obtained. However, a semi-structured interview, rather than a formal structured interview, was selected for this study to better enable the researcher to follow the participants' lead, which resulted in the researcher's comments becoming just as much a part of the analysis as the interviewees' responses (Potter & Wetherell, 1987). To ensure that the discourse was able to construct the spouse's 'reality' (Potter & Wetherell, 1987), no reference was made to the affected individual's communication before or after the accident in the two open-ended questions at the particular time of the interview. The semi-structured interview also allowed the researcher to clarify any uncertainties that may have arisen during the discourse, which would not have been possible had a questionnaire or structured interview been used.

#### **6.4 RECOMMENDATIONS FOR FUTURE RESEARCH**

The following recommendations for future research in the field of communication following MTBI are made:

- Although the current study contributes to the field of speech-language therapy, a dearth of information still exists regarding communication after MTBI. The current study serves only as a preliminary investigation in this growing area of research. More such studies are required to contribute to the growing body of knowledge relating to communication after MTBI and the role of SLTs in this regard. The use of a qualitative approach (for example, a DA) together with a

quantitative approach (traditional tests) could establish whether results from a DA complement those obtained via traditional testing methods, or differ from them.

- It is recommended that future research compare the DA of a spouse of an individual with MTBI with the DA of the affected individual him/herself to determine whether any correlation exists between these two perceptions of communication. The comparison of these two perceptions is expected to provide the SLT with more comprehensive insight into the apparent needs to be addressed within treatment of the individual with MTBI. Since the perceptions of families of individuals with TBI are seen as an ‘untapped resource’ (Snow *et al.*, 1995:367), further studies are recommended to examine other family members’ perceptions of the communication of the individual affected by MTBI. These perceptions may also provide further insight into the treatment and assessment of individuals affected by MTBI.
- Lastly, a possibility for further research would be to investigate the current role of the SLT in the treatment of MTBI in South Africa and how this role can possibly be expanded. The current study confirms that the SLT has a role to play in this population.

## 6.5 CONCLUSION

The Model of Social Communication (Hartley, 1995) demonstrates that social communication is a product of the interaction between an individual’s environment and his internal functioning. As the results in the current study suggest, MTBI may be associated with communication difficulties. Changes in the individual with MTBI may not initially be perceived as *communication* changes *per se*, but may bring about changes in communication as the environment of the individual interacts with his/her impaired internal processes. Since an MTBI affects an individual’s communication, the SLT has a role to play in this population. Adequate understanding of the environment of the individual with MTBI as well as his/her internal processes is necessary when the SLT is faced with treating the communication difficulties of the individual with MTBI. When the spouse’s perception regarding his/her significant other affected by MTBI is applied to the Model of Social Communication (Hartley, 1995), additional insight is gained into the investigation of the affected individual’s environment interacting with his/her internal processing to obtain products of communication. The SLT is then better equipped to address the relevant areas of the environment of the individual with MTBI as well as his/her internal functioning and affected communication products.

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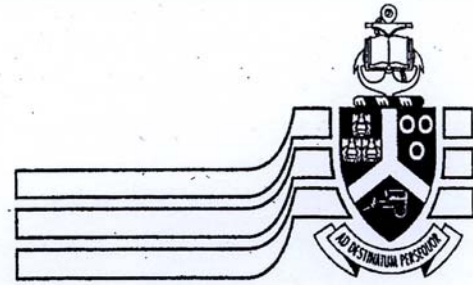
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**APPENDIX A:**  
**Ethical clearance**



University of Pretoria

Research Proposal and Ethics Committee  
Faculty of Humanities

**Members:**

**Research Proposal and Ethics Committee**

Prof D Beyers; Prof C Delpoit; Dr JEH Grobler;  
Prof KL Harris; Prof E Krüger; Prof B Louw;  
Prof IA Niehaus; Prof C Potgieter;  
Prof D Prinsloo; Dr E Taljard; Prof J van Eeden;  
Prof A Wessels

3 September 2003

Dear Doctor Guy

**Project:** The perceptions of a spouse regarding the communicative competence of his/her significant other with mild traumatic brain injury

**Researcher:** SJ Crewe-Brown

**Supervisor:** Dr IO Guy

**Department:** Communication Pathology

**Reference number:** 9432418

Thank you for the application you submitted to the Research Proposal and Ethics Committee, Faculty of Humanities.

I have pleasure in informing you that the Research Proposal and Ethics Committee formally approved the above study on 28 August 2003.

The committee requests you to convey this approval to Mrs Crewe-Brown.

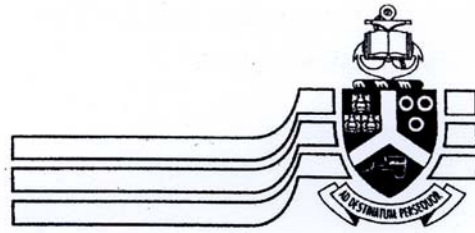
We wish you success with the project.

Sincerely

**Prof Brenda Louw**  
**Chair: Research Proposal and Ethics Committee**  
**Faculty of Humanities**  
**UNIVERSITY OF PRETORIA**



**APPENDIX B:**  
**Letters requesting and granting permission to patient records**



## University of Pretoria

### Department of Communication Pathology Speech, Voice and Hearing Clinic

Tel : +27 12 420 2357  
Fax : +27 12 420 3517  
Email : shugo@postino.up.ac.za

Dear Sir/Madam

As a Master's student in the Department of Communication Pathology at the University of Pretoria, I am conducting a research project to determine: **The perceptions of a spouse regarding the communicative competence of his/her significant other with mild traumatic brain injury.** Information will be gathered from an interview with the participant, being the spouse of the person affected by mild traumatic brain injury. This information will provide us (speech-language pathologists) with a better understanding of how communication abilities are affected after a mild traumatic brain injury, as viewed by the spouse. In so doing, we would be able to provide relevant and appropriate services.

In order to select participants with mild traumatic brain injury, it is necessary that I obtain access to patients' records in the hospital that have been treated by the Speech-Language Therapist. It is ensured that the patients' records will only be used for the purpose of my study.

Thank-you.

Yours sincerely

Samantha Crewe-Brown  
Department of Communication Pathology  
University of Pretoria

Dr Odette Guy  
Supervisor

**EUGENE MARAIS HOSPITAL**

Member of Afrox Healthcare Limited

**Eugene Marais Hospital**

969 Fifth Avenue  
Les Marais 0084  
P.O. Box 30013  
Wonderboompoort 0033

Telephone 012 334-2777  
Fax 012 334-2508

21 January 2004

Dear Samantha,

I hereby acknowledge receipt of your written request

We suggest that you phone the patients and request permission to get access to their Hospital records as well as to be part of your project. These authorizations must be in writing before you can have access to their documents.

Please contact me regarding any uncertainties

We wish you success with your studies.

Regards



Marie Smuts  
Quality Process Manager  
Tel No 3342607  
0824428433

**E.M.H Operating Co. (Edms) Bpk**

Reg. No: 73/13249/07

Trading as Eugene Marais Hospital

A Member of Afrox Healthcare

Directors: Dr. DJJ de Klerk Dr. JJ du Plessis Mr. JH Meiring Mr. CG Redfern Dr. HE Schwalb Mr. CJPG van Zyl

10 February 2004

**Dear Sir/Madam**

I hereby give Samantha Crewe-Brown, Speech-language therapist currently working at Eugene Marais Hospital undergoing her Masters degree, access to my patient records at the hospital.

Name: \_\_\_\_\_

Signed: \_\_\_\_\_

Date: \_\_\_\_\_

**BRIAN R MALLINSON**  
Counselling Psychologist  
M.Sc. (Natal) U.E.D. (Natal)

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**PSYCHOLOGIST**

With a Special Interest in Neuropsychology

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9-May 2005

TO WHOM IT MAY CONCERN

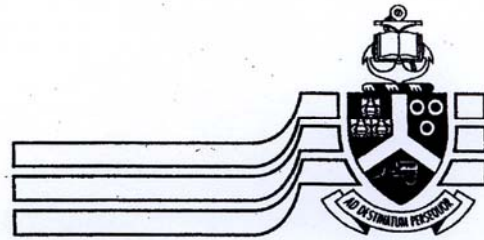
This is to certify that Samantha Crewe-Brown was given permission to extract information from my medico legal patient files for research purposes.

Yours sincerely



Brian R Mallinson

**APPENDIX C:**  
**Information letter and informed consent**



## University of Pretoria

### Department of Communication Pathology Speech, Voice and Hearing Clinic

Tel : +27 12 420 2357  
Fax : +27 12 420 3517  
Email : shugo@postino.up.ac.za

DATE: \_\_\_\_\_

Dear Participant

As a Master's student in the Department of Communication Pathology at the University of Pretoria, I am conducting a research project to determine: **The perceptions of a spouse regarding the communicative competence of his/her significant other with mild traumatic brain injury.** Information will be gathered from an interview with the participant, being the spouse of the person affected by mild traumatic brain injury. This information will provide us (speech-language pathologists) with a better understanding of how communication abilities are affected after a mild traumatic brain injury, as viewed by the spouse. In so doing, we would be able to provide relevant and appropriate services. Your contribution could prove to be useful in providing additional information as well as improving the quality of service received.

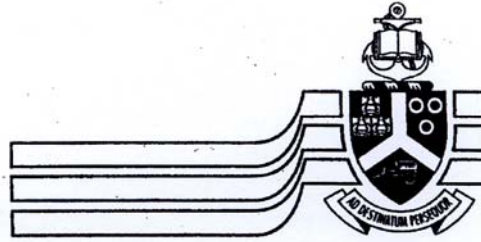
It would be appreciated if you could take part in the interview. Attached please find an informed consent form, of which you are entitled to retain a copy. Your anonymity is assured and your participation is highly regarded.

Thank-you.

Yours sincerely

Samantha Crewe-Brown  
Department of Communication Pathology  
University of Pretoria

Dr Odette Guy  
Supervisor



## University of Pretoria

### Department of Communication Pathology Speech, Voice and Hearing Clinic

Tel : +27 12 420 2357  
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Participant's name: \_\_\_\_\_  
Date: \_\_\_\_\_

Principal Investigator: Samantha Crewe-Brown  
Communication Pathology Department  
University of Pretoria

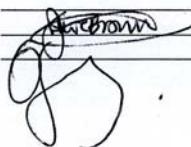
#### Informed Consent:

1. *Title of the study:* The perceptions of a spouse regarding the communication competence of his/her significant other with mild traumatic brain injury.
2. *Purpose of the study:* To determine how the spouse views the communication abilities of their partner. This information will prove to be valuable in planning necessary therapy (if any), which will be beneficial to the client with mild traumatic brain injury.
3. *Procedures:*
  - a. I will be asked to take part in an interview regarding the above-mentioned issues.
  - b. The interview will take place in my home or an appropriate venue agreed upon by the researcher and myself.
  - c. The interview will take approximately 30 minutes to complete.
  - d. The interview will be recorded on audio and audio-visual cassette.
  - e. Once the interview is over, a second appointment will be scheduled to discuss the findings of the initial interview. This appointment should be within 4-6 weeks after the initial interview.
4. *Risks and discomforts:* There are no known medical risks or discomforts associated with this project.
5. *Benefits:* The results of this study will help other professionals (speech-language pathologists) gain a better understanding of how the spouse perceives his/her partner's communication ability and in so doing, provide a better service.
6. *Participant's rights:* I may withdraw from participating in the study at any time.
7. *Confidentiality:* In order to record exactly what I say during the interview a video recorder as well as a tape recorder may be used. Only the Principal Investigator and another professional in the field of speech-language pathology will view the tapes. I understand that the information will be kept confidential unless I ask that it be released.
8. *Other:* If I have any questions or concerns, I can contact the researcher, Samantha Crewe-Brown, at 082 889 1111 at any time.

I understand my rights as participant, and I voluntarily consent to participate in this study. I understand what the study is about and how and why it is being done. I will receive a signed copy of this consent form.

Participant's signature: \_\_\_\_\_  
Signature of Investigator: \_\_\_\_\_  
Signature of Supervisor: \_\_\_\_\_

\_\_\_\_\_



Date: \_\_\_\_\_



## **APPENDIX D: Pilot Study Interview**

## Pilot Participant 1 (PP1): Pilot study interview

(R is for Researcher)

R: Die eerste vraag wat ek vir jou wil vra is: Wat behels kommunikasie vir jou ... hoe sien jy kommunikasie?

PP1: Tussen eggenoot en wat (wys met hande tussen R en haarself) ...?

R: Of kommunikasie as 'n geheel?

PP1: Praat.

R: Uh-huh.

PP1: Praat, absoluut, praat, om te sê ja maar dit, ja maar dat, jy voel so, jy voel so. Kommunikasie *is* praat, volgens my.

R: So, dit gaan net oor die gesproke woord?

PP1: Nee, nee, ek sal seker sê dit gaan darem oor jou hele handeling, jou hele houding met mekaar, maar ek dink tog praat is seker maar die hoof ... middel of doel, of *whatever* jy dit noem.

R: En gesprek en so, hoe sien jy kommunikasie daar?

PP1: Jissie, dis nou moeilik ...

R: Watse deel is vir jou belangrik?

PP1: Luister. Luister, ek moet luister wat jy vir my sê en daarop kan ek dan reageer en jou antwoord. So dit is luister, en weet wat die ander ou sê en dan daarop reageer. En as ek nie luister en inneem wat jy sê nie, dan gaan ek *obviously* nie ... (lig skouers op)

R: So dis dan bo en behalwe gesproke taal, soos wat jy nou-nou gesê het?

PP1: Die luistergedeelte?

R: Ja.

PP1: Ja, ek dink so. En, (wys vanaf R se oë na haar eie) by wees, ek meen ...

R: Ja, by wees, ja ...?

PP1: Kyk, kyk ... jy weet ... jy weet.

R: *OK, OK.*

PP1: Party mense, KR\* is nogals so, hy kyk jou nie altyd in die oë nie. Hy praat met jou en dan voel jy so half, die ou stel nie belang nie, en ek meen, ek wil nie nou sê nie (wys vinnig na die kamera) maar in *anyway*, nee ek dink kyk vir mekaar en luister, *regtig* en hoor wat die ander ou sê, en dan (wys hand tussen mekaar), jy weet ...

R: So dis meer as net, meer as net ... praat

PP1: Meer as net woorde, ek dink so, ja.

R: Kom ons praat bietjie oor KR se kommunikasie.

PP1: Ja-a-a, *OK.*

R: Ek wil hê jy moet net bietjie uitbrei daaroor. Vertel vir my bietjie van jou eggenoot se kommunikasie.

PP1: Hoe hy, hoe hy altyd is?

R: Mm ...

PP1: Jy praat nie van die ongeluk spesifiek nie?

---

\* KR refers to PP1's spouse

- R: Die ongeluk kan 'n deel wees daarvan, voor die ongeluk, na die ongeluk ...
- PP1: Ag nee, hy's nog steeds dieselfde.
- R: Is dit?
- PP1: Ja, ek sou sê hy's stil. Ek wil sê hy's 'n introvert, maar hy's nie heeltemaal nie, maar hy's nie so ... oop en ... ek weet nie, jy moet hom maar net verstaan. Hy praat nie altyd baie nie, hy's partymaal baie stil, en hy kom half stug voor, maar dit is nie noodwendig dat hy stug en onvriendelik is nie. Ook in 'n groep of met vreemde mense soos wat hy jou net ontmoet sal hy jou groet en so maar hy sal bietjie, ek weet nie, um ...
- R: Eenkant bly?
- PP1: Ja, ja. Ek weet nie wat presies wil jy weet van sy kommunikasie nie, maar ... soos ek sê ... hy, ek, ons kommunikeer goed, maar daar's ook dae wat hy stil en instap van die werk af dat ek kan sien *OK*, dis nou nie een van daai dae nie en dan is hy *obviously* stiller en ek karring ook nie, so ...
- R: En jy't nou-nou gepraat van wat kommunikasie is vir jou ... daai luister en, en om te praat, so as 'n mens dit in ag neem, om dan met hom te praat oor sy kommunikasie ten opsigte van daai wat jy genoem het. Wat sal jy ... hoe sal jy sy kommunikasie beskryf ten opsigte van dit?
- PP1: Nee, hy, goed, hy kommunikeer, ek meen, dis net soos ek vir jou sê, maar hy is nog altyd so, ek voel ... hy's nie altyd met my nie, jy weet, en ek het al gesien met, met ander mense ook, jy weet, as hy nou praat of so, kyk hy hulle nie in die oë nie, kyk op die grond, en ek hou nie daarvan nie, maar dit is sy manier, en hy is al die jare so, jy weet, so, ek sal nie sê hy ignoreer mense of, of jy weet, vermy heeltemaal kontak nie, maar dis, hy's nie heeltemaal so openlik soos party ander mense nie, maar hy luister en hy, ja, ja, hy kommunikeer, ek dink nie daar's regtig fout, jy weet ... (glimlag)
- R: En was dit dieselfde ook voor, voor die ongeluk?
- PP1: Ja, ja ...
- R: Jy het nou gepraat in die begin, is dit met die ongeluk in ag of nie?
- PP1: Nee, dis vandat ek hom ken, is hy maar half stil, introverterig, maar, ek kan nie sê ons ... aa, ek weet nie eintlik wat jy wil hê ek moet sê nie, nee, hy kommunikeer goed ... (lig skouers op)
- PP1 & R: (Lag saam)
- R: En dan om die ongeluk, die ervaring om die ongeluk, nou met kommunikasie in gedagte maar *obviously* was dit nie vir jou so groot *issue* nie, was daar ander areas om die ongeluk wat jou aangevat het, of emosioneel geraak het?
- PP1: Ja, wel *obviously* was ek maar emosioneel, was baie bekommerd, met neem die plate en die rug is seer en so ... (harde stem) hy was baie ongeduldig, hy was baie, um, iesegrimmig ... jy weet, "Bel dit, doen dit," nanana ...
- R: By die ongeluk self of by die hospital?
- PP1: Nee, daar het hy baie min gepraat, hoor. Hy't maar meer gekreun en jy weet, gesê, jy weet, "Sorg vir die kar, wat gaan jy met die kinders doen?" Jy weet, daai ... "Ek ry nie alleen in die ambulans nie, sorg dat jy saam met my inklim, en jy sorg dat hulle my nie inspuit nie," jy weet, daai tipe van goed. Nee, maar by die hospitaal, daai hele proses vat mos nou maar lank, jy weet, gaan vir plate, lê in die gang, en jy wag en jy wag, jy weet, so hy was maar met my ge- ... maar ek dink hy was maar met alles en almal geïrriteerd, dit was seker maar seer en ook maar *geworried* en ... ook die aand in die hospitaal en maar vir hom gaan kuier en hy was ... nie baie *talkative* nie, maar ek meen, (lig skouers op) jy moet ook maar in ag neem die man het seer en ... ek, ek weet nie ... ja ek weet nie ... [hoe sleg het hy] ...
- R: En hoe het jy gereageer dan toe hy so stil was in die hospitaal?
- PP1: Nee, ek het maar probeer hanteer, jy weet, en die kinders was daar en hulle het maar gepraat met pappa en 'n ou bly maar geduldig, ek meen, jy verstaan mos nou, en ja, ek het dit goed hanteer, ek dink, was maar bietjie gestres en bietjie *geworried*, maar ek meen die uitslag het toe ook gesê dit is niks, hulle hou hom net vir observasie eintlik, dis nie enige *issue* nie, jy weet ... die rug – een of ander iets het geskuif, in 'n mate, maar ook niks ergs nie, nee ek dink ek het hom goed hanteer, ek ken hom mos so, jy weet mos hoe's dit, as mans siek is of hulle pyn het of so, dan ... raak hulle babas ...
- R: Wil hulle bietjie meer aandag hê.

- PP1: Ja, of hulle raak ... geïrriteerd, met almal om hulle, jy weet ... so hy was nie baie ... maar ek het hom die volgende dag gaan haal en alles was *back to normal*, hy't krom geloop en jy weet, vir 'n paar weke baie seer gehad en fisio gekry en so, maar niks in sy gedrag het verander nie, dit kan ek vir jou sê, nie, nee, ek kan nie regtig agterkom dat enigiets in sy kommunikasie en sy optrede en sy houding, behalwe die pynaspek ... was dit, nee ...
- R: Was dit vir jou 'n bekommer na die tyd wat kon gebeur het, in die hospitaal toe hy so stil was of ...
- PP1: Nee, ek ken hom so... (lag)
- R: Is dit?
- PP1: Nee, nee, jy bedoel dat ek *geworried* dat hy na die tyd 'n ander mens gaan wees?
- R: Ja.
- PP1: Nee, nee, ek was nie bekommerd nie.
- R: So, jy't vroeër ook gesê dit was meer van die ruggyn en die seer waaroor hy rêrig gekla het en dit was maar die hoof ... gevolge na die ongeluk, nie meer as dit nie.
- PP1: Ja, nee dit was meer fisies – die knieg, die skouer en die rug ... ek kan nie eers onthou ...
- R: Gebreek?
- PP1: Nee, nee nee. Net ligamente seergemaak, soos ek sê die rug noem hulle dink ek spondoliese of *something*, jy weet, eerstegraadse verskuiwing, maar met fisio en oefeninge het dit nog reggekom. Ek kan nie eers onthou dat hy eers gekla het van hoofpyn of ... (wys na die kop) dronkheid of iets, ek weet nie of dit gepaard gaan met konku ... *concussion of whatever*, nee, maar weet jy, wat hy van gekla het vir lank was maar die rug ... die spierpyne van die rukslag, als in spasma gegaan en ...
- R: Die fisiese pyn.
- PP1: Ja, ja. ... hy het na die tyd een of twee maal daar verbygery, hy't tot gegaan en fotos gaan neem van die plek ...
- R: By die ongeluk.
- PP1: Ja, die ongeluk *scene*, ja, of die stop en die boom, jy weet, dit was regtig 'n wonderwerk, jy weet hy kon dood gewees het, die manier hoe die kar gerol het, het toe nou teen 'n boom geland, so stukkie van 'n betonmuur af, tussen 'n ander boom jy weet, so hy kon, hy kon dood gewees het en ek dink hy besef dit. Nee, so hy's terug na die *scene* toe en hy't gaan afneem, en ... jy weet, nou, wat ek wel agtergekom het en dis nie seker waarin jy belangstel nie, ek weet nie, maar tot vandag toe nog, as ons 'n stopstraat nader, of 'n robot of 'n *fourway* of *whatever*, hy huiwer, en hy kyk, jy weet ... hy tree anders op as voor die ongeluk, hy's baie versigtiger, hy's baie meer *alert*, so lyk iewers het iets seker maar vasgesteek, jy weet. JR\* het al byvoorbeeld vir hom gesê, "Pa kan al ry," dan sê hy "Maar, jy weet, man jy moet vir die ander ou ook kyk," of *whatever*, so dit het hy bietjie oorgehou, daai ekstra versigtigheid, jy weet ...
- R: So dit beteken hy dink nog eintlik baie daaraan.
- PP1: Ek dink hy dink daaraan. Hy praat nie daaroor, soos ek vir jou sê hy's baie stil, hy praat oor baie goed nie ... Hy praat nie oor die ongeluk nie, hy, so, *obviously* na die tyd as vriende en familie en almal wat jou in die straat kry vra, hoekom dra jy 'n nekstut, so op daai stadium na die ongeluk het hy baie gepraat daaroor en binne 'n maand of wat na almal geweet het en almal *gesubside* het, het hy ook opgehou praat daaroor. Hy praat glad nie meer daaroor nie.
- R: Is dit?
- PP1: Nee, nee.
- R: So die ervaring self vir hom, was, was meer ... dat hy nou meer versigtig is ... die kommunikasie-aspek het glad nie verander nie ...
- PP1: Absoluut, nee ek kan nie vir jou sê oor die kommunikasie nie, regtig, want soos wat wat hy voor die tyd was, so is hy vandag en so was hy 'n maand na die tyd, regtig, en die praat, en die kommunikasie, met ons, met die kinders, met my, by die werk, geen, jy weet, nee, nie 'n ander KR as die KR wat ek ken nie. Jy verstaan ...
- R: En jy sê nou by die werk, het hy onmiddellik teruggegaan werk toe?

---

\* JR refers to their son

- PP1: Nee, nee, hy was afgeboek, um, vir fisiosessies, ek kan nou nie onthou of dit twee weke of, (sug) ... jy weet dit was net voor Kersfees, so ek dink (vryf voorkop) hy't toe nou eers in Januarie, wanneer meeste mense eerste week na nuwe jaar, het hy weer begin of bietjie langer daarna, ek dink dit was so twee, drie weke dat hy fisio gekry en inspuittings wat, wat, wat, vir die rug ...
- R: Want dit was nou Kersfees *obviously* na die tyd en ...
- PP1: Dit was toe nou Kersfees en oor daai seisoen, ja, so ... hy's toe nou af oor daai ruk en hy's toe nou eers Januarie weer terug.
- R: En hoe was daai Kersfees?
- PP1: Waar was ons heen? Ek kan nie eers onthou of ons ... nee, ons het gebly, ons was nêrens nie. Nee dit was normaal, hy't nog saam, ons het by die familie gegaan, ons het 'n vreeslike groot familie en dis altyd groot *do's*, nee, ons het die dag gegaan en ons het 'n ete gehou, die vorige aand het Kersvader presente uitgedeel en ons was daar en weet jy, nee, hy't met sy pyne en skete hinkepink geloop en sy pilletjies gedrink, maar hy was daar ... ek dink hy was effens stiller, as ek nou moet sê, maar *OK* ...
- R: Dis nou Kersdag?
- PP1: As ek nou dink aan daai dae, nou normaalweg tussen sy familie jy weet is hy baie, hy praat en lag en, jy is mos nou, en was hy maar stiller, maar jy moet nou ook onthou dit was sê nou twee, drie dae na die ongeluk, alles is seer, alles is styf, hy was dalk nie heeltemaal so lus vir mense en goed nie, so hy was vir my bietjie stiller, dit kan ek vir jou sê ...
- R: En dink jy dit was net van die pyn?
- PP1: (Sug) Nee, ek dink dit was skok en na-skok, jy weet, ek dink dis 'n traumatiese ding, genade, nee, ek dink nie dit was net van die pyn nie want ek het telkemale gehoor as hy met mense praat of iemand vra, selfs as met die familie dan sal hy sê "Ja, dit was 'n wonderwerk, ek besef ek kon dood gewees het," so ek dink sy kop het bietjie (wys na kop) ... jy weet, *OK*, ek dink dit het darem gevat, nie net die pyn nie, maar die hele ongeluk. Ek het vir hom gesê jis, daai gevoel, hy sê jy sien hierdie kar kom afgepyl en hy probeer uitswaai, maar hy kan nie en ... hom tref en onthou net hy't geskree en gevloek en jy weet, een word geuiter en hy sê en toe's dit net ... (wys met hande hoe rol die kar) so ek dink nie hy was stil net van pyn nie, ek dink dit het tog maar 'n effek op sy (wys weer na kop) kop of *whatever* gehad het, jy weet ... nie kop-kop nie, binnegoed, jy weet, hy't baie daarvoor getob en gedink en wat ... *OK*, baie bly sê is dat hy so bly *BR* was nie in die kar nie, jy meen, ek self het die gesê, hy's so bly hy was alleen, dink nou net as sy saam was kon sy dalk dood gewees het, en daai besef, *OK*, hoe lig hy eintlik daarvan af gekom het, jy weet, so ek dink hy was stil, ja ook pyn, maar hy was vir 'n paar dae dink ek het die stof van na die tyd ...
- R: So het ... baie van sy emosionele gevoelens het ook uitgekom na die tyd, soos wat jy nou gesê het van?
- PP1: Nie baie nie, maar so ... (Wys met haar vingers hoe klein) so hier en daar, jy weet ... en ... of half hy sal nou byvoorbeeld hier in die stoel sit en dan sal hy hiperstil raak, jy weet, baie, baie stil.
- R: Alleen.
- PP1: Nee, jy weet, die kinders hol en gaan aan, jy weet mos hoe's dit, so, maar alleen op sy eie, ja. Die kinders kan skree en aangaan maar hy sit met die koerant of iets maar dit lyk nie vir my of hy regtig ...
- R: Lees nie.
- PP1: Ja-a (lig skouers op) ag, ek weet nie ...
- R: En dan wonder jy wat hy dink?
- PP1: Ja, ja, of dan vra ek vir hom het jy seer, jy weet, is jy *alright*, of *worry* jy oor die kar of ... *whatever* jy weet, daai tipe van, dan sal hy sê "Nee, ek's alright", of "Ja, my knieg is seer," of "Wanneer laas het jy pille gedrink?" "Nee, ek sal nou-nou." Jy weet mos hoe's mans, hulle's ook *babies*, hulle sal nie 'n pil vat ... sal jy dit nie vir hom aandra? Daai tipe van ...
- R: (lag) Dis maar algemeen ...
- PP1: So nee, ek dink dit het emosioneel, jy weet, ook maar bietjie, maar dit was nie lank nie en hy was weer ... homself, jy weet, regtig, jy weet, op alle gebiede soos wat ek hom ken.

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\* BR refers to their daughter

- R: So dit was net vir 'n periode waar hy daai stil oomblikke gehad het?
- PP1: Ja, ja, paar dae, paar dae. Ons was ook, jy weet, dit was toe nou ook Kersfees en die *panel-beaters*, insleepdienste, al die plekke is toe nou toe, so ons kon toe nou eers, nee ek jok, hy't gebel en gereël dat hulle vir hom gaan oopsluit.
- R: O, is dit? Het hy *contacts*?
- PP1: Nee, die *panel-beaters* self. Hy het hulle fisies by die huis gebel en gesê: "Ek wil my kar gaan sien." Ek het vir hom gesê: "Los die kar, hy's 'n *write-off*, hy lyk baie sleg." Nee, hy wil self gaan, so, dit wys ook vir my, hy wou, en mense, ek kan nie onthou die dag of dit die 27ste of *whatever* het hulle 'n spesiale tyd gereël, ingery na die skrootweg of *whatever* jy dit noem, die hekke oopgesluit en toe't hy nou die kar gaan sien, presies hoe dit lyk en so. Toe beseft hy eers, dis nou toe die kamera toe saam was, en daar word die kar toe nou ook afgeneem, jy weet ...
- R: So die eintlike ongeluk was vir hom baie belangrik.
- PP1: Lyk my so, want alles is afgeneem, ek weet nie.
- R: Hoekom dink jy so?
- PP1: Ek weet nie, maar weet jy, die vorige, 'n paar jaar terug, ek wil vir jou sê wanneer, maar ek kan nou nie onthou nie, was hy ook in 'n ongeluk met 'n ander kar en hy het die kar ook nou gaan afneem, nou of net karre net vir hom, of hy net graag 'n foto wil hê om eendag te sê: "Ek het so 'n kar gery," of "Kyk hier, ek was in 'n ongeluk." Ek weet nie regtig hoekom nie, ek sou nie daaraan gedink het om die kar te gaan afneem regtig nie, maar miskien is dit eintlik oulik want (lag) in die toekoms het jy nou, kan sê kyk jy weet, om te sê kyk waaruit het ek gekom en ek lewe nog, jy weet ...
- R: En daai hele wonderwerk om met ander mense te deel ...
- PP1: Absoluut, absoluut, ja, en dit was die Here se hand gewees en hy glo ook so, jy weet, want mens vergeet. In daai tyd sê jy o jinne, dankie Here en jy praat en jy getuig en sê en ag, twee, drie maande later vergeet jy weer en jy gaan aan met jou lewe en ...
- R: Is so ...
- PP1: Alles is goed en jy vergeet, jy weet.
- R: En jy't gesê hy was vinnig terug werk toe ... na die vakansie.
- PP1: Ja, ja, weet jy ek wil sê drie weke, kyk nou, ek praat nou onder korreksie, maar sê nou maar die 22ste, 23ste was die ongeluk, en die skole begin mos so nou by die tweede week in Januarie, die meeste mense keer mos daai week terug werk toe ... Ja, ek skat so drie weke by die huis. Nee, aan, *dress* op en trek aan en gaan werk toe en alles, niks snaaks nie, hoor, *genuine* ...
- R: Niks probleme by die werk ...
- PP1: Nee, nee, nee, glad nie en ook, ek en sy een kollega half vriend wat saam met hom werk, ek en hy het ook baie kontak. Jy weet HL is gou om vir jou te sê: "Hoorie, KR is geïrriteerd," of "Hoorie, wat gaan aan met KR?", of nooit, jy weet, in ons gesprekke vir my gesê, "Hoorie ek is bekommerd," of jy weet, "KR is anders by die werk," of so nie, nee, ek dink hy was regtig heel normaal ... (lag)
- R: Ag, wel dis wonderlik.
- PP1: Ja.

## **APPENDIX E: Interviews with Participant 1**

## Participant 1(P1): Initial interview

(R refers to Researcher)

- R: AM\*, ek wil begin om vir jou te vra, wat behels kommunikasie vir jou?
- P1: Ooo ... (lag). Dis om jouself... te *express* ... ja.
- R: En net ... as jy sê *express*, wat bedoel jy?
- P1: Om by iemand anders ... by iemand te sê hoe jy voel of ... om iets by hom tuis te bring.
- R: OK, OK. So net die verbale woord.
- P1: Ja.
- R: So is dit wat dit is? As ons dink aan ander aspekte van kommunikasie? Kommunikasie is miskien meer as net ... gesproke.
- P1: Mmm, soos, soos hulle sê *body language*. Soos hoe jou lyf kan praat en jou gesigsuitdrukings kan ook maar ... kommunikasie wees.
- R: OK, OK. Is dit al?
- P1: Mmm (lag) so ver ek kan dink, ja.
- R: OK. En as ons 'n bietjie breek dink, kommunikasie in terme van luister, lees, skryf?
- P1: Ja, dit kan ook seker dan onder kommunikasie val, ja.
- R: Enige kommentaar daaroor? Hoe sien jy dit?
- P1: Ja, dit is maar altyd om, jy wil met iemand kommunikeer. Jy wil ... dit is om vir 'n spesifieke groep mense iets te sê, al skryf jy dan in 'n boek of ... (knik kop)
- R: OK. En wat is belangrik vir jou van kommunikasie?
- P1: Mm (klein laggie). Dis maar net om ... seker maar om jouself te kan uitdruk. Ek dink dis vreeslik moeilik as jy nie kan kommunikeer nie ... met iemand.
- R: So jy praat net van taal nou?
- P1: Seker maar, ja, dit sluit seker maar so skryf en luister en alles in.
- R: Uh-huh. Nog iets wat jy van kommunikasie wil sê?
- P1: Nee, nie waaraan ek kan dink nie.
- R: OK. Nou wil ek jou bietjie vra oor NM\* se kommunikasie. Beskryf vir my sy kommunikasie.
- P1: Nee, hy kan goed kommunikeer. Hy kan net sy humeur is net partykeer bietjie ... (lag) bietjie kort met die kinders ...
- R: Is dit?
- P1: Ja. (lag)
- R: Vertel vir my bietjie meer daarvan.
- P1: Ja, hy ... dis baie korter as wat dit was voor die ongeluk, byvoorbeeld, ja, hy sal, en ek dink dis want hy kry nog vreeslik hoofpyn. So ek dink dis meer oor die hoofpyne ... dat sy humeur baie kort is, ja. Nou nie met CM\* nie, snaaks genoeg, sy kan maklik doen wat sy wil, (lag).
- R: O, is dit?

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\* AM refers to P1

\* NM refers to P1's spouse

\* CM refers to one of the daughters



- P1: Ja, die ander tweetjies nogal.
- R: En hoe gereeld gebeur dit?
- P1: Jy weet, sodra hulle by die huis is. As hulle nou byvoorbeeld by die skool was, dan sodra hulle by die huis kom. Hulle is net 'n uur of twee hier, dan sal hy byvoorbeeld op een van hulle afgaan ...
- R: En hoe hanteer jy dit?
- P1: Ja-nee, ek probeer hom maar die heeltyd kalmeer (klein lag). Ja ...
- R: En so, dis een aspek van sy kommunikasie.
- P1: Ja.
- R: Jy't nou gesê kommunikasie is veel meer, baie breek as dit. Noem vir my 'n paar ander aspekte van sy kommunikasie.
- P1: (Lig skouers effens op) Sy ... liggaams- ... kommunikasie het nie rêrig verander nie, dit is maar ... normaal, normaal.
- R: Hoe is hy? Hoe is daai normaal vir jou?
- P1: Nee, hy kan baie, soos my een vriendin sê, hy kan baie *charming* wees.
- R: *OK*. (Skud kop en glimlag)
- P1: Nee, mense hou van hom. Hy's 'n goeie, hy't baie goeie kommunikasie.
- R: So hy hou daarvan om te ...
- P1: Praat, o ja, hy's 'n ekstrovert.
- R: Nog altyd?
- P1: O ja, ja, nee, nog altyd.
- R: *OK, alright*. En nou? Het enigiets verander in terme daarvan?
- P1: Mmm ... nie regtig, behalwe vir sy humeur, wat korter is, en hy vergeet partykeer sekere woorde, soos as mens oud raak en jy sê byvoorbeeld, mens wil praat van die ketel, dan sal hy ketel vergeet. *Stupid* woordjies, dan sal hy, hy kan nie die woord kom nie. Dit vang my van nogal na die ongeluk.
- R: Beskryf vir my een van daai situasies. Gebeur dit baie of ...?
- P1: Ja, dit gebeur gereeld. Dit gebeur nogal baie. Dis asof hy die woord nie kan plaas nie, die ding se naam nie kan onthou nie.
- R: En in 'n gesprek? Jy't gesê hy sosialiseer baie.
- P1: Ja.
- R: Hoe hanteer hy dit dan?
- P1: Nee, hy word kwaad vir himself, ja (lag). Hy kan dit nie hanteer, hy hou niks daarvan nie.
- R: En voor, in 'n gesprek, saam met ander mense, voor ander mense?
- P1: Ja hy, maar hy's maar voor ander mense net soos hy by die huis is, hy's nie regtig dat hy verskillend is nie.
- R: *OK*.
- P1: So hy's maar basies dieselfde.
- R: En as daai geval nou gebeur in 'n gesprek, saam met ander mense nou, wat gebeur? Beskryf vir my bietjie miskien een van daai...
- P1: Ja, hy sal byvoorbeeld vir ons iets sê van die yskas, dan sal hy nie op die woord kan kom nie. Dan sal hy sê, "Ag man, die ding, ag ek kan nou nie die woord onthou nie." Dan sal hy vir homself kwaad raak ... en ek meen hy word basies kwaad as mens nie vir hom dadelik kan weet waarvan hy praat nie.

- R: Is dit? So wat sê jy dan? Verwag hy dat ...
- P1: Ja, dis asof hy wil hê mens moet die stuk insit wat *missing* is.
- R: Is dit?
- P1: Ja, dis asof jy moet weet waarvan hy praat, waar hy nie op die naam kan kom nie.
- R: OK. Dis interessant, want in ander gevalle wil ander mense hê *hulle* moet die woord kry.
- P1: Ja, ja.
- R: Voordat ...
- P1: Dit is ... hy soek die woord en na 'n rukkie dan sal hy sê, "Man, daar's hy", na twee of drie minute dan kom die woord nog.
- R: Is dit ...?
- P1: Dan sal hy sê, ja, dis waarvan hy praat, asof ons nie kon *uitfigure* waarvan hy praat nie. (lag)
- R: (lag) *Shame*, en jy sê dit gebeur gereeld?
- P1: Ja, nee, dit gebeur nogal gereeld.
- R: Soos in elke dag?
- P1: Ja, ja (skud kop). Ja, maklik elke dag. Nou nie in elke gesprek wat hy voer nie, maar omtrent elke dag.
- R: En dit was nie altyd so nie?
- P1: Nee, nee, nee, hy't eintlik altyd 'n vreeslike goeie geheue gehad. Hy't tot sy vriende en onderwysers se name van skool onthou wat ek nie eers kan doen nie.
- R: Nogal *impressive*!
- P1: Ja! (glimlag) Ek kan nie een van my onderwysers se name onthou nie! Maar hy kan almal onthou, so ...
- R: Nou jy't gesê geheue – praat jy van sy geheue van woorde, as hy 'n woord nou ...
- P1: Ja, dis basies net 'n woord ... wat hy verloor ... dis nie soos 'n hele sin nie, dis basies net 'n woord. Hy wil van iets praat en daai woord kan hy nie ... op 'n naam, byvoorbeeld.
- R: So, op 'n naam soos dan mense se name?
- P1: Ja, mense se name. Hy wil van iemand praat en hy kan nie op die persoon se naam kom nie.
- R: Is dit?
- P1: Ja.
- R: Net bietjie erger as ons.
- P1: Ja, soos met ouderdom, my ma is byvoorbeeld so, maar sy is nou maar in haar sestigs. So dit is nou maar met ouderdom.
- R: En nou jy't gesê, daai geheue, dat hy nie woorde kan onthou nie, is dit wat jy bedoel met geheue of strek dit bietjie verder i.t.v. sy geheue?
- P1: Nee, ek dink dis basies, nee, die res van sy geheue is heel normaal, ja, goed reggekrom.
- R: En jy't gesê goed reggekrom?
- P1: Ja, want hy't dit mos vir 'n ruk verloor. Na die ongeluk het hy, was hy vir 'n hele ruk, net 'n paar dae het hy nie omtrent 'n geheue gehad nie.
- R: Is dit?

- P1: Ja hy kon nie my naam onthou nie, hy kon nie een van die kinders se name onthou nie. Hy't byvoorbeeld gesê hy het vier kinders (lag) waarom ek nou nog *worry* ... (lag).
- R: Ja, jy't gesê, ja.
- P1: Ja.
- R: En vir hoe lank het dit aangehou?
- P1: Mmm ... omtrent vier, vyf dae. Toe begin hy alles onthou, alles het teruggekome, maar daai dag, het hy nog steeds nie van geheue nie. Dis net daai eerste dag wat weg is ... en die eerste twee dae van die hospitaal. Hy't byvoorbeeld nie onthou hy rook vir die eerste twee dae nie. Hy't net, en hy kon glad nie op die woord sigaret kom nie, hy't gesê byvoorbeeld hy's lus om, hy's lus vir 'n rook (lag). Toe was sy geheue baie erg.
- R: Ja, ja ... maar jy sê dit het geleidelik ...
- P1: Ja, ja, na die twee weke, toe hy uit die hospital uitkom, toe's sy geheue basies weer, heel normaal, terug.
- R: Mmm, en na die tyd, terug werk toe?
- P1: Toe ek werk toe?
- R: Nee, hy.
- P1: Nee, dit is, maar toe's hy mos nog nie terug werk toe nie.
- R: En hoe affekteer dit, dink jy ... die hele werksoeksituasie?
- P1: Ek weet nie, dit het dit seker heelwat geaffekteer. Nou vir 'n hele lang ruk kon hy nou natuurlik nie werk soek nie.
- R: En hoekom nie?
- P1: Omdat hy nog eers (wys met hande) ... hy't verskriklik baie geslaap, byvoorbeeld, die eerste maand, seker na hy by die huis was het hy vreeslik baie geslaap. Dit was asof die brein besig was om homself te ...
- R: ... herstel?
- P1: ... te herstel, ja, hy't *baie* geslaap.
- R: En nou?
- P1: Nee, en nou is hy weer heel normaal. Ja, ja, al wat ek agterkom is soos sy humeur.
- R: Klink vir my dis die ding wat jou die meeste pla.
- P1: Ja (lag).
- R: Ja, hoe affekteer dit julle verhouding?
- P1: Ja, nee, ons baklei 'n bietjie meer, hy lewe nou natuurlik op, omtrent op hoofpynpille, omdat die hoofpyn is konstant.
- R: Is dit?
- P1: Ja, die dokter het gesê dit sal nog 'n rukkie daar wees omdat die bloeding nog besig is om weg te gaan so, so dis, dit is net met stres dan's dit erger. So as die kinders hom bietjie opwerk dan raak dit erger. By die huis as ek byvoorbeeld en hy alleen by die huis is, dan is hy heel rustig, heeldag, dan het hy nie eers 'n pynpil nodig nie. Dis sodra hulle inkom, dan sien ek, dan gaan drink hy twee pynpille (lag).
- R: So, dis net die kinders, basies?
- P1: Ja, dis basies ...
- R: En wat gebeur? Wat gebeur as hy sy humeur verloor?

- P1: Nee, hy sal, hy kan partykeer bietjie lelik met hulle raak (klein lag), ja. Veral met BM\* nogal, want CM is sy oogappel so hy sal nie met haar so erg raak nie. Maar BM, kan hy, sy kan hom, die kleinste dingetjies irriteer hom vreeslik.
- R: Is dit?
- P1: Ja, dan sal hy haar nou 'n harder pak gee as wat hy eintlik, of oor iets *stupid*s, wat nie eintlik regtig 'n pak regverdig nie.
- R: Ja, ja. Soos klein dingetjies wat karring.
- P1: Ja, hy sal, hy hou hom nogal goed in. Sy sal vir 'n halfuur aangaan, sy sal karring, karring, tot sy nog iets doen (lag), dan's dit nou genoeg. Dan sal hy haar gryp en 'n pakslae gee.
- R: Rêrig. Dis nou as hy opblaas, amper.
- P1: Ja.
- R: En in enige ander areas, kom dit ook voor?
- P1: Ag nee, um, ek het agtergekom as hy enigsins enige alkohol drink, dan raak hy ook baie aggressief.
- R: Is dit?
- P1: Ja.
- R: Meer as gewoonweg?
- P1: Ja, ja. Gewoonlik is hy nie eintlik aggressief nie, behalwe soos ek sê as hulle ... dis ook nie dat hy aggressief is nie, dis net dat hy sy humeur vreeslik vinnig verloor ... maar as hy alkohol in het, dan raak hy kwaad, wat nie rêrig was voor die ongeluk nie.
- R: Drink hy baie of nie baie nie?
- P1: Nee nie vreeslik nie. So *occasionally*, 'n biertjie of twee *occasionally*.
- R: So dis net een of twee biertjies en dan ...
- P1: Ja dan sal hy meer humeurig, of meer ... aggressief begin raak.
- R: Na twee biertjies, huh?
- P1: Nee nie rêrig nie, as hy een of twee drink is hy nog oraait, hy sal net vinniger sy humeur verloor, maar as hy nou bietjie meer gedrink het, mens kan sien hy bietjie, dan sal hy bietjie aggressief ... veral as mens hom aanspreek oor iets, byvoorbeeld, oor hy te veel gedrink het.
- R: En nou as dit in 'n groep mense gebeur?
- P1: Nee, maar dan sal ek hom gewoonlik nie aanspreek nie (lag). Nee, hy sosialiseer dan baie goed. Hy sal nie sommer ... dan sy humeur verloor maklik nie.
- R: As hy drink saam met ...
- P1: Saam met ... sosialisering, ja. En hy sal ook nie met ander mense sommer aggressief raak nie. Dis meer met my, dis asof ek, omdat ek nader aan hom is. Hy sal nie met ander mense sommer nie.
- R: OK, so dis meer hier by die huis.
- P1: Ja.
- R: OK, hoekom dink jy so?
- P1: Ek weet nie, ek, ek, dis seker maar, soos hulle sê, ek het vir Dr Phil (wys na TV) gekyk gister, hy sê mens hanteer partykeer vreemdelinge beter as wat jy jou eie gesinslede hanteer, so dalk omdat ek nader is aan hom, dat hy voel hy mag maar aggressief wees, waar hy nie by ander mense aggressief is nie ... ek weet nie ...
- R: ... wat jy moet doen ... miskien steeds lief wees vir hom?

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\* BM refers to one of the daughters

- P1: Ja, seker, dat hy weet ek sal maar nog ... lief wees vir hom.
- R: Ja, ja. En hoe affekteer dit julle verhouding? Want die feit dat hy oraait is saam met ander mense, maar ... nie altyd ...
- P1: Ja, nee, wel dit maak dat ek nie rêrig met hom gesels as hy byvoorbeeld drank gedrink het, jy weet, ek het dit self agtergekom.
- R: Ja, ja. So jy sal hom net los?
- P1: Ja, ek sal hom byvoorbeeld, ignoreer basies. Nie ignoreer nie, maar ek sal met die ander mense meer gesels as met hom.
- R: Maar dis net as hy bietjie gedrink het, nie die ...
- P1: Ja, dis al ...
- R: Nie in ander opsette nie ...
- P1: U-u, nee, nee.
- R: En nou julle kommunikasie, *OK*, ons vergeet vir nou die hele drankstorie, maar julle kommunikasie tussen mekaar?
- P1: Nee, dis baie goed.
- R: Nou wat is goed? Beskryf vir my bietjie.
- P1: (lag) Nee, ons is mekaar se beste vriende so ons sal oor alles gesels.
- R: Uh-huh.
- P1: Nou byvoorbeeld omdat hy nou nie werk nie, is dit moeilik ... omdat hy nie rêrig groot met ander mense interaksie het deur die dag nie, is hy baie uitgehonger vir geselskap as ek by die huis kom (lag).
- R: *Shame*, so hy's bly as jy terugkom van die werk af ...
- P1: Ja (lag), 'n goeie teken ...
- R: En dan waaroor gesels julle?
- P1: Ag, oor enige iets, oor iets wat hy by die werk gesien het, ag, op die TV gesien het, of iets wat by my werk, of sommer oor die algemeen ...
- R: *OK*, en dan as hy terugkom, of as jy terugkom van die werk af, is die kinders ook hier?
- P1: Ja, want ek gaan haal hulle by die skool voor ek huis toe kom.
- R: Voor jy huis toe kom.
- P1: Ja, so ons het nie rêrig tyd alleen nie, voor die kinders nie. Dis eers na agtuur as hulle gaan slaap dat ons regtig tyd het ...
- R: ... om te gesels?
- P1: Ja.
- R: En daai hoofpyn soos jy gesê het, terwyl julle gesels, daai hoofpyn is daar die hele tyd?
- P1: Ja, hy sê, dis konstant daar, ja.
- R: Hy's sommer net gewoonnd daaraan.
- P1: Ek dink hy't gewoonnd geraak daaraan. Hy drink vir my nou baie minder as wat hy nou, net na die ongeluk, nou die pille, ek was half op 'n stadium bang hy gaan verslaaf raak aan Grandpa's (klein lag).
- R: Ja.
- P1: Maar nou drink hy vir my baie minder.

- R: Nou moet hy eintlik nog die pille drink?
- P1: Nee, die dokter het nie vir hom pynpille voorgeskryf nie, hy het maar vir hom gesê hy kan enige pynpille, hy kan Panado's of Grandpa's, of enigiets drink soos wat hy nodig het.
- R: En hy het dit die hele tyd nodig?
- P1: Ja, hy't basies, deur die dag sê hy drink hy nie rêrig nie, maar as die kinders by die huis kom, dan drink hy gewoonlik.
- R: So as die behoefte opkom, dan ...
- P1: Ja.
- R: Haai, dis 'n ander lewe, om so te leef.
- P1: Ja.
- R: En praat, sê jy, van sy kommunikasie, praat hy oor die insident of die omstandighede daarom?
- P1: Nee, glad nie. Al wat hy daarvoor sê is dat hy kan glad nie onthou nie en verder praat hy glad nie daarvoor nie.
- R: Is dit?
- P1: Ja. In elk geval kan hy die eerste paar dae in die hospitaal ook nie onthou nie, so ...
- R: Rêrig, die eerste paar dae?
- P1: Ja, die Saterdag wat hy opgeneem is want ek het hom eers die Sondag gesien want hulle het gesê ek moet hom nie die Saterdag sien nie ... die Maandag, Dinsdag, is dit byvoorbeeld baie vaag. Hy weet byvoorbeeld van sy susters het gebel maar hy kan nie sê wie nie, hy weet sy ma-hulle het gebel maar hy kan nie sê wanneer, watse dag, want hulle sê net vir hom, die een het gebel, dis baie vaag, en hy het baie geslaap, hulle het hom basies ... baie laat slaap.
- R: Jy't ook gesê kommunikasie, soos ek vir jou genoem het, strek ook na skryf en lees en luister of verstaan en praat. Jy't nou baie gesê van sy praat, wat van die ander aspekte?
- P1: Luister kon hy darem al altyd, en hy luister goed, hy verstaan, hy's nie, hy's baie slim, so hy kan baie logies dink. Maar lees, lees hy glad nie. Hy lees nog nooit nie, hy hou nie van lees nie.
- R: En in die hele prosedure van werk soek en so, moet mens jou CV skryf en ...
- P1: Ja, ek het sy CV vir hom geskryf of getik by die werk. Hy't maar net vir my uitgelê. Ek het hom maar net getik ...
- R: En sy kommunikasie rondom dit, om werk soek en ...
- P1: Ek dink dit het bietjie verander in die drie maande sal ek sê. Hy was in die begin baie ... hoe sal ek sê, hy't nie te veel van homself gedink, maar hy't meer gesê, OK, ek sal nie daai tipe werk sal wil doen nie, waar nou, sê hy byvoorbeeld hy sal enige tipe werk doen.
- R: Is dit?
- P1: Ja.
- R: Hoekom dink jy nou?
- P1: Ek weet nie. Ek kan nie vir jou eerlik sê nie.
- R: Is dit nie dat hy bietjie meer desperaat nou is?
- P1: Ja, dit kan wees maar ek dink hy't ook 'n bietjie groot geword oor hierdie afgelope tien maande (lag).
- R: Wat bedoel jy daarmee?
- P1: Nee, ek dink hy was nog nie baie verantwoordelik nie. Hy't nog alles gekry wat hy wou en nou in hierdie tien maande het dit bietjie swaar gegaan. So ek dink hy't 'n bietjie groot geword.
- R: En swaar gegaan? Praat jy van ...

- P1: Finansieël meer.
- R: Is dit?
- P1: Veral na die kar gesteel is.
- R: Wanneer het dit gebeur?
- P1: September.
- R: Dit is nou die maand van die aanranding is dit nie?
- P1: Ja, dit was die 11 September en aan die einde van die maand is hy aangerand, so dit is basies dieselfde maand.
- R: So die kar is gesteel voordat dit gebeur het.
- P1: Hy't nog van 'n onderhoud af teruggekom en hy't die kar net buite geparkeer en hy was in die badkamer daar en toe hoor hy die kar *rev*, maar toe hy uitkom is die persoon klaar weg. En gewoonlik trek hy hom in, ek weet nie hoekom hy daai dag, hy's te moeg of iets om hom in te trek. Hy't nog altyd die kar ingetrek.
- R: Ai AM, is maar swaar.
- P1: Ja.
- R: So die belangrikste ding wat jy vir my noem nou oor sy kommunikasie, die ding wat jou die meeste pla is maar sy kort humeur.
- P1: Ja, dit is maar die ergste.
- R: Kan jy met hom praat daaroor?
- P1: Hy weet daarvan, ja. Hy sê ook dis al wat hy rêrig agterkom wat aan hom anders is. En hy sê ook hy wil nie so wees nie. Hy sê baie keer hy voel ook dadelik jammer byvoorbeeld as hy haar vreeslik geslaan het oor sy iets *stupid*s gedoen het, of 'n ongeluk gehad het, dan sal hy vreeslik sê, "Jammer", en dan voel hy baie sleg daaroor. Dis asof hy homself nie kan help nie.
- R: Ja, en help jy hom in daai tyd?
- P1: Ja, ek het vir hom al gesê hy moet probeer om tot tien te tel as hy voel hy word so kwaad. Net om eers te dink is dit nou rêrig nodig om so kwaad te word?
- R: En as jy sien dit gebeur?
- P1: Ja-nee, gewoonlik probeer ek dan met hom *sense* praat. Ek sê, "Dit was net 'n ongeluk, dit is nie so erg nie," so iets, ja.
- R: En hoe is sy redenering dan in daai tyd, want dis *obviously* dan 'n baie stresvolle oomblik?
- P1: Nee hy sal partykeer bietjie op my ook afgaan, maar nie, hy sal verstaan naderaan, hy sê, "OK, nee, ek weet".
- R: Jy sê naderaan, so nie dadelik nie?
- P1: Nee, nie dadelik nie, dan's hy te kwaad ek dink op daai oomblik. Ja, ja.
- R: *Shame*, maar jy sê hy werk daaraan.
- P1: Ja, hy werk regtig daaraan ... ja.
- R: Dis maar 'n groot aanpassing, né?
- P1: Ja, dit is.
- R: En vir jou?
- P1: Ja, nogal. Veral net na hy in die hospitaal is en hy kon niemand onthou nie, en hy kan nie onthou wat's niemand se name nie en ...
- R: Hoe het jy dan gevoel?

- P1: Ja dit was nogal 'n aanpassing (klein lag).
- R: Was jy bang vir die toekoms of ... wat het jy ... ?
- P1: Ja, ek het gewonder of hy nou of ek nou, dat hy *incapable* gaan wees om te praat, mens weet nie hoeveel breinskade daar is nie, of daar breinskade is, of hy ooit weer 'n normale gesprek kan voer of ...
- R: En al daai gedagtes wat jy toe dan gehad het?
- P1: Nee, maar hy't baie vinnig daarna weer reggekome. Omtrent die tweede derde dag toe's hy al klaar weer baie normaal.
- R: So jou bekommernis en so wat jy in die begin gehad het, het ...
- P1: Ja, het darem minder geraak, met die tyd.
- R: En nou?
- P1: Nou weet ek nie, want die dokter het eintlik vir hom kalmeerpille voorgeskryf, maar ons het dit nou nie gaan haal nie want dis bietjie duur, maar eintlik ...
- R: Wanneer het hy dit gedoen?
- P1: Desember, toe sê hy, hy het vir hom genoem, vir dokter in sy opvolgondersoek dat hy sy humeur verloor ...
- R: O.
- P1: Ja en die dokter het gesê dit is 'n nagevolg van die bloeding op die brein dalk dat hy sy humeur so verloor.
- R: So dis die ding wat jou die meeste pla.
- P1: Ja, ja (klein laggie). Nee, verder is hy heel oraait.
- R: Nee, dis goed. Nou is dit net vorentoe, né?



## Participant 1 (P1): Follow-up interview

- R: Die eerste tema wat ek nogal agtergekom het was die gevolge na die ongeluk. Dit is die hoofding wat ek gesien het en dan daaronder, die eerste een wat opgekom het was nogal NM se gedragsveranderinge, en ek het daai ingedeel. Sal jy sê gedrag is nogal 'n groot een wat verander het?
- P1: Ja, dis omtrent die grootste een, ja.
- R: OK, so van daar af het ek dit ingedeel in terme van *triggers*, *interne triggers* en *eksterne triggers*. *Interne triggers* is goed soos sy hoofpyne wat altyd opkom en die fisiologiese simptome na die ongeluk, wat sy gedrag beïnvloed, en dat hy sy humeur so verloor. Sou jy sê dis 'n betroubare ding om te sê? Die een ...
- P1: Ja, ja.
- R: ... met die *interne triggers*? OK. En dan, *eksterne triggers* is goed soos enige stres wat inkom, wat sy gedrag kan beïnvloed. En die een ding wat ek agtergekom het, was dis persoon-spesifiek ... met die kinders, sou jy saamstem?
- P1: Ja.
- R: Ja?
- P1: Definitief.
- R: Ja, enige iets te sê daaromtrent?
- P1: Nee, nie rêrig nie.
- R: So dis net die kinders. Een keer het jy genoem, hy toon nie rêrig aggressie teenoor jou nie.
- P1: Nee, nee, nie rêrig nie.
- R: Jy het net een keer genoem, met die alkohol beïnvloed dat hy dan 'n bietjie kwaad is, maar dis meestal met die kinders.
- P1: Ja, ja.
- R: En die ander een, nog een van die *stres triggers*, *eksterne triggers*, is die alkohol.
- P1: Mmm.
- R: Die feit dat hy alkohol in het, dan kom dit meer tevore?
- P1: Ja, definitief. En dis erger ook. Ja.
- R: Wat is erger? Hoe hy optree?
- P1: Ja.
- R: En is dit, jy't gesê, sosiaal, as hy sosiaal verkeer, dan is dit nie so erg nie?
- P1: Nee. Nie as hy by ander mense is nie.
- R: OK
- P1: Dis basies as ons as gesin is.
- R: Ja. So is alkohol nogal 'n ding wat hy sal ... 'n drankie vat, as julle net saam is en dan is dit 'n *trigger* wat gedrag kan beïnvloed?
- P1: Dis nie rêrig as hy 'n drankie ... net een byvoorbeeld. Een of twee kan nog gaan, maar sodra hy nou bietjie te veel, te veel drink, dan haak dit bietjie uit.
- R: En hoe gereeld gebeur dit?
- P1: Nie baie gereeld nie. Hy sal so twee, drie maal 'n week, soos een of twee biere drink. Maar sê maar, so een keer elke twee weke ...
- R: OK

- P1: ... sal hy nou regtig uitermatig te veel drink.
- R: Ja, ja, en dan is dit nogal 'n probleem?
- P1: Ja, definitief.
- R: Is dit?
- P1: So deesdae is ek al kwaad vir hom as hy net een bier drink.
- R: Is dit?
- P1: Ja, omdat hy nie kan verstaan nie.
- R: Want jy weet dis nie die einde nie, né?
- P1: Presies. Dis wat ek vir hom gesê het. Ek het vir hom gesê as hy stop by een is dit *fine*, maar ek weet hy gaan nie stop by een nie.
- R: Ja, *OK*. So dan in daai geval is dit ook, dan teenoor jou en nie die kinders nie.
- P1: Ja, hy sal byvoorbeeld 'n *fight* wil *pick* intussen.
- R: *OK*
- P1: Spesifiek wil *nasty* wees net om ...
- R: ... So amper meer vatbaar?
- P1: Ja, definitief.
- R: *OK*. So persoon-spesifiek, en dan alkohol is ook 'n *trigger*. En dan, ek weet nie of ek reg verstaan het nie, die werkloosheid, aan sy kant, en die finansies?
- P1: Definitief 'n stresfaktor.
- R: Dink jy so?
- P1: Hy voel basies asof hy niks beteken nie. Ek het dit al agtergekom 'n paar keer.
- R: Ja.
- P1: Byvoorbeeld, as hy vir my kwaad is dan sê hy vir my, ja, maar hy's mos *useless*, so ...
- R: Is dit?
- P1: Ja.
- R: So dit beïnvloed definitief sy gedrag?
- P1: Ja nee, definitief. En dink dis ook hoekom hy meer drink, want hy't nie so baie gedrink toe hy werk gehad het nie. Hy drink meer. Ek weet nie, dis seker maar om die stres te vergeet.
- R: Ja. En dink jy dis iets met depressie te doen? Dat hy drink?
- P1: Ek weet nie. Ek dink hy kan partykeer ... Ek dink dis hoekom hy drink, want dis meer soos 'n depressie asof hy voel hy beteken niks. Dis hoekom ek dink dit gaan goed wees, deurdat hy na die kinders kyk hy dan darem kan dink hy doen iets.
- R: Ja, en hy beteken iets.
- P1: Ja.
- R: Ja, maar dis steeds 'n tydelike ding, né?
- P1: Ja nee, dis tydelik. Sodra hy werk kry, en hy kan dadelik begin dan gaan hy begin, dis hoekom ons klaar 'n plan van aksie, 'n plek waar die kinders heen kan gaan.
- R: Ag *shame*. En, terwyl hy nou na die kinders kyk, gaan hy werk soek of nie?

- P1: Ja, ja. Ons soek maar nog altyd. Ek faks vir hom CV's deur en bel, en as hy vir 'n onderhoud gaan dan reël ek maar dat hulle of 'n dagkleuterskool vir die dag gaan, of dat iemand hulle nou maar kom haal, of ek reël af.
- R: OK. So dis ook 'n ding in sy agterkop seker, dat hierdie nie vir altyd is nie.
- P1: Ja, nee.
- R: Maar dis iets wat nou iets beteken.
- P1: Ja. Ek dink ek kan nie meer wag tot hy weer werk kry nie.
- R: En ook, bietjie minder stres in terme van die finansies, né?
- P1: Ja. En ek dink hy raak eensaam. Hy't niemand om mee sosiaal te wees nie. Ek meen, soos hulle sê mos die huisvrouens kom ook daai sindroom waar, hulle het nie sosiaal ... hulle kan nie met grootmense praat meer nie. Ek dink hy, hy't dit ook nogal. Hy't niemand met mee te praat nie, behalwe die kinders.
- R: En jy sê dis so teen sy persoonlikheid, want hy is 'n baie ...
- P1: O! Baie sosiaal, ja.
- R: So is dit net naweke dat dit gebeur? Die sosiaal ...
- P1: Ja, ja. Dan gaan hy maar partykeer, soos vanaand, gaan hy weer met sy vriende bietjie uit, net om bietjie uit te kom. Ek gun hom nou maar dit.
- R: So dit was die hoof *triggers* wat ek kon noem. Dis daai persoon-spesifiek, die alkohol en dan die werkloosheid.
- P1: Ja.
- R: Dink jy dis reg?
- P1: Ja.
- R: OK. En die ander gevolge na die ongeluk het ons bietjie gepraat oor sy kommunikasie. Maar nou, om te dink oor kommunikasie as 'n breë term, en nie net *chat* nie.
- P1: Ja.
- R: Eers sy woordvinding, het jy gesê dit kom nogal voor.
- P1: Ja.
- R: So dit beïnvloed sy kommunikasie definitief ... steeds.
- P1: Ek moet sê ek dink dit raak beter, met tyd.
- R: Mm.
- P1: Ek dink dit raak al meer beter, ja.
- R: Wat jy kan agterkom.
- P1: Ja, ja.
- R: OK. En dan sy nieverbale gedrag. Ek praat nou van sy lyftaal, en dat hy toepaslik op dinge reageer. En dit het ek agtergekem is baie beïnvloed deur sy aggressiewe gedrag soms, dat hy nie altyd toepaslik optree in 'n gesprek nie. Dis nou meer in 'n familiekonteks, maar sal jy daarmee saamstem?
- P1: Ja nee, definitief.
- R: So die aggressie kom daardeur dat hy nie altyd reg reageer nie.
- P1: Ja.
- R: Wil jy enigiets daaroor sê?
- P1: Nee.

- R: Laas keer was dit net dat hy probeer onthou, byvoorbeeld as BM iets doen sal hy heeltemaal oorreegeer.
- P1: Ja, ja. Maar ek moet sê dit raak ook beter as ek na hulle kyk.
- R: Is dit?
- P1: Hulle beweeg ... hulle twee kom nou bietjie nader aan mekaar.
- R: Want jy was bekommerd oor hulle twee.
- P1: Ja, definitief. Hulle begin nou nader aan mekaar beweeg.
- R: OK, goed. En dan die ander aspek is sy geheue en ek wou net bietjie daar by jou hoor. Dis nou nie in terme van sy woordvinding nie, dis in terme van gebeurtenisse, daai tipe goed. Jy't gesê dit was baie erger net na die ongeluk.
- P1: Ja nee.
- R: Maar nou is dit baie beter.
- P1: Ja, ja.
- R: En ek wou net by jou hoor in terme van sy korttermyngeheue, dit beteken die alledaagse gebeure en onthou van klein detailtjies, daai tipe goeters. Kom dit voor dat daar enige veranderinge daar is?
- P1: Nee, nie rêrig nie.
- R: Is dit?
- P1: Nee.
- R: So geheue is nie rêrig 'n aspek nie?
- P1: Al wat ek agterkom in sy geheue is byvoorbeeld as hy oor sy skooldae gepraat het, kon hy elke een se naam onthou, die onderwysers, maar nie nou nie, as hy daarvan praat, dan kan hy nie byvoorbeeld op die onderwysers se naam kom nie, of die een wat saam met hom was op skool. Dit kan hy nie byvoorbeeld onthou nie.
- R: En dit het verskil.
- P1: O ja, nee, voorheen het hy 'n verskriklike goeie geheue gehad. Ek kan nie eers al my onderwysers se name onthou nie en hy kon hulle onthou, al die onderwysers se name, al die kinders wat saam met hom atletiek gedoen het, hy't beide naam en van onthou en nou kan hy nie meer nie.
- R: Ja.
- P1: So dit het definitief verander.
- R: En net name, of die gebeurtenisse ook? Soos wat julle drie jaar terug gedoen het, of vier jaar terug gedoen het?
- P1: Nee, gebeurtenisse onthou hy nog *alright*.
- R: So dit is net klein detail soos name, datums, miskien?
- P1: Ja, want hy kan ook datums vergeet.
- R: OK. So dis meer daai ...
- P1: Ja, net klein detailtjies. Ja, sy korttermyn is nogal heel goed ... nou. Maar net na die ongeluk was dit bietjie erg. Toe kan hy omtrent niks onthou nie.
- R: Ja, ek onthou jy't gesê. OK. Dan het ons baie gepraat oor NM se veranderinge na die ongeluk, maar in terme van die aanpassing wat julle twee gemaak het in julle verhouding na die ongeluk: Wat het daar gebeur, of is dit steeds besig om te gebeur? Hoe het jy aangepas nadat die hele insident gebeur het?
- P1: Ek dink dis meer, dis nog besig om te gebeur, maar ek dink ek het baie, soos na die ongeluk het ek baie van, soos 'n ouer-rol gevat. Soos wat hy amper soos een van die kinders was.
- R: Ja.

- P1: Net verantwoordelikheid gevat, want hy kon dit nie hanteer op daai stadium nie. Ek dink daar het dit verander maar dis nou besig om reg te kom, want nou vat hy weer die verantwoordelikheid om na die kinders te kyk deur die dag, waar hy wou niks verantwoordelikheid vat nie, hy wou niks weet van die finansies nie, hy wou niks weet van enige verantwoordelikheid nie. Waar hy nou moet, hy's gedwing.
- R: En sou jy sê dis nou honderd persent nou terug na wat dit was?
- P1: Nee, definitief nie. Nee. Maar hy was in elk geval, voor die ongeluk, hy's nie 'n baie verantwoordelike persoon, ek's baie meer verantwoordelik as hy, byvoorbeeld soos finansies.
- R: Ja.
- P1: Sal ek al die geldsake in elk geval hanteer het, al het hy gewerk ... want hy is nie verantwoordelik daar nie.
- R: Jy's seker *geskilled* in daai area.
- P1: Ja.
- R: So dis besig om te verander.
- P1: Ja, ja.
- R: *OK. Alright.*
- P1: En ek dink dit sal nog beter word as hy werk ook het.
- R: En in terme van hierdie gevolge met sy gedrag na die ongeluk, daai aanpassings, met dit in gedagte?
- P1: Ja, dis bietjie, dis omtrent waar al ons bakleiry vandaan gekom het. Dis asof hy op die kinders afgaan, of drink, byvoorbeeld soos as ek sê ek raak nou vir hom kwaad, as hy net een bier drink, waar voorheen het dit my nie gepla nie, want voorheen was dit net een dan bly dit by een.
- R: Ja. Sal jy sê daai is steeds besig om te gebeur? Dis nie, daai aanvaarding en daai aanpassing is nie klaar nie?
- P1: Nee, nee, en dis nog besig om te gebeur, ja.
- R: *OK.*
- P1: En dis nog nie op 'n stadium waar ek dit kan aanvaar nie, want dis nog steeds vir my onaanvaarbaar, eintlik ...
- R: ... Ja. So dis 'n ding wat die hele tyd gebeur.
- P1: Ja.
- R: Daai aanpassing, as ek kan sê adaptasie amper, na hoe hy verander het.
- P1: Ja.
- R: *OK.* En julle verhouding? Het dit aangepas?
- P1: Ja, ek sou nie sê dit het rêrig verander nie, behalwe dat ek wil, byvoorbeeld soos, meer die verantwoordelike rol gevat het.
- R: Ja, en dit is nogal 'n aanpassing.
- P1: Dit is. Vir my veral. Ek kon nie altyd die een wees wat na iemand kyk nie, ek wil hê iemand moet 'n bietjie na my ook kyk nog.
- R: Dis amper 'n man se rol, né?
- P1: Presies, ja.
- R: Ja.
- P1: So hy't nou basies amper sy rol verloor.
- R: Ja, voel dit vir jou so?
- P1: Ja, ek dink dit voel vir hom ook so.

- R: Is dit?
- P1: Ja, ek dink dis wat hom die ergste vang.
- R: Ja, maar dis besig om weer terug te kom, stadig maar seker?
- P1: Ja, ja. Nee, ek dink so. Maar, ek weet dit gaan tien maal verbeter as hy net werk kry, dat hy weet hy weer kan *sort of* voel hy sorg nou weer vir ons.
- R: Ja.
- P1: Geldelik.
- R: Ja.
- P1: En 'n man se ego is mos naby aan sy ...
- R: Ons hoop dit gebeur vinnig! En dan die hele ervaring van die insident en die gevolge na die tyd en so. Dink jy ... dit was moeilik, oor die algemeen?
- P1: Ja.
- R: As ek 'n algemene stelling kan maak.
- P1: Ja. Dit was baie moeilik.
- R: Mm. En steeds?
- P1: Ja nee. Dis nou baie makliker, moet ek sê. Maar dit was, op daai stadium was dit baie moeilik.
- R: Ja, so meer 'n negatiewe siening op die hele storie as 'n positiewe een.
- P1: Ja nee. Daar's nie regtig positiewe punte nie. As hy opgehou drink het sou ek gesê dis 'n positiewe punt.
- R: So selfs nie nou nie?
- P1: Nee, nee.
- R: Niks positief nie?
- P1: Nee, nie regtig nie.
- R: En as jy die pad vorentoe kyk?
- P1: Jis, nou hoop ek maar dit gaan beter, want dit het beter begin raak die afgelope paar weke, as ek dit nou vergelyk met net na die ongeluk, het dit baie beter geword, so ek hoop net maar dit gaan net al beter en beter.
- R: Ja. So daai element van hoop is nog daar?
- P1: Ja, definitief.
- R: Miskien nie heeltemaal positief nie, maar meer negatief op hierdie stadium, maar ook, hoop is nog daar. *OK*, goed. Is daar enige ander aspekte wat jy aan kan dink wat ek uitgelaat het?
- P1: Nee.
- R: Verkeerd geïnterpreteer het, miskien?
- P1: Ek dink nie rêrig so nie.
- R: *OK*, ek dink dis dan alles. Jy't eenkeer gesê hy's voor ander mense net soos hy by die huis is, dis dieselfde mens. Is dit waar?
- P1: Ja, behalwe as hy alkohol in het. Maar as hy nugter is, is hy dieselfde mens altyd as hy nou sosiaal is of nie.
- R: Of by sy familie.
- P1: Ja.
- R: *OK*.

- P1: Nee, by die familie is hy eintlik anders as by ander mense, moet ek sê.
- R: Jou eie familie of ...
- P1: Nee, nee, sy familie.
- R: Hoe so?
- P1: Omdat sy susters die heelyd op hom, dis basies asof hulle die heelyd sê, “Hou op drink, doen dit, doen dat”. Hulle skryf vir hom voor en hy’s vreeslik, hy’s nie, hy’s nie soos homself as hy by hulle is nie, hy’s vreeslik teruggetrokke, hy praat nie eintlik nie, hy sal sit, hulle sal vir my sê hy’t die hele dag gesit dikbek by hulle, want hy is, hy praat nie rêrig met hulle nie, behalwe vir sy ma en pa, hulle is vir hom, maar sy susters ...
- R: Is hy bang vir wat hulle gaan sê of ... wat dink jy?
- P1: Ek dink nie hy’s bang nie, hy stel net nie belang nie.
- R: Ja.
- P1: Ek dink hy’s by daai punt verby.
- R: Hy wil nie soontoe gaan nie?
- P1: Nie eintlik nie, hy wil nie een van hulle eintlik sien nie. Dit het so erg geraak hy wil hulle regtig nie eintlik sien nie.
- R: Dit raak seker aan sy selfbeeld ook, nê?
- P1: Ja, ek wil, dis die grootste rede.
- R: Ja. As hulle net kon sien ...
- P1: Ja.

## **APPENDIX F: Interviews with Participant 2**



## Participant 2 (P2): Initial Interview

R refers to Researcher

- R: Die eerste vraag wat ek vir jou wil vra, is hoe sien jy kommunikasie? Wat behels kommunikasie vir jou?
- P2: Ek dink dis 'n baie belangrike aspek. Jy moet kan goeie kommunikasie hê om 'n goeie verhouding op te bou, en sonder jou kommunikasie dink ek nie enige verhouding kan sterk wees of het eintlik enige voet om op te kan staan nie, want jy moet al jou dinge kan uitsorteer en uitredeneer en ... jy moet praat oor dinge.
- R: Ja, ja.
- P2: Ek dink dis baie belangrik.
- R: Ja. So jy sê kommunikasie is die praat.
- P2: Ja, praat en ... Ja, ek dink praat is baie belangrik ... vir my.
- R: Ja. So dis vir jou die belangrikste. Dink jy kommunikasie strek verder as dit ... as net die praat?
- P2: Ja, dit doen seker in sekere mate maar ... ek weet nie, vir my staan praat bo alles uit, ek weet nie, praat en seker maar jou houding van hoe jy optree en wat jy uitstraal as persoon ... en van dit tog is (die) kommunikasiepunt in mens se lewe.
- R: So jy sê wat jy uitstraal beteken ...
- P2: Ja, jou houding, en hoe jy optree as persoon self. Of jy 'n negatiewe houding uitstraal teenoor ander mense of positief, of hoe jy optree, maar ...
- R: Mm, mm. En oor die algemeen of net in 'n gesprek?
- P2: Nee, ek dink oor die algemeen. Jou hele houding straal uit hoe jy as persoon seker maar is, dink ek. Jy kan maklik tussen of jy maar terughou en of jy 'n spontane mens is, of hoe ook al.
- R: En as ons bietjie wyer dink oor kommunikasie? Aspekte soos lees, skryf, luister ... dink jy dis ook deel daarvan?
- P2: Ja, dis maar alles op die einde van die dag, is maar deel van kommunikasie.
- R: Maar praat is vir jou ...
- P2: Ja, ek weet nie, (klein laggie) ek dink dis belangrik.
- R: Ja, dit klink so. En nou wil ek jou spesifiek vra oor NJ\* se kommunikasie. Beskryf dit vir my.
- P2: Hy hou van praat. Hy hou daarvan om sy emosies uit te druk, deur te praat en ook te wys hoe hy voel. Hy's nie iemand wat daarvan hou om alles in homself te hou nie. Hy hou daarvan om te wys hoe hy voel oor dinge en hoe hy, wat hy dink en dit wil hy graag uitdruk. Lees en skryf, (lag) nee, glad nie. Hy sal ... hy het vroeër jare was hy baie lief vir skryf, hy kon nogal mooi skryf op sy tyd, maar dis nou nie meer deel van hom nie.
- R: Is dit?
- P2: Hy's baie lui om te lees en hy's nie een vir daai tipe van dinge meer nie (klein lag). Hy sal eerder gesels.
- R: Het enige iets, dink jy, 'n invloed daarop gehad?
- P2: Ek weet nie ... van skool af weet ek was hy nog nooit een vir lees regtig nie. So dis maar iets wat hy probeer vermy. Hy's maar lui daarvoor, as ek vir jou kan sê, ja. Al is dit iets wat hy baie voor lief is, stokperdjies of iets, is hy baie lui om selfs daarvoor op te lees.
- R: So dis nie sy sterk punt nie.
- P2: Nee, glad nie (lag).
- R: So jy hanteer daai aspek by die werk (lag)?
- P2: Ja, ek hanteer daai aspek, as hy 'n *manual* of iets moet lees, is ek die een wat lees, hy sal doen.

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\* NJ refers to P2's spouse

- R: Is dit?
- P2: Hy's meer tegnies.
- R: So met sy kommunikasie jy't nou uitgelig meer die spraakaspek van hom. Enige ander aspekte wat jy wil noem?
- P2: *OK*, soos wat, ummm ...
- R: Jy't gesê nou in die begin daai kommunikasie is hoe jy jousef uitstraal en jou hele houding en so ...
- P2: Ja, hy's maar basies soos ek, jy ... ons altwee is meer geneig om te wys hoe ons voel deur ons houding en ons optredes en dié klas van dinge, maar nie regtig op ander maniere nie, soos eerder partykeer meer teruggetrokke as jy nou nie lus is vir die dag nie, en maar andersins maar, nie regtig op ander maniere veel nie.
- R: Ja, ja. En het enigiets verander in hierdie aspekte met die ongeluk in gedagte?
- P2: Um, kommunikasiegewys het hy vir my, direk na die ongeluk, was hy meer teruggetrokke, hy was meer stil gewees, en um, ...ek weet nie, hy het 'n bietjie verander na die tyd. Maar dit het nou, seker die laaste jaar en 'n half, is hy nou weer besig om meer te wees soos wat ek hom ken.
- R: Is dit?
- P2: Ja, so hy het 'n bietjie meer ingekeer geraak in homself en ... hy het nie maklik gepraat op 'n stadium nie, hy was maar baie teruggetrokke.
- R: Op 'n stadium?
- P2: Ja, dit was nou direk meer na die ongeluk gewees, vir 'n rukkie, en um, hy't nou die laaste so jaar en 'n half, het hy meer begin gesels, en meer oopmaak weer.
- R: So 'n jaar en 'n half, dis nou 'n jaar en 'n half waar hy meer stiller was ...
- P2: Dis hy ...
- R: Hoe was dit vir jou?
- P2: Dit was nogal partykeer, het dit frustrerend geraak want hy't altyd baie gepraat en sê hoe voel hy en wat dink hy en gewys hoe hy redeneer oor dinge, en in daai tyd het hy nie, so dit was nogal 'n aanpassing om te sien dit is nie nou daar nie en ek moet dit nou maar los ... en kans gee.
- R: Ja, ja.
- P2: En gelukkig is hy weer besig om sy ou self te raak (lag).
- R: En praat julle daaroor?
- P2: Ag, ja, ons het 'n baie oop verhouding so ons gesels baie ...
- R: Lyk so ...
- P2: Daar's nie iets wat ons ... as iets jou pla, dan praat jy daaroor en jy sorteer dit uit.
- R: Dis fantasties. Dis meer as wat ander mense kan sê, huh?
- P2: Ag nee, ons is baie oop met mekaar. Niks word teruggehou word of weggesteek nie.
- R: So in daai jaar en 'n half waar hy stiller was, hoe het ... het julle daaroor gepraat ... die feit dat hy verander het?
- P2: Ja, ek het vir hom, ek dink, na sy eerste sielkundige besoek wat hy moes deurgaan het daai tyd, moes ek 'n lys opstel van aspekte hoe hy verander het en hoe hy reageer nou ensomeer, en ek het dit neergeskryf en ek het gesê vir hom, "*OK* wel, dit en dit is hoe ek dit sien", so hy weet daarvan, ons het daaroor gesels en hy't net gesê, "Ag, ons moet maar tyd gee en kyk dalk verander dit of iets," want hy weet self dit is dinge wat verander het en gelukkig nou is hy weer (kop knik) sy ou self (lag).
- R: Sy ou self, ja.

- P2: So ons het gesels daaroor.
- R: So julle was oop selfs gedurende daai tyd.
- P2: Mm, ja. Hy was bietjie ... hy was nie so geduldig nie in daai stadium nie, dan sê ek weer, "Jy's nou weer kort van draad," so hy was bewus dat dinge nie heeltemaal was soos wat dit moet wees nie.
- R: Is dit?
- P2: Ja.
- R: So dit het ook verander van die ongeluk dat hy 'n bietjie *short-tempered* is ...
- P2: Ja, ja.
- R: Meer as gewoonweg?
- P2: Dis hy, en hy's eintlik nog altyd vandat ek hom ken 'n perfeksionis gewees, en daar was 'n tyd gewees wat hy, dit was ook maar laks gewees, waar hy nou 'n ding so aanpak dan is dit nou klaar, dan's dit, "Ag, ek's nou nie lus om klaar te maak nie," dan los hy dit. En ek dink van dit het hy nog 'n bietjie oor gehou (lag). Hy is nog 'n perfeksionis, maar hy sal partykeer nog bietjie, ag, "Nee ek's nie lus om dit nou te doen nie." Daai vlammetjie wat daar moet wees is nie meer daar nie.
- R: Is dit?
- P2: Ja.
- R: En dit was nie altyd so voor die ongeluk nie?
- P2: Ag nee, hy was 'n *go-getter* gewees en hy's nou bietjie meer, ek weet nie, daar kort iets met daai vlammetjie nou.
- R: Het hy verwag dit gaan gebeur?
- P2: Nee.
- R: Ek bedoel daai dinge wat na die tyd gebeur, mens is nie altyd ...
- P2: Nee, jy's nie, ... ek dink nie jy dink daaraan nie, jy dink aan ag, hy was in 'n ongeluk gewees, so wat kan ek ... alles moet mos maar aangaan soos wat dit was, en ek meen dis tog dingetjies wat verander het en dinge wat jy moet by aanpas.
- R: Ja. En is dit net dingetjies wat jy agterkom?
- P2: Wel ... ek dink soos my ma-hulle wat ook baie na aan hom was, daai stadium, en nog steeds is, maar ... hulle het ook maar die dingetjies agtergekomp dat hy bietjie meer, hy's net 'n bietjie meer ... onrustig partykeer gewees op 'n stadium daai tyd ... en um, toe't hy weer op 'n stadium gekom waar hy net te rustig is, want hy't gaan sit en stilsit vir ure wat hy niks doen nie, maar dit pla hom nie ...
- R: Net daai passiwiteit ...
- P2: Ja, en dis nie hoe hy was nie, hy was altyd besig, altyd besig gebly. So hulle het dit ook in 'n sekere mate agtergekomp en ... uh ... maar toe moet ons dit maar los. (Trek skouers op)
- R: En hy self? Hoe het hy... het hy dit agtergekomp?
- P2: Ek dink nie hy het dit so agtergekomp nie, maar wat hy wel vir my gesê het, is dat hy ja, hy het nie meer daai lus vir dinge nie en hy het nie meer daai um, hoe kan ek sê ... daai motivering wat 'n ding aan te pak en hom klaar te maak partykeer, dis vir hom 'n bietjie *slack* gee ...
- R: Deursettingvermoë ...?
- P2: Nee nie regtig nie, dis 'n bietjie weg.
- R: Maar praat jy van deursettingsvermoë om 'n ding te begin en klaar te ...
- P2: Ja, te begin en klaar te maak, ja.
- R: OK, so meer daai inisiëring van iets.

- P2: Ja, dis hy, ja. Maar tog as hy 'n ding begin, en as hy wil, dan maak hy hom klaar (lag).
- R: Ja. Het jy dit agtergekom nou?
- P2: Ja, ag, hy kry maar nog dae waar hy 'n bietjie laks is, maar dis eintlik minimum, maar dit is maar nog daarso.
- R: Ja, ja.
- P2: Maar dis net partykeer 'n aanpassing vir 'n mens van hoe hy was na wat hy toe was (klein lag).
- R: Ja, en dis net in daai jaar en 'n half jy sê in die afgelope paar maande, of jare ...
- P2: Ag ja, gaan dit nou heelwat, hy's seker eintlik vir my nou heel *fine*, dis maar meer daai eerste jaar en 'n half was vir my bietjie baie, jy kon dit duidelik agterkom ... dit was partykeer baie frustrerend gewees.
- R: Vir jou ... ?
- P2: Ja, en ek dink vir hom ook in 'n sekere mate, maar ... soos ek sê, dit gaan gelukkig beter.
- R: Ja, dit lyk so – julle lyk aan die gang en ...
- P2: Ja, heel bedrywig.
- R: Jou skedule klink baie vol ...
- P2: Ja, hou onself uit die kwaad uit. (lag)
- R: Ja, ja. ... Maar jy sê hy nou ... in daai tyd het hy ook bietjie gefrustreerd met homself gevoel. So hy het ook besef ...
- P2: ... daar ... iets is anders. Ja, ek dink wat hom ook baie gefrustreer het in daai tyd is, veral direk na die ongeluk, ek dink die eerste maand, twee maande het hy baie keer, as hy fisiese werk wou doen, het hy nie die krag gehad om dit regtig te doen nie. Dit was asof sy krag was uitgekap gewees en omrede hy iemand is wat altyd sy dinge self doen, self kyk, na homself, en alles, en ewe skielik het hy bietjie magteloos gevoel. En ek dink die ding wat hom nou frustreer is die feit dat sy rug so bietjie vir hom moeilikheid gee en dit is iets wat hom nou terughou en dit is iets waaraan hy gewoond was.
- R: So die gevolge langtermyn ...
- P2: Ja, is maar daarso ...
- R: Ja.
- P2: ... en ek dink dit is iets wat hy besef hy sal daarmee moet saamleef en dit is iets wat jy nie weet vorentoe wat jy meer voor het nie, maar dis darem nie 'n daaglikse ding wat daaglikse probleme gee nie, maar dit is maar van tyd tot tyd daar.
- R: So baie het verander né?
- P2: Jaaa, dit het seker, maar mens kom dit nie regtig eintlik ... as jy nou teruggink daaraan dan dink jy, "Ja, daar was baie," maar dit voel nie nou meer so nie.
- R: Ja, ja. Maar het dit gevoel ... jy't gesê daar was dingetjies wat jy eintlik nie kon *pinpoint* nie, maar dit klink asof jy het al klaar daaroor gedink.
- P2: Ja, ek dink mens, jy tog, ja, daar's seker maar baie tyd waar mens tog besef het daar is maar dinge wat vir jou uitstaan en dis uitgelig vir jou en jy besef, daar is, dis definitief daar ... en jy's bewus daarvan.
- R: Ja, ja. So die kort-van-draadheid is nou ...
- P2: Ja-nee, hy's nou weer heel, sy selfdraad, ja-nee, heel rustig. (lag)
- R: (lag) ... Was dit 'n probleem gewees?
- P2: Ag nee, nie regtig 'n *probleem* probleem nie, dit was seker nie so groot probleem, maar dit was daar, dit is nie dat dit nie was nie, hy sou nou 'n ding begin het en geduldig aangesukkel het tot hy hom nou regkry en klaarkry maar, en vinnig is hy nou "Ag, ek sukkel, ek los dit sommer," en dan draai hy om en loop hy weer liewers ...
- R: En as jy sê sukkel, sukkel nou as gevolg van die ongeluk?

- P2: Ja, ek dink dit was in 'n mate gewees, soos ek sê het hy partykeer sy fisiese kragte was nie daar nie en dan sukkel hy baie en dit het hom *baie* frustrer, en ek dink dit was seker vir hom op 'n stadium die ergste gewees om nie te kan doen wat hy altyd gedoen het op daai stadium nie ...
- R: Ja ...
- P2: ... ek weet nie, en hy't ook baie kopsere gekry wat hy nie ken nie ...
- R: Kort na die ongeluk, of ...
- P2: Ja, na die ongeluk het hy baie gekry en seker vir 'n jaar daarna en ons was vir 'n opvolgbesoek gewees, seker so ... amper twee jaar later, toe't hy nog steeds baie kopsere gehad.
- R: Nie aanhoudend nie ...
- P2: Nee nie aanhoudend nie, dit was, dit begin en dan kan hy maar medikasie gebruik maar dit gaan nie altyd weg nie, en tot dit darem op 'n punt nou gekom het waar dit redelik stil is weer.
- R: Is dit? Gaan hy nog vir opvolge?
- P2: Nee, glad nie meer nie.
- R: Is dit?
- P2: Nee, maar net die rug wat partykeer probleme gee wat hy moet gaan vir inspuittings en ensomeer, maar dis darem nie soos ek sê ... ons weet nie wat vorentoe gaan voorlê nie (lag)
- R: Uh-huh. Maar sover gaan dit goed?
- P2: Ja-nee.
- R: Ja. En enige ander probleme wat jy of hy opgetel het net na die ongeluk? ... Party mense noem geheue ...
- P2: Ja, weet jy, wat geheue aanbetref (lag) dit is nogal 'n ding wat hy ... hy't *genuine* 'n geheue soos 'n olifant altyd gehad, maar ek weet nie (lag), deesdae kan jy vir hom 'n ding sê en hy sal hoog en laag sweer jy het dit nie vir hom gesê nie (lag).
- R: Is dit?
- P2: Ja, so partykeer dan dink ek die geheue laat hom in die steek ... en ek kyk nou die naweek toe ons in Sabie was, toe praat ek oor een of ander plek daarso sê hy, "Jis, ek weet nie dat ons daar was nie," en dan was ons by die plek gewees en gesels ek en dan begin ek nou goed opnoem, dan sê hy, "Ja, dit klink bekend," maar hy kan nie onthou wanneer dit was nie ...
- R: En dit was nou onlangs gewees?
- P2: Ja, dit was nou die naweek gewees.
- R: So dis rêrig daai kort ...
- P2: Korttermyn geheue dink ek of ek weet nie of jy dit regtig langtermyn kan noem nie, daar is sekere omstandighede waar daar is duidelik 'n *blank* vir hom, soos ... ag, seker so verlede jaar, het hy vir die eerste keer wat ons oor die ongeluk gepraat het eendag weer, toe't hy genoem, ja, hy onthou van die slag, hy kon nooit die slag onthou nie, en nou sê hy hy onthou nou van die slag en begin nou goed wat hy hom *recall* wat gebeur het met rukke, maar daar is nog maar *blanks* wat hy het en daar is maar met rukke goed wat hy nie regtig kan onthou nie.
- R: Praat jy nou spesifiek van die ongeluk?
- P2: Nee, oor die algemeen.
- R: O, oor die algemeen ... OK. So meer episodes ...
- P2: Ja, ag, goed soos ek sê plekke waar ons was of ...
- R: Klein details ...
- P2: Ja, klein, simpel goedjies wat hy oor die algemeen sou onthou het ...

- R: Uh...
- P2: ...onthou hy partykeer nie.
- R: So dit was nie altyd so ...
- P2: O nee...
- R: ...voor die ongeluk nie...
- P2: Nee, hy was altyd die een wat alles onthou het, ek sou eerder bietjie vergeet het van goedjies en wat ook al ... en hy sou my altyd herhinner, maar dit het nou net ... hy's maar meer ... bietjie vergeetagtig op party goed, ek weet nie of hy dalk net nie ingestel is op sekere goed of wat nie ...
- R: En pla dit hom nogal?
- P2: Um, ag nee, ek sal nie sê dit pla hom regtig nie, maar partykeer dan kan ek sien hy twyfel nou: "Het dit gebeur of het dit nou nie gebeur nie?"(lag) Hy twyfel 'n bietjie in homself en tot hy seker maar bietjie dink daaroor en homself daarop kan stel dan sal hy sê, "OK, ek onthou dit nou".
- R: Is dit? So dis interessant, dis meer gebeure as woorde wat ...
- P2: Ja, dis hy. Nie regtig ... soos jy kan hom enige iets vra van sy kleintyd af ... hy sal vir jou enigiets kan vertel daaroor. Dit onthou hy baie goed, maar intussen ... ek sal sê amper in 'n bestek van die laaste ... sê vyf, ses jaar, is daar sekere goed wat hy nou nie kan lekker onthou nie. So dis nie 'n baie lang tyd nie, maar dis ... omtrent daai tydsaspek.
- R: So dis definitief ook 'n aspek?
- P2: Ja, dit moet seker wees, want dit is iets wat nooit so was nie ... en dit is iets wat hy en ek altwee opgetel het. Want ek het eers gedink dit is net miskien, ag, verbeel jou maar, tot hy self dit begin agterkom het as daai goed begin, mmm ... dan kan hy nie dadelik *pinpoint* wat's dit of waaroor gaan dit nie.
- R: So omdat dit gereeld gebeur, kom jy agter, wel ...
- P2: Ja, ja, ag nee, dit gebeur so 'n paar keer in 'n maand, maar nie baie nie, maar dit gebeur.
- R: Mm.
- P2: Nou nie 'n groot problem of 'n ...
- R: Dit affekteer seker nie die werkinkomste of so nie ... (lag)
- P2: Nee (lag), nee, darem nie. (lag)
- R: OK.
- P2: Nee, maar andersins is hy *fine*.
- R: Is dit? Dit klink so.
- P2: Ja. (lag)
- R: Ek's bly. Daai kommunikasie in 'n verhouding is ... niemand kan dit *match* nie.
- P2: Nee, nee, dis wat ek sê. Dis vir ons verhouding baie belangrik.
- R: En dis ook seker hoe jy deur alles ...
- P2: Ja, ons praat maar altyd, ek's eerder meer geneig om in 'n gat te kruip en hy sal eerder nou weer praat, maar oor die algemeen hou ons daarvan om ons dinge uit te *sort*, praat en kry dit oor en verby.
- R: Ja.
- P2: En ek voel dit help ons baie.
- R: Ja.
- P2: Pak elke dinge maar aan soos dit kom.

R: Dis wonderlik. Dankie, AJ\*.

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\* AJ refers to P2

## Participant 2 (P2): Follow-up interview

- R: Die eerste ding wat ek agtergekom het, die tema wat nogal voorgekom het, is gevolge na NJ se ongeluk.
- P2: Mm.
- R: En die een ding wat jy nogal baie genoem het is daai, jy't genoem daai vlammetjie wat weg is?
- P2: Ja.
- R: En ek het genoem, in Engels praat ons van daai *drive*.
- P2: Dis reg.
- R: Daai dryfkrag.
- P2: Daai dryfkrag, ja.
- R: Ja, is ek ...?
- P2: Ja, die dryfkrag is weg, hy kom met rukke terug, maar hy's nie daar waar dit moet wees nie. En dis ook nogal 'n groot leemte eintlik. Ek glo enige ou het daai dryfkrag nodig in jou lewe, om vorentoe te gaan, om jou te motiveer, positief te hou.
- R: En daai deel is nou ...
- P2: Ja, hy's nou bietjie, ja, hy's anders. Hy's nie wat hy moet wees nie. Jy weet, enige ou raak negatief, seker maar depressief soos hulle sal sê, maar ek dink syne is nog meer weg as wat hy moet wees.
- R: Ook afhangende van ...
- P2: Omstandighede ja, omstandighede speel 'n groot rol, maar um ... as ek dink, daar is maar 'n leemte.
- R: Mm. So ek was reg om te sê dis 'n ...
- P2: Dis 'n raakpunt, ja, definitief.
- R: Die ander ding is die fisiese veranderings. Jy't gesê sy rug wat pyn soms en daai is die grootste eintlik.
- P2: Ja, ja. Dit hou 'n groot gevolg in die sin dat dit raak hom fisies as hy werk, dit raak hom as hy byvoorbeeld as hy wil sosiaal verkeer kan hy nie altyd nie, so hy moet hom distansieer van sekere dinge om te doen partykeer.
- R: Hoe bedoel jy sosiaal verkeer? Soos in hardloop en ...
- P2: Soos fisiese dinge doen saam met vriende en, so hy sal baie keer *uitchicken* op sekere goeters wat hy vroeër sal hy gedoen het, sal hy nie nou nie.
- R: Ek hoor jou ...
- P2: En dit is ook goed wat ons saam sou gedoen het wat ons nou maar moet vermy om dit te doen.
- R: So dit eindig nie by die fisies nie, dit beïnvloed ander areas ook ...
- P2: ... ander areas ook, ja ...
- R: *Alright*, en dan sy geheue?
- P2: Raak beter! (lag)
- R: Maar dis definitief 'n gevolg.
- P2: Dit is 'n gevolg, ja, ja. Daar is maar nog steeds sekere dinge wat uitgeskakel word, wat hy nie onthou word nie en ander dinge weer wel, maar dit is ook 'n definitiewe punt wat hy aangeraak is, en bietjie stadig raak partykeer.
- R: En dis daai wat ek genoem het van klein details wat hy ...
- P2: Ja, wat hy nie onthou nie ...



- R: En gebeure ...
- P2: Dis reg ja, gebeure, plekke waar hy was en situasies waar hy in is en meer jou langtermyngeheue ...
- R: Meer langtermyn, so nie rêrig korttermyngeheue nie?
- P2: Nie rêrig korttermyn nie, langtermyn sal ek meer sê dinge wat lank terug gebeur het, voor die ongeluk, al daar is insidente waar hy korttermyn ook is, maar dis in die minderheid.
- R: Dis in die minderheid?
- P2: Ja, mm.
- R: Soos in gesprekke wat jy gister gehad het ...?
- P2: Ja, dit gebeur, maar dit is nie so opvallend soos die langtermyngoed gebeur nie, ja.
- R: Ja, OK. Goed. Dit was vir my die drie hoofgevolge na die ongeluk. Is dit ... is daar enige ander areas wat so in jou kop inkom?
- P2: Nee, dit is die drie hoofdinge gewees. Die ander situasies kan ek nie regtig onthou nie.
- R: Ja, OK. En die ander area, jy't genoem ... jy't ook baie gepraat van jou aanpassing en jou *adaptation* na die ongeluk ... dat jy besig is om ... jy't baie gepraat van om te aanvaar ... en 'n paar maande na die tyd was hy só, maar nou is hy só, so daai tydsaspek en aanpassing na die tyd, vir jou en vir hom. Is dit nogal 'n groot een?
- P2: Ja, ja, gereeld. Soos gister was ons in 'n situasie waar 'n taxi agter jou is en jy speel nog gereeld daai situasie af, so dit is nog steeds in jou geheue en jy's nog steeds skrikkerig en jy's nog steeds bewus van die hele ongeluk en die hele situasie en die ongemak en al die goed waardeur jy moes gaan, so dit bly maar in jou, en jy kom nie verby daai punt nie.
- R: Ja, ja. En daai drie gevolge wat ek genoem het, die aanpassing rondom dit? Sou jy sê dis al aangepas of is dit nog besig ...?
- P2: Ek dink dis nog in die proses. Ek dink dis nie regtig aangepas nie, dis maar 'n ding wat ... hy bly en ek dink jy moet op een of ander stadium moet jy seker verby hom kom, maar nog nie heeltemaal nie.
- R: Maar dis definitief een van die temas as ek dit so kan noem, daai aanpassing wat plaas moes vind omdat hy bietjie verander het in daai areas.
- P2: Dis reg, ja.
- R: En van sy kant af ook.
- P2: Van sy kant of ook, ja. Definitief. Hy raak partykeer ongeduldig as hy, as ek vir hom sê het ek dink so, dan sê hy, "Nee man, dit was nou so," so hy twyfel homself, maar hy twyfel my dan ook en dan moet jy hom nou oorreed, "Hoor hierso"... (lag) Partykeer dan los jy hom net, om hom nie in 'n verleëtheid te stel nie en vir sy selfvertroue dink ek ook maar, want anders dink ek hy sal homself baie begin wantrou seker ...
- R: Ja, so jy speel die goeie vrou ... (lag)
- P2: Ek weet nie (lag)... ek dink enige iemand sal dit doen.
- R: En dan, AJ, dan definitief kommunikasie as tema.
- P2: Ja, dis vir ons baie belangrik. Praat baie.
- R: En dit is selfs met die ongeluk nie eers in gedagte nie, dit was altyd daar ...
- P2: Dit was altyd daar ...
- R: ... en nog steeds baie belangrik, ja.
- P2: Ja, ons maak 'n punt daarvan. Nie om gevoelens op te krop nie, te sê as dinge pla of snaaks voel oor iets of ...
- R: Dink jy daai goeie kommunikasie het gehelp om deur daai drie gevolge te werk?
- P2: Ja, ek glo so want jy's bewus van hoe die ander een voel en wat hy dink ek wat hy beleef en ek dink dit is 'n goeie ... ek weet nie, dit moet deel wees van jou, en dit maak dit dan makliker seker as wat jy stilbly en weet

nie wat dink die ou of wat ervaar hy, hoe voel hy, of hoekom voel hy miskien 'n bietjie af. Dis belangrik om te kommunikeer.

R: So dis baie deel van jou en van NJ.

P2: En van hom, ja. Ons altwee.

R: *OK.* So dit was baie ... dit het sterk voorgekom. En dan die hele ervaring om die ongeluk, oor die algemeen was vir julle maar moeilik.

P2: Ja, ja, ek dink dit was moeilik in die sin dat dit gebeur altyd met iemand anders, dit gebeur nooit met jou nie en die feit dat dit so onverwags was, jy's rustig by 'n robot en dan skielik hierdie oorverdwende slag en alles, jy verwag dit nie, so ek dink dit is nogal 'n *issue* om verby te kom en te dink dit kan gebeur en dit gebeur so skielik.

R: En die aanpassings wat jy moes maak.

P2: Ja, die hele ding wat jy moet deurgaen, van die ongeluk af, van die ongelukstoneel af, van die opneem in die hospital en die ambulans, dit is alles wat jy, ek dink nie enige mens wil dit hê nie en ewe skielik word jy gekonfronteer daardeur en jy moet dit beleef, jy moet daardeur. Ek dink dit is bietjie 'n moeilike, ongemaklike situasie.

R: En definitief meer negatief?

P2: Ja, nee, definitief meer negatief, jy sien geen positiewe sy daarin nie. Jy sê dankie dat hy lewe en jy sê dankie daarvoor, dit kon erger gewees het, maar die feit bly staan dit is nie lekker nie.

R: Selfs nou.

P2: Ja, dit kon erger gewees het, daar kon groter skade gewees het, maar jy bly dink daaraan. Jy vrees vir volgende keer.

R: Ja, en dan in ons gesprek het jy partykeer gesê hy's besig om sy ou self te raak. Maar ander kere het jy gesê hy is nou sy ou self. Watter een van die twee sou jy sê?

P2: Ek sou sê hy's meer besig om sy ou self te raak. Die negatiewe deel van wat hy oorgehou het is nie so sterk soos wat hy weer homself begin raak. So dit kom meer na vore as wat hy geword het na die ongeluk.

R: Nog nie honderd persent nie?

P2: Nee maar dit is definitief beter, ja. Definitief sterker op hierdie stadium.

## **APPENDIX G: Interviews with Participant 3**

## Participant 3 (P3): Initial interview

R refers to Researcher

- R: SM\*, the first question I would like to ask you is: What does communication entail for you?
- P3: Communication?
- R: Mm.
- P3: Communication ... I don't know whether maybe I put it in the wrong side, or the right side ... communication, me and my wife ... (brings two index fingers together side by side) OK, let's say if I have done something wrong and then my wife she says to me, 'Hey, my husband' or she talk to me or whatever, 'Today you have drink too much, I don't like it'. And then what I'm going to answer or what I'm going to say, 'Ah, sorry dear, I didn't expect that', and then I will drink so much to come to that 'stage', so I'm sorry for that, you see?
- R: Uh-mm. So communication is ...?
- P3: Uhh ... it's what I've just explained. If I've done something wrong ... my wife ... and then she say, 'I don't like this' ... Communication, I'm going to say ... alright, let me put it this way ... I say, 'Sorry, I've done this wrong, forgive me, I won't do it any more'. That's communication (brings two index fingers together side by side), good communication.
- R: So it's being honest with each other?
- P3: Exactly.
- R: Alright.
- P3: Like now, my children, that one, she feel want to go to that other school, over there, I must pay a lot of money, like now, OK I'm not working, you see, so me and my wife we sit together and we explain ... let's give him that opportunity, she must go there, see, if we can't do that and then tomorrow ... she fail at school, she's going to blame us, 'You didn't give me that opportunity because my friends at school they went there so I was not happy' ... that's the good communication.
- R: OK, yes ... So the communication you're describing now is discussing.
- P3: *Ja*, me and my wife.
- R: OK. Any other aspects of communication, if we look a little wider in terms of communication? You focused on the speaking part, what about other parts like listening, reading, writing?
- P3: Exactly, one, if I don't understand, and then you will say, 'I'm sorry, come again? What did you say?' And I'll explain ... and I'll say, 'Oh ... it's like last, the time when you phone, I was sitting that other room.'
- R: Yes ...
- P3: I was alone there, and thinking: I'm not working, but what's going to happen? I must pour petrol in that car and I must buy food ... and ... I don't know what's going to happen but ... it's what I've told myself – Jesus is there. If I pray, things will be easier, it's true.
- R: Yes.
- P3: After you have just phone me you know what happened? You didn't know OK, let me explain to you. That uh ... what they call ... uh ... that embassy ... it's uh ...
- R: The British Embassy?
- P3: No, no, no, that's where I was, at ... UNF.
- R: Mm-mm.
- P3: And they phone me, they always give me temporary job. One week, two weeks, one weeks, two weeks, after ... I'm just speaking to you, then phone me they say, 'SM, that (points with hands) you must come, actually tomorrow.' I'm going there, they're going to give me the card, that swiping card. They offer me a job for one week ... So thanks God, I was worrying about ...

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\* SM refers to P3

- R: That's great.
- P3: *Ja, ja* (laughs).
- R: So coming back to that understanding part of communication, that's obviously very important to you as well then, to clarify the information that comes in.
- P3: *Ja*, understanding, you see, like the way I'm sitting, especially in English (laughs), English, if like now OK, we speaking together, in English uh, I'm not so good in English, I grow up during apartheid time so, now let's forget about that, OK. Understanding, I sit like this in English (sits forward in chair with arms folded and resting across knees) OK, OK, if, you say, How's my hands? It's not, you don't underst ..., you don't listening, (puts head down) you are not interesting ...
- R: Oh, I hear you, so it's your body language (points to his body)?
- P3: *Ja, ja*, exactly. In English, ... you see, you sit like this (sits with back against chair and puts on a high-pitched voice) 'Ah SM, it was raining, I went to my mother-in-law's place, it was so raining when I came it was raining.' Now from there, after the comment, after tears, you know, you drink beer, not so much, to don't cry any more, well you're cry but, not so much, little, little. That day, you must forget that person (points away from himself) who have passed (shows drinking with his hands).
- R: Mm. I'm not sure I'm understanding you correctly now though. We were speaking about the nonverbal language, about your body language?
- P3: Body language, *ja*, body language OK, *ja*, I'm sorry (gives a little laugh). Body language ... the way we talk, and then, seriously, you must look the person straight to the eyes (points with his fingers from R's eyes to his eyes) ...
- R: OK, and that's important for you?
- P3: *Ja*, very important. And when you talk, you don't throw hands like this (flings hands in the air).
- R: Mm-mm.
- P3: And you can't do like this (folds arms up against chest).
- R: OK.
- P3: If you fold your hands, it means that you don't ... I mean, you don't listen (folds arms up high against chest).
- R: You don't want to talk. So your body language is very important in communication, for you?
- P3: *Ja, ja, ja*. And, you must look that person straight (points to R's eyes). I'm sorry to do that to you (gives a little laugh)!
- R: No, but I hear what you are saying.
- P3: And like this ... If I'm talking lies, you'll see me from the face and the body language (points to his chest).
- R: OK, good ... alright.
- P3: (Laughs)
- R: Now I want to ask you, can you describe to me, your wife's communication? Let's talk a little bit about that.
- P3: My wife's communication ... I like it that one, it's very important. One, OK, if I don't want this, let's say ... uh, how can I put it, as simple as ABC, ... I don't like chicken, I like fish, my wife, she cook fish nicely, the way I like it.
- R: Mm-mm. Is that ... communication?
- P3: *Ja*, it's communication because if, if it's not communication, OK, she will cook beef or stew meat ...
- R: So is it an understanding?
- P3: It's understanding and a good communication.
- R: So am I understanding you right by saying she understands that you prefer fish and that's why she cooks fish?
- P3: *Ja*, yes, exactly.

- R: She understands you. OK, let's talk about her communication. You described it as the spoken language, as body language ... Tell me a little bit about that, from her now, specifically.
- P3: Body language ... sometimes, like now, my children, they are not here, OK. My wife sometime she sitting there (shows one couch), OK? I'm sitting there, (shows another couch) OK? We don't talk, we just look each other and find out the TV it's on, and just look at the TV, then we turn, we look each other, you see, and then we talk, but, we don't, ... how can I put it, mm, we don't answer each other, or each other doesn't answer but, the way we sitting like this (looks purposefully into R's eyes), we talk.
- R: Just by looking at each other.
- P3: Exactly.
- R: OK, OK.
- P3: *Ja, ja ...*
- R: And what about in a conversation, with the two of you?
- P3: Say it again, I don't understand that.
- R: When – you said communicating is also about communicating verbally and discussing ...
- P3: *Ja*, and body language...
- R: Yes ...
- P3: And to look each other ...
- R: Uh-huh. But now specifically in spoken language, tell me a little bit about that.
- P3: It's what I've just said earlier, you see, OK, I don't like chicken, I like fish, OK, I don't say OK, I won't buy fish just because I like chicken, you like fish, I buy fish, I like chicken ...
- R: And now SM, if we take the accident into consideration, the communication considering the accident ...tell me a little bit about that.
- P3: About the accident, I was at work, on duty.
- R: Mm-mm, but I'm talking about now.
- P3: *Ja* now, OK, alright, what happened OK, it's fine, from there and then um ... I was uh worried because my wife, I used to talk to him, then I ask him did your sister come today? And then: 'I didn't see anybody'. I was worried.
- R: Is this in the hospital or now?
- P3: *Ja, ja*, no, in the hospital.
- R: Uh-huh.
- P3: And then after, OK, and then the doctor, then he says its going to take a little bit while, three to four months, but she'll be alright. And then exactly, she's alright.
- R: Now?
- P3: No, really, she's alright. I can't remember from when until when, but she's alright. Since she came from the hospital, (puts hand on head) OK, the doctor, he has said to me, 'If you talk to your wife, don't talk faster, slowly' ... If you are upset you say (in a loud voice) 'Why you take this thing and put it there?' ... no, no, no (quietly) 'Take this one and put it there'.
- R: So are you more aware of the way you speak to your wife now?
- P3: Exactly.
- R: More than before?
- P3: More than before.

- R: OK.
- P3: *Ja* and ... it's what I've just said earlier ... I mean, I don't talk faster, (hands motioning to show steps) slowly.
- R: Do you think she needs that? Do you think she needs you to talk slower?
- P3: She need that. She enjoy actually, she enjoy. If I talk faster, somehow, she says to me, 'I didn't hear, what did you say?' (puts hand to his ear) What you have said?' You see, if I talk slowly (shows thumbs up).
- R: OK. Was it always like that? Or before the accident ...
- P3: ...No, no, no. Before the accident, I don't want to tell you lies, before the accident I used to talk fast, I say ... (imitates himself) uh-huh I say, 'What you say this one you can put it there' (moves his hands around on the table to show movement), you know and then fast, but ...
- R: And she could understand you then?
- P3: Yes, before, but ... before she get the accident, the way I just said, the doctor said, 'Talk slower' ...
- R: And you felt that that's important.
- P3: It's very important, because sometimes I forget, and I talk fast and my wife say (put hands over ears) 'I didn't hear', and I say, 'No, I've told you, you must take my sunglasses' *ja* ...
- R: And I just want to clarify, is it that she doesn't *hear* you or is it that it is slower for her to *process* (points with hand to head to show 'understanding') what you've said?
- P3: No, she hear, she hear, but to *process*, it's just because, the accident, *ja*, the accident, so, that's why (screws up face to show confused look) ... mm ...
- R: So it takes her a little bit longer ...
- P3: *Ja* ...
- R: ... to do things ... and to respond to you.
- P3: Yes, and then uh, too, when I talk to my wife, I don't talk faster, ... slowly (shows hands motioning from fast to slow) and then she understands, she understands..
- R: OK.
- P3: So that's why they say – good communication.
- R: Alright. And that's the spoken language. What about her spoken language?
- P3: It's very good.
- R: What's very good? Explain that to me.
- P3: It's very good, because when I spoke to my wife, I spoke slowly, she understand, and even when ... she answer me, slowly nicely, nicely and sometimes, actually how can I put it, she's better than mine ...
- R: Is that so? (laughs)
- P3: Yes, she's 100, 100 per ... 100 *ai*, whatever you say, my English is not very good.
- R: 100 percent better, is that what you wanted to say?
- P3: Yes, yes.
- R: So would you say that she is a better communicator than you?
- P3: Exactly, exactly.
- R: Really?
- P3: Exactly. But when I talk fast. (screws up face again)
- R: Aah, aah. So it is the understanding part for her that's really been affected after the accident, am I right?

- P3: Yes, exactly.
- R: And the spoken part for her after the accident?
- P3: Well before it was not good, but now, I really think it's ...
- R: What do you mean before it was not good?
- P3: Uh, the time when she was involved in the accident, she didn't remember, like even now you can ask him (raises shoulders).
- R: So you're talking now before, it wasn't good, you mean before, when she was in hospital?
- P3: Say it again.
- R: You said **before**, her spoken language wasn't so good, but now it's good, you mean while she was in hospital it wasn't good?
- P3: No, it wasn't good.
- R: You don't mean before the accident?
- P3: No, no.
- R: OK. So she struggled to communicate while she was in hospital.
- P3: *Ja*, but now ... she's fine.
- R: And her understanding?
- P3: It's clear.
- R: OK. Are there other parts of her communication that you notice that are different. The last nine months?
- P3: Alright, after this accident, the way I've just said earlier, if I speak faster and then there's no good communication, she doesn't understand ... then tomorrow you hear, then she asking, 'You have mentioned something, what did you say?' I said, 'No! I've said like this'. And so, like now, I know myself. She doesn't understand. Talk slower ... 'No', I say, (uses cushion to demonstrate) 'Take that and put it at the end of that cushion'.
- R: OK. Any other parts? Nine months is a long time that's past and I'm sure you've seen how she's developed.
- P3: *Ja*, like now, let me tell you something, you see there's a sewing machine there ... now my wife she can make me jerseys, and my wife she get up and she go to the shop and she buy material, and then, she's always busy. Sometimes you can come here and then you will see there's nobody and to find that she's in, she's busy.
- R: Has that always been like that?
- P3: Yes, even before. Even before.
- R: OK, so she's quite hard-working.
- P3: Yes, uh. What I like ... you won't find that she's to my neighbours, she's always ... indoors.
- R: And that's something that hasn't changed.
- P3: No, that one – won't change.
- R: OK. So before the accident she worked hard, now she works just as hard.
- P3: All like, same like before, same like before. Most important what I like, she's not going to next doors, especially to, you know, Africans, you know what's happened, if you go next door, you talking lies, you haven't got time ... if you don't talk lies then you must stay in your house ... you clean, or you see the curtain is broken ... you see, things like that ... I don't know, like (points to himself) my, me and my family, you see, OK, I got the machine, she can make a dress, a jean, *ja*, she make it ...
- R: So she's very capable.
- P3: Exactly, exactly...



- R: That's wonderful ...
- P3: ...Exactly. It's what I've asked myself, I say, maybe after the accident, because that time she used to lose the ... uh ... (points to his head)
- R: Memory?
- P3: *Ja*, the memory, so now when the doctor says no, after three months, six months ... she'll be OK, and it's true.
- R: And is it true? ... OK?
- P3: And she just buy that material she's making blouses for himself, skirts, *ja* (points to machine) she's *always* busy.
- R: And coming back to the memory, is that ever a problem now, remembering things, names ...
- P3: The problem is that she ask me what did happen, I said to him 'I was not there, I was on duty', and then she was from the doctor and then, there's a pedestrian where you walking ... that car just came ... at the back and then hit him from there, he fall to the side ...
- R: ... So she was walking?
- P3: Yes, she was walking, she was not aware that there's a car who's going to come and because she was not right in the street (claps hands together to show 'crash') and then there and then that car hit my wife and another one, was a small boy ... was busy washing the car then from there. You know, she didn't see what's happened and then from there to the hospital, from the hospital then I came there, I take him to Eugene ..., then after two to three days, 'You know what it happens?' She say, 'No'.
- R: Mm, mm. And that worries her, that she doesn't remember?
- P3: No, she ask me, like this ... like this. I just get it from the doctor. From there, and the neighbours, it's the doctors there next to the shopping complex (points outside) ...
- R: So her memory from day to day isn't affected ...
- P3: No, uh, no, no, especially after the accident, no, everything it's fine.
- R: Now it's fine.
- P3: *Ja*, it's fine.
- R: Well that's wonderful. That she's made such a wonderful recovery.
- P3: She asks ... like now you ... you can ask him. What did happen? And I don't know anything?
- R: So obviously, that's a very common thing as well, one doesn't remember the accident.
- P3: Yes, yes, because.
- R: So ... sorry you were going to say ... because?
- P3: No (laughs) ... she was walking from the doctor on his way to home ...
- R: Aah ... and that's when it happened ...
- P3: *Ja*, the car just came behind and (claps hands together) ...
- R: Aah, and any other things that concern you now?
- P3: Ah, ... no, no, nothing, nothing. How can I put it, there's something, OK, how can I put it, it's just to talk slowly, not fast. If let's say sometimes you find out she's here in the lounge (points to couch), let's say I'm there (points to dining room), eating, I'm drinking, sometimes, then I say something and then she says, 'Pardon, I didn't hear properly (cups hands behind ears), what he says'... oooh!! And then (shows with his hands and then she understands) ...
- R: OK, sounds like you have a good communication between each other?
- P3: Exactly ... exactly.
- R: And that hasn't changed?

- P3: No, not yet.
- R: You've just become more adaptable.
- P3: (Laughs)
- R: When you say ... you talk slower ...
- P3: *Ja*, slower, I always remember the doctor's words (points to head): 'His memory was lost, now ... when you talk, just talk slowly.'
- R: And is she, you say she's busy here at home making clothes and that, she hasn't gone back to work?
- P3: No, (laughs) no work. It's like myself.
- R: Did she have a job at the time of the accident?
- P3: No, no she was at home.
- R: Was she unemployed or was she at home by choice?
- P3: No she was here at home.
- R: OK. She wasn't working for the ...
- P3: No, she was working at the Morula Sun, they used to retrench them, it's about four to five months ... that's why I say, like now, you ask me, SM, you and your wife, when did you marry? (points to R) It was that ... Ask my wife (laughs).
- R: (Laughs) So she's got the memory?
- P3: Exactly, exactly.
- R: And she remembers that one.
- P3: When she come here, you ask him, she will tell you, and then I remember she used to write it what you call them, the album, for the album (makes writing action with hand)...
- R: For the photographs?
- P3: *Ja*, she knows ... I don't ... I know, it's my wife ... (throws hands to the side).
- R: You give her all the glory (laughs) ...
- P3: Exactly ... (laughs)
- R: So she's coping very well at the moment?
- P3: Very well, very well.
- R: Well that's wonderful that she's made such a remarkable recovery.
- P3: *Ja*.
- R: And it's just the leg, it looks to me, that worries her.
- P3: *Ja*, because I remember the time, we went to the doctor, and the doctor he says its just because the blood didn't come out, so its making (shows a bulge in the leg) ...
- R: It collects there.
- P3: *Ja*, you see so its going to take a while before ...
- R: *Ja, ja*. And she would like to go back to work? Would she like to work?
- P3: Exactly.
- R: Would she?

- P3: Yes.
- R: And how does she feel about going back to work?
- P3: Well, the reason is that you know, these nowadays, if you don't know somebody, won't get a job.
- R: It's sad.
- P3: *Ja, ja*, you see, if, you know the job ... I mean ...
- R: ... It's the connections ...
- P3: It's like myself ...
- R: But you've been getting little jobs?
- P3: Sometimes I've been at home now for ... a month ... it's sad ...
- R: You and your wife then obviously spend a lot of time together.
- P3: Yes, during the day, during the night, we are together ... we sitting ... we talking ... most of the time, you know she says to me, 'Don't panic, you get a job, don't panic'.
- R: So she's good to have around.
- P3: *Ja*, she say, no, relax, relax. I say aaah, OK, OK.
- R: She's a good wife to have, huh?
- P3: Exactly, it's what I've just said earlier. There's a good communication with me and my wife, I like it.
- R: You understand each other.
- P3: *Ja*, I like it, I like it.
- R: Mm.
- P3: Even my brother-in-law, they are afraid for my wife (points to his head) ... *Ja!*
- R: What do you mean?
- P3: She's good, she's good (points to his head) she says something, no don't do this ...
- R: You mean giving advice?
- P3: Yes, the good advice, very good advice, it's just a pity she's not a lawyer (laughs) ... really!
- R: (Laughs) Ooh, *ja*, so she's very good at giving an argument, if you say it's a pity she's not a lawyer.
- P3: Exactly, *Ja*.
- R: And that hasn't changed, she's very good at solving problems...
- P3: ... Exactly.
- R: ... Even now.
- P3: *Ja*, even now, actually I can say, after the accident, she's better than before.
- R: That so?
- P3: Exactly.
- R: Why do you think so?
- P3: No, you just hear it from his mouth. You saw things like that. I still remember the time when she was involved in an accident, my mother-in-law, she passed away, and then it was sad and I was thinking that my wife ... she won't come back to normal, ...
- R: ...wouldn't handle it...

P3: *Ja*, because the accident, and his mother ... passed away, but, from there, after that and then everything is normal, good advice to ... (shows 'everyone' gesturing with his hands)

R: ... the family.

P3: *Ja, ja*, so that's why ... and I'm proud to say that ... even now.

R: Wonderful.

P3: And she doesn't shout ...you know soft, softly.

R: And she's always been like that?

P3: *Ja, ja*.

R: Wonderful. I'm glad that you have a good understanding.

## Participant 3 (P3): Follow-up interview

- R: Alright, so the first big theme that came up, the big issue, was the changes after the accident.
- P3: The accident.
- R: Alright.
- P3: *Ja*.
- R: That I saw as a big theme, and then it was just one thing in specific that came up that you talked about, and that was adapting in communication.
- P3: *Ja*.
- R: Changing, your changes in communication, from your side and from your wife's side.
- P3: That's right.
- R: Is that ...?
- P3: *Ja*.
- R: Uh huh.
- P3: *Ja*, it's true.
- R: OK. So from your side, you emphasised the talking slower, is that correct?
- P3: That's correct, *ja*.
- R: Anything extra?
- P3: No, it's just, you see, especially somebody like my wife and the way into the accident and she didn't understand what did it happen, just there at the hospital.
- R: Yes.
- P3: You see, and when you tell her, just talk slowly so she can understand.
- R: Yes, but that was just after the accident at the hospital, but now you said it's still quite apparent that you have to talk slower *now*.
- P3: Yes, even now.
- R: Even now, yes.
- P3: Even now, you see.
- R: Yes, and is that the main big change that you have had to make?
- P3: Yes, because either I can talk quickly somewhere, somehow, she doesn't understand.
- R: OK, and then she says ...
- P3: *Ja*, and then, *Ja*, she says, 'No, I didn't understand what you say'.
- R: OK, and then, EM's\* change in communication, you didn't mention it so often but it came across that she maybe struggles a little bit more in her understanding ...
- P3: Yes, yes, yes.
- R: ... Since the accident, if I could put it, she is a little bit slower, is that correct?
- P3: Yes, you are quite right.

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\* EM refers to P3's wife

- R: OK? Slower in understanding? Even when you talk slowly, does she have to take a while to think about what you say?
- P3: No, no, no. When I'm talking slowly she understands quickly, when I'm talking fast she goes "Huh, huh? I don't understand", you see.
- R: So it's very much related to how you speak to her, her understanding?
- P3: Yes, yes.
- R: If you speak slowly, she understands well.
- P3: Exactly.
- R: But if you speak fast ...
- P3: Well, then, um ...
- R: She gets lost a little bit. Alright. And does she sometimes take a little bit longer to respond? When you speak and you ask her maybe a bit of a complicated question, does she take a little bit longer ... ?
- P3: *Ja*, a little bit longer to answer, sometimes. But it's not so often.
- R: Not so often.
- P3: *Ja*.
- R: OK.
- P3: Sometimes.
- R: OK. So that doesn't worry you so much?
- P3: No, no.
- R: Alright, OK. The other thing that was very important to you that we spoke about in the beginning was the communication.
- P3: Communication.
- R: Yes, and that you said that is such an important part of your relationship. First the verbal communication, the speaking to each other, is that right?
- P3: Yes, it's right, yes.
- R: OK. And you said that your wife's communication to you now, interestingly enough, is *better* than before the accident.
- P3: Exactly.
- R: So that's quite an interesting remark to make!
- P3: (Laughs)
- R: Why do you think that is so?
- P3: Pardon?
- R: Why do you think that is so?
- P3: Um? How can I put it? Before, let's say before, when I talk to her, you see, I used to talk a little bit faster, you see, and then after this accident then I think that, you know, his mind, maybe little bit, his brain was damaged, so I must talk slowly. So she can understand.
- R: Um.
- P3: Yes, before I used to just talk a lot, but when you play, you know, rough, when you are playing, let's say some games, you jump and you catch the ball and things like that.

- R: Now you're a bit more careful?
- P3: Yes.
- R: OK. But in terms of *her* communication, the way that *she* talks, the way that *she* expresses herself, would you say that that's better *now*?
- P3: Yes.
- R: Compared to before? Even before the accident?
- P3: Yes.
- R: *Sjoe!* That's quite something, huh? It's a very positive thing to say.
- P3: [Laughs] Yeah!
- R: And then we talked about her nonverbal communication, that means her facial expressions, the way she takes turns, her eye contact, her body language.
- P3: Exactly.
- R: So not speaking, but using, her body language, speaking at the right time, that kind of thing. That's also important in your relationship. Is that true?
- P3: Yes. It's like yourself and you and your husband. Sometimes you just, you don't talk, you just look at each other, but, uh ... you talking, but you don't talk like the way I talk now, just look each other.
- R: So you don't use words.
- P3: Yes.
- R: You just use eye contact.
- P3: Yes.
- R: OK.
- P3: We talk and after say, 'Uh, I forgot you know, take this letter (takes letter from table) it's not mine. I've received this letter by mistake, oh, this one is for my neighbour'.
- R: What do you mean now?
- P3: I mean, I just give you an example.
- R: Yes.
- P3: OK. We're sitting, oh, let's say two hours or one hour but we don't talk to each other, we just look at each other.
- R: For one hour?
- P3: I'm just giving you an example.
- R: OK, OK.
- P3: OK. From there, and you start talking someone will say, 'Ah, I saw this letter but they deliver it in this house by mistake. Whose letter is that?' And I say, 'No, it's my next door neighbour'. 'Oh, OK, I'll take it there.' So you see. [Laughed]
- R: OK, OK.
- P3: I don't know whether you understand clearly now?
- R: Not a hundred percent clearly. It's when you say eye contact. You're not using words.
- P3: Yeah, you look each other.
- R: Alright, alright. But the body language is also important when you are using words.

- P3: Yes, you see. OK, you looking each other.
- R: You said the eye contact is important.
- P3: And then, you don't talk.
- R: *Ja*.
- P3: Is that 10 minutes or 30 minutes, and then you say, 'You know, I forgot to tell you yesterday, your friend, who ... ah, *ja*' ... 'The thing that makes me that I must forget is just because I was busy ... my mind was going to clean the car' ... something like that ...
- R: Oh, OK, OK.
- P3: You see, *ja*.
- R: So it brings up other things that you need to speak to each other about?
- P3: Exactly, exactly.
- R: In the times of silence?
- P3: Yes.
- R: OK, alright, and um ...
- P3: Did you notice it? Not?
- R: Did I notice it?
- P3: Yes.
- R: With what?
- P3: With what I just said now?
- R: Do you mean, do I understand it?
- P3: No, I mean have you ever noticed that, you and your husband and ...
- R: Oh, yes! Yes! And then you remember something that you have to tell him.
- P3: Exactly.
- R: *Ja, ja*. And the way that EM uses her body language while you are talking, that hasn't changed?
- P3: No.
- R: Since the accident? That is something that I picked up. It is the same, her communication is still good, that's what I understood. Alright.
- P3: Yes, yes.
- R: Alright. Then you also spoke quite a lot about the doctor, hey? In the whole process in helping you understand the accident, the doctor seemed to be quite important?
- P3: Yes. I still remember the time when she was at the hospital and I was worried because when she get accident, was hit by her head and, but I once was still at the hospital, she used to lose ... her mind, you know.
- R: She was a bit confused.
- P3: *Ja*, and when you say, 'Did you see my sister?' and I say, 'No, I didn't see her,' and to find out my sister ...
- R: Was there.
- P3: Yes.
- R: So she didn't remember.



- P3: Yes, and then the other doctor, he says to me, 'No. Don't worry, don't panic, because it can take a little bit to worry, others they take about three months to six months'. Luckily my wife didn't take so long.
- R: Not long at all.
- P3: *Ja*, I think it was two months, two months, *ja*. Three months.
- R: So you put quite a lot of faith in the doctor.
- P3: Yes, yes, yes. *Ja*, he said, 'No, don't panic'. And then went there again for checkup and he said, 'No, she'll be fine'.
- R: *Ja*.
- P3: And it's true.
- R: So the doctor played a very important role.
- P3: Yes.
- R: In *your* mind.
- P3: Yes, he said, 'Don't panic'.
- R: And dealing with the whole accident afterwards. So you kept thinking about what the doctor said.
- P3: Yes. So that's why now when I speak to my wife I don't speak fast, I speak slowly.
- R: And that's because ...
- P3: The doctor ...
- R: So the doctor is quite important. You have a lot of faith in him.
- P3: Yes. And he says, 'No, it will take quite a while, but speak slowly so she can understand'.
- R: Yes, yes.
- P3: So even now, even now I'm still doing what the doctor said.
- [R: What the doctor said] so he plays an important role in your life even now.
- P3: Yes, yes. Even now, like this morning I can tell you something. There's a big rat sometimes I run get inside the engine when it's warm in the evening ...
- R: Really?
- P3: *Ja*, this size. So when I come in the evening, before I close the gate and everything, I just take that little poison and put it there, you see. And my wife, this morning, when I wake up I went and check, 'Oh,' I thought, 'No, that was not there'. And I came inside the house and I tell her, 'No, the rat didn't eat there'. So, OK, take that poison, OK, I throw it in the dustbin, I put another one in the evening, you see.
- R: OK. [Laughs]
- P3: *Ja*, OK, so *ja*, OK, it's fine, you see.
- R: And that, you wanted to use this as an example of ...?
- P3: That she understands the way that it is.
- R: OK, OK, that she understands. Alright. And while you were talking in that first little conversation that we had, I got quite an impression that the whole, all of the events after the accident, were experienced quite positively, and that a lot of hope came through from your side. Would that be a true reflection?
- P3: Yes, yes, I don't know how I can put it.
- R: You, like, the comparison of your wife before the accident and after the accident. Most people have quite a few disappointments, and it's a difficult time for them. But very little of that came through with you. Was it dealing with the accident and the events afterwards, was it generally a very difficult time? For you? Or was it quite a good experience to go through?

- P3: No, it was difficult, it was difficult. And then after when I take my wife for a checkup and the doctor that time when he explained for me how to talk, you know, don't be fast, slowly you see, and then I still remember one of my wife's friends, they work in the hospital there and then since, I see them that time, they never came there to my home and say, 'Oh, so EM\*, you fine or what?' I have experienced same, because I have heard others say, 'Ah no, SM\*'s wife, she lose the memory'. You see things like that, but after, after everything is fine.
- R: So your experiences after the accident were quite positive. Is that a reliable statement to make?
- P3: *Ja*, because I have learnt something, you see.
- R: And do you see that it is a positive thing?
- P3: *Ja*.
- R: Not a negative thing?
- P3: *Ja*.
- R: Even when you were explaining about the way your wife dealt with the death of her mother and how the family looks up to her and gets advice from her, those are all positive things?
- P3: *Ja*. [Laughs]
- R: And that was wonderful because so many times a bad situation can lead to even further bad things. But you haven't let that happen.
- P3: No.
- R: *Ja*. So the experience after the accident and right now, you're positive. Am I right to say that?
- P3: Yes.
- R: That's wonderful! And the road ahead? Looking forward?
- P3: Forward?
- R: Is it good?
- P3: Good, uh ... how can I put it? Good relationship?
- R: Yes.
- P3: Yes, *ja*.
- R: So it's looking forward with a positive outlook?
- P3: *Ja*.
- R: *Ja*, that's wonderful! That's encouraging for me to hear! And then the other aspect – you spoke a lot about the changes that you've had to make in your communication. Would you say that since the accident you have adjusted pretty well and adapted pretty well to how things are now?
- P3: Yes.
- R: In your relationship?
- P3: Yes.
- R: Would you say that there has been quite a lot of adjusting that has had to take place?
- P3: *Ja*, adjusting, I don't know what are you saying.
- R: Adjusting, like making changes to how things are now.

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\* EM refers to P3's wife

\* SM refers to P3

- P3: Yes, I don't know how I can put it ... how can I put it, but the way I've just said earlier, you see, OK, I have changed since this accident to speak slowly so she can understand, so even now if there is something which it's not right or maybe she's doing something which I don't like, I don't shout, I just say, 'No, I don't like this'.
- R: So the adjustment has mainly been in your talking?
- P3: Yes, that's right.
- R: OK. And, have you, would you say your life now is pretty much back to normal?
- P3: Yes, yes.
- R: OK. So the changes you've had to make, have almost come to a ... you don't feel that there are still changes taking place?
- P3: No.
- R: It's pretty much as it was before.
- P3: Yes.
- R: OK. And the adjustments in your relationship? There don't seem to have been many adjustments emotionally.
- P3: No.
- R: To make at all.
- P3: No. [Laughs]
- R: That's been the same.
- P3: *Ja*, the same ...
- R: That's great, huh? OK. I just wanted to clarify one thing. You said her problems with her memory were mainly in the beginning when she was still in hospital, am I right?
- P3: Yes.
- R: There's no worries right now that you have with her memory?
- P3: No, no, no, no.
- R: She remembers the day-to-day events?
- P3: Yes.
- R: She remembers little details that you told her yesterday?
- P3: Yes.
- R: OK, so you're not worried about her memory at all?
- P3: No, no, everything is OK.
- R: Great, great. And we ended off with how she feels about going back to work. I know there's not work at the moment, but if work came up would she feel ready to do it and competent?
- P3: Yes, yes, yes.
- R: So she's not afraid of going back?
- P3: No, no, no she's not afraid.
- R: Because of the accident.
- P3: *Ja*, I remember after this accident, after this mother's funeral, she used to work temps at, what do you call it? Warehouse, Clicks warehouse. You know that one at Midrand.
- R: Oh yes.

- P3: She used to work there.
- R: OK. Did she go through with a taxi?
- P3: Yes, there's a kombi who takes them here from town until there in Midrand.
- R: OK.
- P3: Ja, after that accident, her mother's ...
- R: Her mother's death.
- P3: Yes, so that's why she has got no worries to go to work. I get home to find she's cleaning the whole house.
- R: And sewing, and busy, busy?
- P3: Yes, we've got a sewing machine.
- R: Yes.
- P3: We've got a computer, you can come there during the day. You'll see there's nobody.
- R: But she's actually busy.
- P3: Yes, she's busy.
- R: And, was that pretty much how she was before as well?
- P3: *Ja*, well, even before, she used to do her sewing ...
- R: Very busy.
- P3: *Ja*, busy, busy, busy.
- R: So that stayed the same?
- P3: *Ja*.
- R: Great.
- P3: *Ja*.
- R: SM\*, that's it. Thank you very much.
- P3: Thank you for coming.

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\* SM refers to P3