

**Exploring dimensions of fortitude:
A qualitative investigation of sources of resilience
among university students with a physical disability**

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Declaration

I declare that *Exploring dimensions of fortitude: A qualitative investigation of sources of resilience among university students with a physical disability* is my own work. It has not been submitted for any degree or examination in any other university and that all the sources I have used or quoted have been indicated and acknowledged by complete references.

Jeanine Hundermark

April 2004

The logo of the University of the Western Cape, featuring a classical building with six columns and a pediment.

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Abstract

Much of the research within the field of psychology on the subject of physical disability tends to highlight difficulties and challenges. This is reflective of the pathogenic paradigm, in which the focus of interest is psychological illness, vulnerability and risk. Similarly, a great deal of general research in the area of disability is structured within the medical model perspective, predominantly concerned with functional limitations of an impaired body. However, according to the social model of disability, the biggest challenge to the disabled is not individual impairment but the way that society responds in a generally negative, discriminatory way to those with disability. Disability activists have highlighted the oppression of the disabled and the importance of human rights and emancipation issues.

The current trend within the field of disability is towards integrating multidisciplinary approaches, rather than focussing exclusively on social issues. The present study explores dimensions of *fortitude* (or strength despite adversity) among university students with a physical disability. Fortitude is a construct that forms part of a salutogenic or fortigenic paradigm, concentrating on psychological health or strength. Other examples of similar constructs include: sense of coherence, hardiness, potency, resilience and coping.

The construct fortitude was developed as a result of research by Pretorius (1998). Individuals who experience high levels of well-being in spite of the presence of high levels of stress in their lives may be described as having fortitude. Fortitude is made up of three dimensions; a positive appraisal of self, a positive appraisal of the support from family and a positive appraisal of support from others. Each of three dimensions may also function

independently but fortitude comprises the interaction of the three. Research has demonstrated a consistent negative relationship between fortitude and various measures of distress as well as a positive relationship between fortitude and measures of well-being.

The purpose of the study was to determine whether the three dimensions of fortitude apply to students with physical disability and whether other dimensions of fortitude are revealed. A qualitative research design was employed using unstructured individual interviews. Participants were six university students with a physical disability. The transcripts of the interviews were analysed using qualitative data analyses. Results revealed that all participants displayed fortitude in spite of many difficulties relative to the disabling experience. The three dimensions of fortitude as described above were evident and no other significant dimensions were revealed.

Notwithstanding limitations of the study, recommendations are made for further research in the area of fortitude among those with physical disability. South Africa has one of the largest populations of trauma related spinal cord injuries caused by motor vehicle accidents and violent crimes. The subject of fortitude among those with physical disability therefore requires further research particularly from the perspective of tertiary preventative programmes.



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Chapter 1

Introduction

1.1 Background

This thesis explores sources of fortitude or psychological strength, among students with physical disability. The disabled are not generally portrayed in terms of positive attributes. In South Africa the majority of individuals with physical disabilities are faced with unfavourable social conditions that have been implicated in psychological ill health and particularly in depression (Cock, 1989). Many physically impaired South Africans experience social and environmental obstacles that result in limited access to social services like healthcare, mainstream education and recreational facilities (van Niekerk, 1997). These environmental obstacles or barriers prevent those with disabilities from having equal opportunities compared to other citizens (van Niekerk, 1997). A common theme within disability literature is the conviction that difficulties with respect to social barriers outweigh the physical problems of impairment (Marks, 1999a). As a consequence, the civil rights of the disabled have become a priority both locally and abroad (DPSA, 2000; Oliver, 1990).

Critical disability literature opposes the so-called 'medical model' of disability that has been censured for labelled physical impairment purely in terms of illness or pathology (Pfeiffer, 1998). Notwithstanding the contribution of medicine in relieving suffering and improving the quality of life of those with impairment, opponents of the medical model contend that the biomedical approach fails to acknowledge the impact of discriminatory social or political practices on the lives of those with impairment (Read, 2000).

Dissatisfaction with the status of the disabled in society brought about the emergence of the 'social model' of disability in the 1960s. The social model was driven by disabled activists voicing opposition to what they experienced as the social oppression, exclusion and the violation of their civil rights (Morris, 1992; Read, 2000; Thomas, 1999; Watermeyer, 2000).

Rather than focussing on medical problems, it was argued that disability is not an illness and that there is no opportunity to recover from impairment in the way that people get over other bouts of sickness (Quinn, 1998). In contrast, the social model stressed the difference between having an impairment, which is a common human experience, and being disabled, as a result of the social consequences of impairment (Shakespeare, 1994). The essence of this distinction can be found in social constructionist theory. The theory of the social construction of disability contends that disability is not an absolute or objective condition, but an artificial state or construct, brought about by negative perceptions and practices that have become entrenched in society (Brett, 2002).

The ongoing debate between the medical and the social models is reflected in the problems of defining disability. No single definition appears to have universal acceptance. The most commonly used definition is the World Health Organisation definition (1980), referred to as the 'International Classification of Impairments, Disability and Handicaps' (ICIDH):

- i) *Impairment* is defined as any loss or abnormality of psychological, physiological or anatomical structure or function.
- ii) *Disability* is any restriction or lack (resulting from impairment) of ability to perform an activity in the manner or within the range considered normal for a human being.

iii) A *handicap* is a disadvantage for a given individual resulting from impairment or a disability that prevents the fulfilment of a role that is considered normal (depending on age sex and social and cultural factors) for that individual.

Many disability scholars do not accept the WHO definition (Pfeiffer, 1998). Criticism is based on concern that the definition expresses negative bias in reflecting a medical or diagnostic model and does not sufficiently reflect the impact of social exclusion and discrimination against the disabled (Watermeyer, 2000). Disability activists and organisations prefer to use the term 'impairment' in the context of individual limitations and 'disability' when referring to social restrictions (Zinkin & Mc Conachie, 1995).

Current disability literature reflects recent trends that are moving away from the debate over the merits of the social or medical models in favour of a more inclusive approach to the complex subject of disability (Marks, 1999a). Universities in the UK and US have introduced a course known as Disability Studies that integrates multidisciplinary perspectives on disability (Linton, 1998). Disability Studies has provided the opportunity for a broader understanding of disability and opens the way for incorporating approaches like the present study on the subject of psychological strength and disability.

The study of psychological strength or wellness reflects a so-called 'salutogenic' or 'fortigenic' perspective (Wissing & Van Eeden, 2002). The term 'salutogenesis' was developed by Antonovsky (1979) who was interested in the origins of health rather than of illness. He studied individuals who were able to function well in spite of the presence of hardship and stress in their lives.

He developed an understanding of health, not as a complete lack of illness but rather as part of what he described as the ‘health-ease / dis-ease continuum’ (Antonovsky, 1979).

Antonovsky’s perspective on health provides an alternative to the usual sense that hardship or trauma inevitably results in pathology or illness (Goldstein, 1997). In interpreting Antonovsky’s theories, a South African industrial and organisational psychologist by the name of Strümpfer (1995) suggested that Antonovsky’s work did not simply explore sources of health but sources of strength in general (Wissing, 2000). Strümpfer introduced the term ‘fortigenesis’, derived from the root word ‘fortitude’, signifying strength or courage in adversity.

There are a number of different constructs with characteristics that fall within the salutogenic/fortigenic paradigm that will be discussed in detail in section 2.6.2. This thesis utilises the construct fortitude as developed by Pretorius (1998), describing the ability to maintain psychological strength in the face of challenge and adversity. Like Antonovsky, Pretorius (1998) was interested in the stress reducing and health sustaining effects of certain individual and environmental characteristics that explain how people cope with life’s challenges. Pretorius (1998) posed the question “where does the strength come from”? (p. 7). After thorough research on the construct, Pretorius concluded that fortitude is the strength derived from a positive evaluative appraisal of oneself and the world that enables a person to cope with stress. He also showed that the presence of fortitude is consistent with low levels of depression (p. 23).

Pretorius identified three dimensions of fortitude that he regarded as subsections of the construct:

The positive appraisals of the self.

The positive appraisal of one's family.

Support received from others.

Although fortitude is made up of three dimensions, these are not regarded as separate. Different individuals may appraise different dimensions as being more positive than others (Pretorius, 1998). Fortitude is the sum of the three dimensions. In this respect, fortitude provides a model of psychological health and strength that can be applied to minority groups like the disabled. In contrast, certain measures of psychological well-being have been criticised for an over reliance on individualistic constructs that can only be applied to affluent, healthy members of society who have achieved the 'good life' (Christopher, 1999). Fortitude concerns strength despite the presence of stressors. This may be contrasted to the popular notion of 'happiness' in which the positive predominates (Diener, 1984).

1.2 Aim of this study

In his original development and validation of the construct fortitude, Pretorius (1998) employed a quantitative research design, administering a number of different questionnaires measuring various constructs of health to a large heterogeneous group of undergraduate psychology students at the University of the Western Cape (UWC). The present study employs a qualitative methodology, using individual interviews posing Pretorius' question "Where do you think your strength comes from"?

The purpose of this study is to explore characteristics or dimensions of fortitude among a group of six students with physical disability from a number of different faculties at the University of the Western Cape.

Life at university can be stressful and challenging (Julius, 1999). Students with physical impairment are faced with extra challenges as a result of disabling barriers (Baron, Phillips & Stalker, 1996; Holloway, 2001). Barriers apply to environmental limitations, like problems of access as well as to difficulties in respect to the negative perceptions of others (Swain, Finkelstein, French & Oliver, 1993). According to the Department of Quality Assurance at UWC, disabled students consist of only about 1% of all students (personal communication with Institutional Planning Office, May 6, 2003). Disabled students are a minority group within a university and tend to put in extra effort to fit into university life (Holloway, 2001).

In view of the many stressors in the lives of students with physical impairment, this research aims to discover where participants believe that they find the strength or the courage to continue despite obstacles. The study is interested in identifying whether the three dimensions of fortitude described in the previous section (Pretorius, 1998) are evident and whether other dimensions may be present. These might include a spiritual belief (as identified in a study by Alling, 2000), an important focus interest like sport (Bressan & Rossouw, 2002; Jonker, 2002) or social involvement (Wissing & van Eeden, 2002).

1.3 Rationale for the study

According to Khan and Durkin (1995), about 85% of disabled children in the world live in developing countries. Although this is not a study of children, it is clear that research on different facets of disability is vital in a developing country like South Africa in which the prevalence of physical disability is reported to be about 1.4% (Statistics SA, 1998).

In January 1999, as a result of The African Seminar on Development Co-operation on Disability and Human Rights in Cape Town, the years 2000–2009 were declared 'The African Decade of Disabled Persons' (Hernandez, 1999). Although the country is now almost halfway into this period, literature on the subject of physical disability in South African is generally restricted to the rehabilitation and human right's arenas.

Within the field of psychology the bulk of disability research is concerned with intellectual disability. The South African Journal of Psychology has made no reference to disability over the last ten years. Globally, the majority of research on disability within the field of psychology is situated within a pathological perspective (Marks 1999a). In South African, only a very small percentage of disability research reflects a fortigenic perspective. Exceptions all appear to originate from the field of health psychology. These include a study by Jonker (2002) comparing the psychological well-being of wheelchair athletes to other individuals in wheelchair who did not partake in sport or physical activity. The wheelchair athletes were found to have higher levels of self-esteem, satisfaction with life, active coping patterns and lower levels of alcohol and drug dependence than those who did not partake in sport.

Bressan and Rossouw (2002) investigated various sources of enjoyment in sport reported by participants with visual impairment. The study was conducted among 20 sportsmen competent enough to compete in South African National championships in various sporting events. Results identified themes consistent with those found among sportspersons without disabilities.

A review of current literature reveals much interest in issues of wellness and other positive human attributes (e.g. Folkman, 1997; Fredrickson, 2001; Seligman & Csikszentmihalyi, 2000; Wissing & van Eeden, 2002). However, research on the subject has largely been confined to non-disabled individuals. The paucity of disability research in the area of psychological health provides the rationale for this research that aims to integrate the construct fortitude into disability studies.

Disability Studies is beginning to include all facets of the disabling experience. It is thus logical that positive as well as negative experiences should be incorporated. This kind of integration may counterbalance negative perceptions about disability (Read, 2000) and confirms the fact that those with physical disability are equal members of society, notwithstanding physical impairment (Senge & Dote-Kwan, 1995). The identification of underlying strengths or protective factors that counteract disadvantage related to disability and other negative social labels, contribute to a positive quality of life for all individuals. This research study strives to form part of a body of literature aimed at honouring diversity, rather than stigmatising and restricting those who are different (Campbell, 2002; Read, 2000). It is hoped that the study will make a contribution towards the theory of fortitude as well as to disability studies in general.

1.4 Overview of chapters

This first chapter began with an overview of background information on disability research. Thereafter the salutogenic or fortigenic paradigm was presented. After a brief introduction and explanation of the construct fortitude, the aims and rationale of the thesis were explained.

Chapter two consists of various theoretical models. The medical model of disability is discussed, followed by the social model. Various definitions of disability are clarified and current trends in the area of disability studies are highlighted.

The second part of chapter two deals with disability and psychological strength. An explanation of the construct fortitude is given, followed by a description of other constructs of psychofortology. Argument is presented for integrating the theory of fortitude into disability studies.

Chapter three covers research methodology. The qualitative design is explained together with its application in disability research. This is followed by a debate on the subject of a non-disabled person researching disability. Specifics of the current methodology are provided concerning data collection procedures and analysis as well as details of participants. Finally, the evaluation of the trustworthiness of results and the limitations of the present methodology are examined.

Chapter four presents the results of the research. The main themes are introduced first, followed by a detailed discussion. The subject of reflexivity concludes the chapter.

Chapter five offers conclusions, limitations and recommendations for further study.

Chapter 2

Theoretical framework

2.1 Introduction

The chapter will begin with current issues and debates on the two theories of disability most commonly discussed in the literature. The medical model of disability will be presented first, followed by a discussion of the social model. Thereafter, the controversy around definitions of disability will be highlighted.

The second part of the chapter will introduce new directions in which disability studies are moving as well as a brief overview of general psychological perspectives on disability. Theories of psychofortology, the study of psychological strength will be presented next. The construct fortitude will be explained followed by other constructs of psychofortology. The chapter will be concluded as arguments are given for the integration of the construct of fortitude into disability studies.

2.2 The medical model of disability

The medical model has been the dominant framework for understanding disability throughout modern times until around the 1960s (Hughes, 2000).

The medical model refers to a rational, empirical and scientific approach to understanding the body and human behaviour (Goldstein, 1997). The model follows the principles of the philosopher Descartes who regarded the body as a closed system, not influenced by elements outside of itself and subject to the laws of causality (Marks, 1999a).

Using the example of a mute child, the logical, causal explanation may be that the child was born with a hearing impairment as a consequence of an inherited genetic condition. The absence of normal speech in the child is seen as a direct result of the inability to hear speech sounds and thus an inability to reproduce sounds. This logical scientific explanation locates the problem within the individual (Abberley, 1987). In contrast, a more primitive understanding may contribute muteness to factors outside the child like bewitchment or punishment for parental evil.

Using the above example, a 'medical model' approach to the treatment of hearing impairment may include the performance of surgery or the prescription of a hearing aid. Treatment is based on the philosophical understanding that both the problem and solutions are located within the child. The solution is aimed at dealing with the source of the problem, in this case deafness, rather than muteness. However, without further intervention of some sort, the child's state of muteness may be little changed. Further intervention cannot simply be restricted to making changes in the child but will have to include environmental and familial changes to encourage the development of communication between the child and others.

General criticism of the medical model is that since it regards the problem as contained within the person, too much emphasis is placed on treating the problem within the individual without including social and environmental changes. The social model of disability that will be discussed in the next section emerged as a result of dissatisfaction with the medical model in this regard (Camilleri, 1999).

In summary, the term 'medical model of disability' refers to the philosophy or scientific understanding of disability according to the principles described above. On a practical level, the philosophy translates into an understanding that disability is a result of physiological impairment due to damage or disease (Llewellyn & Hogan, 2000). Although opponents take issue with the philosophy and principles of the model, criticism is most often levelled at members of the medical profession who are regarded as utilising the philosophy in their treatment of the disabled (Brett, 2002; Camillieri, 1999; Hughes, 2000).

As a group, the disabled have a great deal of contact with members of the medical profession. In general, disability, whether as a result of congenital or acquired impairment, is regarded as primarily a medical dilemma (Oliver, 1993). The assessment, treatment and rehabilitation of the disabled is predominantly undertaken by medical professionals like orthopaedic surgeons, occupational therapists and physiotherapists. The birth of a baby with impairment usually results in an immediate medical response in the form of an attempt to medically reconstruct, transform or rectify the impairment. Similarly, the first reaction to an acquired impairment like paralysis is a medical one. Medical professionals rely heavily on scientific solutions like surgery, medication or assistive devices like hearing aids, or prostheses. Although medical procedures may be life saving, what has been described as the (over)medicalisation of disability has been highly criticised by disability activists (Pheiffer, 2002).

2.2.1 Criticism of the medical model of disability

A large percentage of current literature on disability refers to criticism of the medical model (e.g. Lunt & Thornton, 1994; Swain & Cameron, 1999; Marks, 1999a; Watermeyer, 2000). The model has been censured for framing disability purely in terms of illness (Pfeiffer, 2000). A definition of impairment in terms of illness and deficit can easily result in negative perceptions towards disabled individuals without regard to positive aspects of the person (Quinn, 1998).

A consequence of the illness or abnormal perspective on disability is that intervention is aimed at transforming the impaired individual into a 'normal' state of functioning. On the face of it such an approach appears to be a noble intention. Informal discussions with individuals with a physical disability reveal a general desire to be regarded like everyone else. However, critics feel that excessive attention on normality places a burden on disabled people to continue to strive for impossible cures (Camilleri, 1999). According to Quinn (1998) in most cases, the disabled person may stabilize, adjust or cope, but will never 'get well' or be entirely restored to health in the way that people recover from other illnesses (p. xix). He suggests that this places the disabled individual in a hopeless position.

Consequently, disability activists take issue with what they regards as the conceptualisation of illness and health as mutually exclusive conditions. The argument is that individuals with impairment never attain health in the general sense of the word as their chronic state of 'ill – health' represents the very opposite of the ideal healthy state (Marks, 1999a).

Hughes (2000) refers to modern Western society's obsession with physical perfection or beauty that he describes as the 'aestheticism of everyday life' (p. 560). He cites examples of the massive consumer market that promises to provide solutions for every bodily imperfection. He is of the opinion that medicine has played a major role in what he calls "the aesthetic tyrannies of contemporary life" (p. 567) in which there are promises that the body can be reconstructed, changed and enhanced. This tyranny is particularly destructive towards the disabled who are unable to attain normal social standards of beauty and perfection and find themselves marginalized from society (Brett, 2002).

The strength of the social pressure to aspire to standards of normality was identified in a qualitative study among a group of eight women with physical impairment conducted at Syracuse University. In researching the meaning of health and disability for women, Tighe (2001) revealed the pressure that women experience in having to define their health by the unachievable standards of able-bodied individuals. In her discussion, Tighe (2001) uses the terms 'kingdom of the well' and the 'kingdom of the sick' (p. 511) to describe the two very different states of health, one for the disabled and one for others.

In the UK, Brett (2002) conducted a small-scale research study among four parents on the experience of having a profoundly disabled child. In a qualitative study during individual interviews, the parents reported experiencing immense pressure to push their children to conform to social standards of normality. By virtue of the inability of their children to achieve normal milestones, parents reported feeling "stigmatised and judged" (Brett, 2002, p. 834). Parents also expressed disappointment with members of the medical profession. They cited examples of what they perceived as lack of

empathy and a sense of exclusion from decision-making processes. The parents also felt that medical professionals abused the expert relationship in deciding what was in the best interest of their child and at times conducting what parents regarded as unnecessary procedures. Brett (2002) attributes problems to the medical model approach of treating symptoms rather than the needs or concerns of the disabled child and their families.

Marks (1999a) uses the term 'medical violations' (p. 68) to describe the way in which all aspects of disabled patient's lives are seen as secondary to medical solutions. She quotes Mason, writing from personal experience:

Other children play, but you do therapy. Other children develop but you are 'trained'. Almost every activity of daily living can take on the dimension of trying to make you less like yourself and more like the able-bodied. The world is often quite happy to reinforce this (p. 27).

One of the consequences of a failure or deficit model of disability is that impairment is regarded as a great calamity. Oliver (1986), a disabled writer, introduced the term 'personal tragedy theory of disability' (p. 6). This is not a theory as such but an exposition of the way that disabled people are regarded as objects of pity and treated accordingly. Part of the personal tragedy view is that disabled people's lives are not afforded the same value as able-bodied individuals. The death of an impaired individual is commonly described as a "relief from suffering rather than a crisis which needs to be prevented" (Marks, 1999a, p. 49). Personal accounts of disability reveal emotions ranging from discomfort or irritation to pain and anger at the negative misperceptions of others (Reeve, 2002). These negative perceptions and practices serve to distance those with impairment from others (Watermeyer, 2000).

Another negative consequences of regarding disability as a medical problem located within an impaired individual is that the power to cure is seen as located outside the person and within the medical system. This perspective may set up the establishment of a potentially dangerous power differential (Barnes, 1992). It is particularly in relation to issues of power that criticism is targeted against the medical profession. Medical professionals are regarded as experts, possessing high status and power, a position open to abuse.

As a consequence, patients or relatives of disabled patients may be cast in a passive, helpless role in the face of what Brett (2002) describes as 'medical superiority' (p. 530). Camillieri (1999) an academic with a disability contends that the medical profession is implicated in partaking in the oppression of the very people that they profess to assist. He further suggests that the medical profession is benefiting from assigning a sick role to the disabled and thereby furthering their own careers and status.

Given that impairment is very often a medical crisis, the above criticism may seem overly harsh. However, there are numerous examples of gross abuses of power by the medical profession against the disabled within the twentieth century. These include acts of atrocity against those with impairment like the Nazi 'euthanasia' programme, the enforced sterilization of those with learning difficulties in Scandinavia and North America as well as publicised accounts of neglect and abuse in certain residential homes for the disabled (Marks, 1999b). Although these are extreme examples and may apply to only a small proportion of disabled individuals, it has been argued that passive or hidden forms of discrimination and oppression continue (Marks, 1999a).

Hughes (2000) contends that many medical procedures do more for the reputation of those in the medical profession than for the disabled, other than sustaining the myth of illness. Harsh criticism by Hughes and others (e.g. Camillieri, 1999) that completely denounces the medical model has itself been censured for ignoring individual experiences of disability in the lives of disabled people (French, 1993; Reeve, 2002).

However, a number of empirical studies have concurred with what appears to be overly harsh criticism. Read (2000) conducted a qualitative research project in the British Midlands among 12 mothers of children with disability. She concluded that although medical services were intended to provide relief and support, actual experiences with the medical profession were mostly negative. Duckett and Pratt (2001) reported similar findings from a community psychology project in Scotland. In a qualitative design, utilising individual interviews the authors researched the experience of medical interventions among a group of 30 visually impaired adults. Results showed that participants reported feeling disempowered in the patient-doctor relationship during diagnosis and treatment.

Although the medical model and medical professionals have made a valuable contribution towards improving the quality of life and alleviating suffering among the disabled, there are a number of negative effects of ascribing to this model of disability. A study of disability literature identifies that most of the condemnation originates from disability activists aligned to the social model (e.g. Abberley, 1987; Barnes, 1999; Camillieri, 1999; Morris, 1992). Disabled scholars appear to be the authors of the majority of critical articles.

It is common practice in disability literature for the author to include a personal statement about impairment. This also applies to able-bodied writers who tend to make clear statements about their motivation or interest in the subject, with the emphasis on ethical practices. Consistent with the criticism of the medical model approach, non-disabled authors, when writing about disability are usually very clear in distancing themselves from exploitative practices towards the disabled. It is regarded as inappropriate within the critical movement for the non-disabled to speak on behalf of those with impairment (Drake, 1997).

However, in a study examining the subjective experience of disability research in Ireland, Kitchin (2000) found a difference between theory and reality. He interviewed 35 disabled individuals with a variety of impairments, from Dublin and Belfast. All the participants had previous experience of being research participants. Results revealed general apprehension about the misrepresentation and misinterpretation of data. Participants expressed concern that research findings did not represent their own views. Many felt exploited by researchers, as they believed that they were not adequately informed post-study. Three of the participants believed that only disabled researchers should conduct disability research. However, the majority were of the opinion that disability research should be undertaken in conjunction with disabled people. Participants expressed strong support for the use of qualitative research methods. Kitchin's research revealed a discrepancy between the intentions and actions of researchers and provides an explanation for the continued reticence of those with disability to be objects of research.

2.3 The social model of disability

The social model of disability is principally a political model that emerged from the political writings of disabled activists during the 1960s, (Camilleri, 1999). In contrast to the individual approach of the medical model, the social model regards disability as a group or social phenomena (Gleeson, 1997). According to the model, disabled individuals face problems that cannot be accounted for purely on the basis of qualities that reside within an impaired body. Functional limitations are regarded as only part of the difficulties of impairment (Swain et al. 1993).

The biggest challenge to the disabled individual is considered to be the way that society responds to those with impairment in a generally negative, discriminatory way (Marks, 1999a). This negative response is credited with undermining the identity of disabled individuals. Social model activists take issue with the fact that the non-disabled world has a specified blueprint of personal and social identity (Swain & Cameron, 1999) not achievable by those with impairment and from which they are therefore excluded. In fact, many disabled people feel that they do not aspire to the current standards of normality but instead desire to have more active participation in society (Gleeson, 1997). The social model strongly rejects the dominant focus of disability as abnormality, inferiority and dependency in favour of celebrating differences and taking pride in a disabled identity.

The social model is not a single theory but a body of political ideas with common aims. The orientation of the different writers is unique to the social and cultural climate in which ideas were developed. In the United Kingdom, a great deal of literature on the social model has emerged from activists within

the British Disabled People's Movement (Barnes, 1999) who were influenced by socialist thoughts on citizenship rights (Marks, 1999a). These theories appealed to the disabled who experienced themselves as a group that were separated and marginalised from able-bodied society and who began to see themselves as a minority group. Knowledge and political ideas were drawn from other minority groups who were demanding equal rights and participation in society (Linton, 1998).

In the United States, disabled citizens identified with the ideas drawn from the Civil Rights Movement and Women's Movement (Camilleri, 1999). The social model gained further momentum in the US after the Vietnam War. Vietnam veterans, who had previously been part of mainstream society but had acquired impairment during the war, became a powerful force in protesting against the marginalisation of the disabled (Camilleri, 1999).

The fundamental argument of the social theory is that disability is not about individual impairment but is created as a consequence of the social barriers faced by the impaired individual (Abberley, 1987; Oliver, 1993; Shakespeare, 1994). The model has been called 'the social oppression theory' (Barnes, 1992, p. 118) based on the conviction that social barriers result in discrimination of disabled individuals to the point of oppression (Abberley, 1987). The model also emerged in reaction to the medical model's over-emphasis on intervention at the individual level or what has been called "person fixing rather than context-changing" (Linton, 1998, p. 527). The model contends that the primary focus of change should be the context rather than the person. This may be contrasted with of the medical model that requires that the person should adapt to society (Hughes, 2000).

An example of the negative influence of an individual understanding of disability without taking social factors into account was provided by a study at a university in the UK by Holloway (2001). In a qualitative, phenomenological study using semi-structured interviews, he examined the experience of higher education from the perspective of six disabled students. The students reported that the administrators were unwilling to make necessary changes to accommodate their needs and instead expected disabled students to conform to social norms. This left the students feeling marginalized, disempowered and excluded from general university life.

One of the aims of the social model is to achieve social inclusion of the disabled in all areas of life without the need to conform to social prejudices (Marks, 1999a). Ardent proponents of the model believe that disability research should be exclusively aimed at the emancipation of the disabled (Barnes, 1999). Research that does not have this goal is often regarded as trivial or meaningless. Emancipatory research aims at demystifying the social structures and processes that create disability and facilitating empowerment (Barnes, 1992). The insistence on emancipatory research is the subject of debate among disability scholars since there is scepticism as to whether any research can achieve major change. Insistence on only emancipatory research may be restrictive and possibly grandiose (Shakespeare, 1996).

In contrast, Zarb (1992) suggests that participatory research in which there is collaboration with non-disabled researchers may achieve more towards the emancipation of the disabled and involve a mutual learning process. He draws on the ideas of Oliver (1990) who reflects that empowerment is not something that can be given but must be taken for oneself.

Although the debate continues and has not been resolved it has resulted in a greater emphasis on ethics and consultation in disability research (Zarb, 1992).

In spite of certain practical differences among social model theorists, there is general theoretical consensus regarding the exclusion and oppression of individuals with impairment within mainstream society. Exclusion is seen to occur within mainstream economic, educational and social areas of society (Marks, 1999a). Obvious examples are certain elements in the average built environment that serve to disable or restrict those who have particular kinds of impairments. The difference made by the provision of enabling factors in the environment has been noted (Swain et al., 1993). These include the provision of simple aids like wheelchair ramps, auditory as well as visual indicators in elevators and beepers at pedestrian crossings.

In South Africa changes have been introduced within the built environment. Article 10 of the charter of the Disabled People's Organisation of South Africa clearly states that all new environments should be accessible and safe (DPSA, 2000). However, there are obviously a greater number of older inaccessible built environments that continue to create problems of access for the disabled. Van Niekerk (1997) cites a study by Hattingh detailing typical obstacles faced by wheelchair-bound people of rural areas or townships, home to the majority of the physically disabled. Although Hattingh's study concerns conditions more than 15 years ago, van Niekerk notes that these conditions still apply. Obstacles include irregular surfaces like potholes and poor roads, bucket toilets, insufficient access to water, small dwellings in which mobility is limited, difficulty with location of healthcare, shops and offices and a budget that does not fully accommodate extra expenses for transport.

A disabling environment does not only refer to the physical, built environment, but also to “attitudes, organisational dimensions and work practices” that restrict and disable an impaired individual (Lunt & Thorton, 1994 p. 226). Restrictions include limited educational and occupational opportunities. These have significant implications in a capitalist society like our own in which it is important for an individual to be able to be self-supportive. Restricted educational and employment opportunities available for the disabled encourage dependency and limit opportunities for self-sufficiency.

There appear to be many more obstacles confronting disabled people who wish to enter higher education than their able-bodied peers (Baron et al., 1996). Many higher educational institutions do not have the infrastructure to cater for disabled students. It is expensive to adapt buildings and acquire the necessary resources to upgrade facilities (Preece, 1995). Research in the United Kingdom identified that the disabled are more likely to underachieve at school and are less likely to have acquired a professional qualification than their able-bodied peers (Preece, 1995). The reason given for this discrepancy was attributed both to educational disadvantage and to the physical and emotional restrictions relating to society’s response to disability. By virtue of being generally separated from able-bodied peers, the disabled individuals may be led to believe that they are unable to cope in mainstream educational institutions. Thus, although social model theorists attribute difficulties directly to environmental constraints, factors both within and outside the individual may limit the disabled person’s ability to partake fully in so-called ‘normal’ society (Marks, 1999a).

In the case of employment opportunities for the disabled, discriminatory social (mis)perceptions and practices create further obstacles that exceed individual limitations (Finkelstein, 1993). Misperceptions may account for employer's reticence to hire an impaired individual. Reticence may be based on the fear that the individual would not be able to cope or would require excessive medical attention.

Worldwide, work opportunities continue to be a challenge for disabled individuals. Pearson, Wong and Pierini (2002) studied the subject of social inclusion among a group of ten families with a learning disabled member in China. They identified many difficulties faced by the disabled in finding work beyond a very menial level, due to lack of inclusion of the disabled in China.

However, several countries, including South Africa, offer compensation to encourage companies to employ the disabled (Lunt & Thorton, 1994). It may however be argued that these practices are reinforcing a personal tragedy perspective on disability. Conversely, the employment of a person with disability may help to demystify disability and may serve a positive function. In general, disabled activists feel that disabled individuals have to work extra hard to prove themselves in spite of the belief that they are quite capable of participating in and contributing to community life (Read, 2000).

2.3.1 The social construction of disability

An explanation for the exclusion and oppression of the disabled within society has been offered in terms of theories of the 'social construction of disability' (Marks, 1999a). According to social constructionism, our understanding of the world is developed as a product of cultural, symbolic and historical

relationships among people and that this truth or knowledge remains in place only as long as there is consensus among people (Gergen, 1985).

Accordingly, the term disability is not regarded as absolute or objective condition, but an artificial state or construct, brought about by perceptions and practices that have become entrenched in society (Brett, 2002). Over time, these ideas and practices become taken for granted as facts. Oliver (1993) cites an example of this practice in the common impression that all disabled individuals are dependent. He attributes the creation of the perception of universal dependency among the disabled to the need of industrial society for an efficient work force. He asserts that disabled people were not always excluded from the work force but were integrated into home industries prior to the advent of industrialism. However, the rise of industrialised society brought about the exclusion of the disabled who were no longer able to contribute equally. This resulted in the inability of individuals with impairment to be self-supporting and led to the perception of the disabled as dependent. Modern capitalist economies have been criticised for continuing to favour production over people and attribute worth only to those with able-bodies and minds as modern social environments are geared towards the “young, fit and non-disabled” (Marks, 1999a, p. 4).

The social construction of disability within industrialised Western society has been compared to other societies. Kisanji (1995) observed and interviewed eleven children with impairment from Botswana, Kenya, Malawi and Tanzania as part of a study on the experience of growing up disabled in sub-Saharan Africa. Results revealed that individuals with impairment were generally treated with sympathy and acceptance and were relatively well integrated.

Kisanji (1995) compared African communities with a high level of illiteracy, a subsistence economy and extended families, with more sophisticated technological societies. He found significant difference between the two types of societies in terms of the provision of education and employment opportunities for the disabled. He concluded that although the disabled in modern cultures have the benefit of playgroups, schools or rehabilitation centres they tend to be isolated from general society. He regards isolation as destroying the disabled individual's sense of being a normal valued member of society. However, in the African societies that Kisanji studied, those with impairment were well integrated into society but were dependent by virtue of limited earning ability. This rendered them open to exploitation and abuse.

From a social constructionist perspective, both types of societies that Kisanji compared have created the concept of disability, albeit in different ways. A disabled individual is therefore only dis-abled as long as he or she is unable to meet the criteria of providing that which is of value in a given society. One could speculate about whether the status of disabled individuals in modern society may change in the information age. Currently, computer literacy is regarded as more attractive than physical ability on the job market. This may be a favourable trend for disabled individual's who are technologically competent.

2.3.2 The positive influence of the social model

The introduction of the social model marks an important shift from describing disability in medical, diagnostic terms, to a social understanding incorporating the disabling barriers faced by people with impairments. The social model has been described as providing "an understanding of disability removed from

(good) health” (Tighe, 2001, p. 512). The model represents a positive step away from a personal tragedy view of the disabled.

The disability movement and particularly social theory has played an important role in highlighting disability issues and lobbying for change. The United Nations declared 1981 as ‘The International Year of Disabled Persons’ (de Zaldo, 2000). Although this was an acknowledgment of the need for equal rights for the disabled in society, changes have happened slowly.

In 1993 the United Nations adopted “The Standard Rules on the Equalisation of Opportunities for Persons with Disabilities” (McClain, 2002). This is regarded as an important document that has had an effect on legislation in many countries (de Zaldo). In January 1999, as a result of ‘The African Seminar on Development Co-operation on Disability and Human Rights’ in Cape Town, 2000 –2009 was declared “The African Decade of Disabled Persons”. (Hernandez, 1999). In Africa as in other parts of the globe, non government organisations or NGO’s, led by disabled person’s themselves have played an important role in furthering the cause of disabled people and lobbying for social inclusion for those who have generally been excluded from mainstream society (ISEC, 2000).

The Disabled People of South Africa (DPSA) makes important contributions towards representing those with disability. The motto of this organisation is “Nothing about us, without us”. All these developments reflect the fact that disability has become a social or human rights issue. This was evident at ‘The 4th Convention of the African Human Rights Institutions’ in Kampala in 2002 in which the protection and promotion of the rights of people with disabilities was a topic of discussion (McClain, 2002).

Finally, the influence of the social model is evident in the introduction of Disability Studies in the US and UK. Linton (1998) describes Disability Studies as “a socio-political, cultural model of disability “ different from the traditional medical approach (p. 525).

2.3.3 Limitations and criticism of the social model of disability

Notwithstanding the importance of the social model, limitations of the model have been noted (e.g. Marks, 1999a; Corker & French, 1999; Hughes, 1999; Shakespeare, 1994). The model has been censured for setting itself up as the only way to understand disability (Marks, 1999a). It has also been accused of being too narrow in focus, since it is regarded as neglecting or ignoring the physical body and experiences of individual impairment in favour of an overly socio-political group approach (Hughes, 1999).

Subjective accounts of disabled individuals reveal that problems are clearly not entirely socially produced but include the personal experience of impairment (French, 1993). Social model theorists are often critical of individual accounts of impairment as they are sometimes regarded as detracting from the larger goals of attaining political change (Marks, 1999a). It may be speculated that the model may have lost sight of the individual with impairment in its effort to distance itself from the individualising medical model.

Marks (1999b) criticises both the medical and the social models for regarding the subjective experience of disability as having little significance in understanding or treating disability. She believes that it makes no sense to separate the personal from the social aspects of disability, as both are relevant. It is worth noting in this regard that fortitude is a construct that includes the perception of both individual and social characteristics.

Studies in the UK indicate that personal narratives can function as important sources of insight into experiences of disability and may serve to demystifying impairment (Roker, Player, & Coleman, 1998). However, it appears that social ignorance about disability prevails. This was the conclusion that emerged in a research thesis by Watermeyer (2000). He facilitated a focus group consisting of eight visually impaired students at the University of Cape Town that took place over the period of one year. All participants reported numerous instances that revealed lack of awareness of the experience of disability among able-bodied people. Watermeyer's research provides useful insight into the personal experiences of visually impaired students and confirms theories on the social model of disability.

In conclusion, although there is strong support for the social model within the general field of disability studies, there is a growing consensus that further development is required. Disability scholars (e.g. Corker & French, 1999; Marks 1999a) are finding that an approach based purely on the social model is too narrow and limiting. Suggested changes are in the direction of a multidisciplinary approach, incorporating diverse models that can contribute to the development of new theories and practices. Marks (1999a) suggests that disability be studied on a number of different levels that should not be regarded as competing with one another, but complementary ways of adding value to disability studies. She believes that disability studies can benefit from drawing on the expertise of a number of different ideas even though these may at times appear to be incompatible.

2.4 Defining disability

The definition of disability engenders much debate and it is thus confusing at times to make sense of who exactly the disabled are. Disability is not a unitary state but consists of many different categories. This renders a description somewhat complicated. There is a vast range of physical, sensory and intellectual abilities within the disabled community as there is within the general population (Barnes, 1992). Dis-ability, like any human ability occurs on a continuum; there are various degrees of impairment. Using the example of visual impairment, not all those who are categorized as visually impaired people have the same visual limitations. Although mobility impairment forms the largest category of the disabled, there is great variation of abilities within that broad category.

Since the concept of 'disability' is a broad subject, some definitions may only relate to certain aspects of the disabling experience. A case in point is the South African White Paper titled 'An Integrated National Disability Strategy' (1997) that defines a disabled person as follows:

An individual whose prospects of securing and retaining suitable employment are substantially reduced as a result of physical or mental impairment (White Paper 1997, p. 78).

The White Paper is skewed in the direction of defining disability only in terms of employment opportunities and the provision of a disability grant.

The most commonly used definition of disability is the World Health Organisation definition (1980) referred to as the 'International Classification of Impairments, Disability and Handicaps' or ICIDH:

Impairment is defined as any loss or abnormality of psychological, physiological or anatomical structure or function.

Disability is any restriction or lack (resulting from impairment) of ability to perform an activity in the manner or within the range considered normal for a human being.

A *handicap* is a disadvantage for a given individual resulting from impairment or a disability that prevents the fulfilment of a role that is considered normal (depending on age sex and social and cultural factors) for that individual.

In separating disability into three components, the ICIDH is regarded as attempting to recognise the influence of social factors. However, ICIDH has been criticised for relying too heavily on a medical paradigm and not going far enough to acknowledge prejudice against the disabled, since social factors have not been sufficiently stressed (Marks, 1999a).

It is worth noting that the term 'impairment' is used to denote physical, sensory as well as intellectual deficits in most countries, including South Africa. One of the exceptions is the United States that does not regard intellectual deficit in the same category. However in general, worldwide, 'impairment' is an inclusive term that is applied to a variety of different conditions in recognition of the link between the physical, psychological and intellectual components (Barnes, 1999). Although it is beyond the scope of this study that is only concerned with physical disability, there is debate over whether intellectual disability should be regarded in the same category as other forms of disability.

In 1999 the WHO released the International Classification of Functioning and Disability, Beta 2-version (ICIDH-2) (WHO, 1999). The ICIDH-2 was designed to provide a general "framework for health reporting and decision making" (WHO, 2001) and not specifically as a way of defining disability.

Although the ICDH-2 retains the term 'impairment' the term 'disability' has been replaced with 'activities' and 'handicap' with 'participation' (Bury, 2000). It would appear from the literature that positive responses to the ICDH-2 are all found within a medical or hospital system. Examples include an article on the subject of assessing degree of functioning after injury (Soukup & Vollestad, 2001) or the effectiveness of certain medical interventions (e.g. Boyd & Hays, 2001).

The ICDH-2 makes a distinction between the body level 'impairment', the individual level 'participation' and the societal level 'handicap'. However, it has been criticised for not sufficiently stressing social factors and placing too much emphasis on chronic illness (Bury, 2000). Within the disability movement there appears to be a great deal of disappointment that disability issues have been minimised in favour of larger issues of health.

Criticism ranges from the mild to the extreme. Hurst (2000) asserts that members of the disability movement were not consulted in the development of the new version. She accuses the ICDH-2 of being "very white and industrialised country centred" (p. 1086). Pfeiffer (2000) concurs in her description of the ICDH-2 as "based on Western, able-bodied male ideas of normality" (p. 1081). In essence critics are disappointed that ICDH-2 has become a tool in categorizing chronic illness, a great area of concern in modern Westernised society. There is a sense that the disabled have been sidelined. In fact the word 'disability' does not appear in the ICDH-2.

Consequently, it is no wonder that the WHO definitions are often rejected in favour of a definition that differentiates between the biological condition (impairment) and the social aspects of disability (Barnes, 1999).

An example is the two-tier definition of Gleeson (1997, pp. 193-194):

Impairment refers to the absence of a part of or all of a limb or having a defective limb, organism or mechanism of the body.

Disability is the socially imposed state of exclusion of, or constraint that physically impaired individuals must be forced to endure.

The above two-tier definition shows a clear distinction between impairment and disability that roughly aligns itself to the social/medical model and individual/group splits. Neither of these terms alone represents the lived experience of an individual with impairment. Current thinking is that the experience of disability is a combination of social and individual factors and that the two need to be integrated (Barnes, 1999).

For the purposes of this thesis, the two-tier definition will be utilised. The term ‘impairment’ will signify a physical deficit or functional limitation. The term ‘disability’ will apply to the larger social limitations that result from impairment

2.5 Disability studies: an inclusive, interdisciplinary approach

As has been discussed above, the current trend within disability studies is towards an integrated multidisciplinary approach. Disability studies is developing into a field of discipline in which traditional narrow boundaries are being challenged in favour of what Marks (1999a) describes as “theoretical openness” (p.11). Different approaches are no longer regarded as competing with one another, but rather as incorporating different levels of understanding the complex experience of disability. By virtue of its complexity, no single theory is regarded as being able to offer a full theoretical explanation of

disability (French, 1993). Instead, an interdisciplinary approach is believed to be a way to bridge the gap between “the personal and the political, the internal and the external experiences of disability” (Marks, 1999a, p. 13). Different approaches are regarded as being complementary rather than in opposition to one another. Each is able to enrich the understanding of disability without invalidating the social model.

It is the contention of this thesis that the construct of fortitude is able to contribute or enrich the field of disability studies. Fortitude is a psychological construct concerned with psychological health. Instead of only dwelling on the ill, dysfunctional part of disability, fortitude integrates both positive and negative aspects. This would seem to resonate with the plea within disability literature urging a move away from pathologising disability.

The psychological strength perspective is not generally adopted towards the disabled. Psychological understanding has tended to concentrate on more difficult experiences of disability. Theories of loss and mourning are often utilised in understanding disability (Shakespeare, 1996). Psychological studies often focus on the psychosocial affects of social exclusion, negative stereotypes and prejudice (Reeve, 2002). The relationship between stress and disability has received attention within the field of psychology (e.g. Davies, 1991; Markman, 1992) as well as problems of low self esteem among the disabled (Finkelstein & French, 1993; Marks, 1999a).

Given the focus of psychological attention, it is understandable within disability studies that psychological theories are criticised as being overly pathologising of the disabled (Marks, 1999b) and aligned to the medical model perspective (Duckett & Pratt, 2001).

Critics reject what they regard as the assumption by psychologists that the disabled individual has to come to terms with an impaired body in order to be psychologically whole (Lenny, 1993). According to Susman (1994) disabled writers and researcher see themselves as far less “depressed, anxious and hostile than others judge them to be” (p. 17). Studies have also shown that many disabled people believe that their lives are changed for the better as a result of impairment (Finkelstein & French, 1993).

2.6 Disability and psychological strength.

This study proposes an understanding of disability within the sub-discipline of psychofortology, or the study of psychological strength. There are a number of different models of psychological strength (Wissing & van Eeden, 2002). However, as will be discussed later, the construct fortitude appears to be particularly applicable to the experience of disability. Examples of other constructs within the psychological strength metaphor are coping, resilience, hardiness and sense of coherence.

The sub-discipline psychofortology is concerned with psychological health instead of psychological ill-health or psychopathology. It is a reflection of the influence of the medical model that health is generally described as an absence of illness rather than as a particular state in its own right (Wissing, 2000). In contrast, the strength perspective does not define psychological health or strength in terms of dichotomous, mutually exclusive categories that classify people as either sick or healthy. Instead there are a large number of theories that assume a complex, multi-dimensional approach to health that take different facets of the healthy individual into account (Eberst, 1984).

The World Health Organisation offers the following definition:

Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity (WHO, 1981, p.1).

The WHO definition that first appeared in 1948 makes a positive contribution, as it does not emphasise disease or pathology but a paradigm of wellness. The definition indicates the integration between the mind, body and social aspects of the individual. However society seems to have made very little progress towards emphasising health in contrast to ill health over the years. Ryff and Singer (1998) offer an example of the way that certain practices that emphasise ill health, are taken for granted. They question why research continues to publish rates of pathology and mortality and not statistics of wellness and positive functioning.

In contrast to the above, a positive approach, reflecting an alternative or complementary way to view the human condition has been offered as a new paradigm (Strümpfer, 1993). Research and practice reflecting the alternative paradigm, concerned with elements of human nature and behaviour like psychological strength or wellness is regarded as reflecting a 'salutogenic' or 'fortigenic' perspective (Wissing & Van Eeden, 2002).

These terms refer to the origins of health and strength respectively (Choabi, 2000). The word 'salutogenesis' was coined by a medical sociologist in Israel, Antonovsky (1979) who was interested in understanding the origins of health rather than of illness. He was intrigued with how certain people manage stressful situations and yet remain well. He studied individuals who were able to function well and do more than expected in spite of having experienced great hardships like surviving concentration camps, poverty or slavery.

He conceptualised health, not as a complete lack of illness but rather as part of a response continuum, which he termed the 'health-ease/dis-ease continuum' (Pretorius, 1998, p. 10). He postulated that rather than categorizing a person as healthy or unhealthy, people could be placed in different positions along the continuum. He believed that people are "in part healthy and in part sick" (1979, p.5). He identified that there were certain factors that contribute towards facilitating progress towards the healthy pole of the continuum.

Antonovsky developed the construct 'sense of coherence' (SOC) to describe a quality that acts as a moderator between stress and outcome. He found that individuals with a strong SOC were better equipped to cope with stress. Those with weak SOC would more easily succumb to stress, increasing the likelihood of moving towards the dis-ease end of the continuum. Antonovsky regarded stress and struggle as everyday occurrences and acknowledged that many people succumb to illness or pathology. However, he was far more interested in understanding the origin of health and of developing positive resources than in the study of pathology. He strongly advocated that researchers explore sources of health as well as sources of ill health, since he believed that the study of health was a neglected area of research.

Antonovsky's work encouraged interest in the subject of psychological health both in his country and abroad. In South Africa an industrial and organisational psychologist named Strümpfer further extended and researched Antonovsky's ideas. In analysing Antonovsky's work, Strümpfer (1995) concluded that Antonovsky's theory was in fact an exploration of sources of strength rather than of health.

Strümpfer (1995) suggested the use of the term 'fortigenesis', derived from the root word 'fortitude', indicating strength or courage in adversity. He believed that the term provided a broader description of the construct of psychological health than 'salutogenesis'. He was concerned that the term 'health' might be too limiting since it had undertones of suggesting a single endpoint instead of a continuum (p. 82).

Strümpfer (1995) was particularly interested in the role played by work experiences in enhancing strength. He cites a number of studies conducted in the US and in other parts of the world that reflect the importance of occupational factors in the psychological functioning of both men and women. He showed that it was not only positive work experiences that were personally enhancing. He gives examples of research into stressful and demanding working conditions in which individuals reveal fortigenesis. Examples range from the demands of the multiple roles required of working mothers, to combat situations like Vietnam and Korea.

The relationship between salutogenesis and work orientation was the subject of a quantitative study at the University of South Africa among a large heterogeneous group of industrial and organisational psychology students (Viviers & Cilliers, 1999). The authors assessed salutogenesis according to measures of sense of coherence, hardiness and learned resourcefulness, all of which are similar to fortitude (as will be discussed below in 2.6.2). The study concluded that work orientation and salutogenesis are independent constructs but are related since both characterise movement towards a more optimal level of functioning.

The research by Strümpfer (1995) and others as described above, is regarded as an expression of 'psychofortology', a sub-discipline within the field of psychology concerned with the science of psychological strength (Wissing & van Eeden, 1998). A fortigenic or strength perspective does not attempt to deny pathology or illness, but rejects its inevitability as an outcome for all individuals experiencing hardship or trauma (Goldstein, 1997). This thesis proposes that general theories of psychofortology and in particular the theory of fortitude as described by Pretorius (1998) could contribute towards the study of disability. Although disability contains elements of illness and hardship, it is clear from the earlier discussion that a purely pathological perspective is limiting or restrictive at best and oppressive at worst.

A fortigenic perspective, interested in factors that contribute towards health, appears to be a useful approach to disability, a subject that has tended to be framed exclusively within a medical pathogenic or illness paradigm (Read, 2000; Susman, 1994). A purely negative approach that only focuses on inabilities obscures all other qualities of the disabled person (Finkelstein & French, 1993). As has already been mentioned, fortitude refers to strength in the face of adversity and therefore represents a paradigm that differs from the usual pathological approach.

2.6.1 The construct fortitude

Fortitude is a construct developed by Pretorius (1998) based on the theories of Antonovsky and others within the psychofortology paradigm, developed to understand and explain the origins of psychological strength. Fortitude poses the question: "Where does the strength come from?" (Pretorius, 1998, p. 22).

Pretorius (1998) describes fortitude as 'the strength to manage stress and stay well' (p. 58). His research identified that strength or the lack thereof is derived from the construction of the self and one's world and in particular the strength derived from a positive appraisal of one's self and one's world. He identified three dimensions or domains of fortitude as follows (p. 31 - 32):

An evaluative awareness of the self: This includes both the global appraisal of the self, as well as more specific appraisals such as problem-solving efficacy and mastery or competence.

An evaluative awareness of the family environment, for example support from the family, level of conflict and cohesiveness in the family and family values.

An evaluative awareness of the support from others. This would include both quantitative (i.e. perceived levels of support), as well as qualitative (i.e. satisfaction) dimensions of support. In addition it would include beliefs about the efficacy of using such support resources.

Each of the individual dimensions of fortitude, like self-esteem, social support and family factors has been well research independently. However, fortitude is regarded as comprising the interaction of these three and not simply the sum of the different components. Pretorius' research confirmed that while each of the dimensions were independent from one another, they were also all related to the construct of fortitude (p. 49). Statistics revealed a negative relationship between fortitude and various measures of distress and a positive relationship between fortitude and other measures of well-being.

After having thoroughly investigated and confirmed the validity of a Fortitude Questionnaire, Pretorius empirically tested the relationship between psychological well-being and fortitude as a stress resistant construct. He conducted a study using a large group of university students. A stress resistant group were identified who experienced high levels of well-being in spite of the presence of high levels of stress in their lives. The stress resistant group obtained high scores on the Fortitude Scale, compared to the stress-troubled groups. It was concluded that fortitude has a direct affect on well-being irrespective of the level of stress.

The relationship between fortitude and the kinds of problems experienced by students receiving counselling at the Institute for Counselling at the University of the Western Cape was the subject of a research study (Julius, 1999). It was concluded that students high in fortitude (as measured by the Fortitude Scale) appeared to be less stressed and presented with problems of a less serious nature than students who were low in fortitude.

Prior to discussing the relevance of fortitude to disability studies, a number of related constructs that measure psychological strength will be presented.

2.6.2 Other constructs of psychofortology

(i) Positive psychology

Positive psychology is a somewhat loose term to describe psychological interest in positive attributes within individuals and communities (Sheldon & King, 2001). Seligman and Csikszentmihalyi (2000) advocate that psychology should move away from preoccupation with repairing lives towards building positive human qualities.

Since psychological strength is a positive human quality, psychofortology shares elements of positive psychology. However, positive psychology seems to be particularly interested in the extraordinary (Seligman, 1998) and may be overly positive in its effort to reject the traditional pathological approach. As a result, negative human qualities and experiences may be denied or minimised.

Psychological strength is not all positive and does not require a ‘rose-coloured view’ (Ryff & Singer, 1998, p.10). The usefulness of the psychofortology model is that it tends to assume an integrated approach in which there is a balance between positive and less positive elements.

(ii) Sense of coherence

Sense of coherence (SOC) is a central construct in Antonovsky’s salutogenic model. SOC has been described as a confidence that what life presents is “comprehensible, manageable and meaningful” (Ryff & Singer, 1998). The construct SOC comprises three components or elements that function separately and yet are interrelated (Antonovsky, 1987).

Comprehensibility refers to the knowledge or sense that life has order, structure and meaning.

Manageability is about the extent to which one perceives that one’s resources can meet the demands of a situation.

Meaningfulness refers to personal involvement and motivation in one’s destiny.

For example, a woman with a strong belief that the world makes sense (comprehensibility) would more likely view herself as capable of dealing with life’s demands (manageability) and would be motivated to invest energy into being proactive (meaningfulness). Given that life is stressful and demanding, having a strong SOC does not imply a stress-free existence but concerns a

person's response to stress and the ability to avail oneself of resources to manage stress. Antonovsky (1979) refers to these as "Generalised Resistance Resources" (GRR's), which he describes as follows:

Any characteristic of the person, the group or the environment that can facilitate effective tension management (p. 99).

Antonovsky (1987) developed the Sense of Coherence Scale to operationalise the construct. The scale shows positive reliability and validity results both globally and in South Africa (Choabi, 2000).

Research has confirmed that individuals with a high SOC are more resilient to stress (Korotkov, 1994; Wissing & van Eeden, 1998). A study by Venter (2000) among a group of 226 nurses involved in caring for Alzheimer patients revealed a negative correlation between burnout and sense of coherence. However, since sense of coherence correlates with other moderators of stress, it may be difficult to determine the exact stress reducing contribution of SOC.

This was the case in a research study by Edwards and Besseling (2001) investigating the response to stress among 50 workers at a sawmill in a poor rural community. The workers had been affected by industrial action and a strike that had resulted in loss of pay for six weeks. The researchers administered tests measuring anxiety and depression in order to determine the effects of stress. They also measured three stress response moderators (social support, sense of coherence and religious practice). Although there was a stress moderator effect, the study was unable to confirm that SOC has the ability to moderate a stress response. However, the other measures (social support and religious practice) appear to fit Antonovsky's description of GRR's. According to Sullivan (1993), a person with a strong SOC is more easily able to mobilise his/her GRR's and that this promotes coping.

(iii) Hardiness

Hardiness is a construct developed by Kobasa (1979). It has been described as a personality characteristic that functions as a buffer, reducing strain and illness (Funk, 1992). Hardiness consists of three parts; personal *commitment* (to people and activities within which one is involved), a sense of *control* over events, and the ability to accept change as a *challenge* (Funk, 1992). In developing the construct, Kobasa (1979) compared two groups of executives with comparably high degrees of life stressors. Based on the findings, it was proposed that those with high stress and low illness displayed more hardiness compared to those with high stress and high illness.

In spite of the fact that the concept of hardiness shares elements of other constructs, follow-up research has been unable to provide empirical support for the construct (Ryff & Singer, 1998). Dyer and Mc Guinness (1996) note that hardiness is difficult to apply to people who have grown up in less than optimal circumstances. They question how a child could control a mentally ill or alcoholic parent for example (p. 278). Other critics contend that the construct was developed within a pathogenic paradigm (Strümpfer, 1993). The criticism is based on the way that hardiness is assessed using negative measures like “alienation from the self and from work, need for security, powerlessness, and external locus of control” (Pretorius, 1998).

(iv) Potency

Potency refers to “an individual’s enduring confidence in his/her own capacity” (Ben Sira, 1985, p. 399). A particular experience may feel threatening to one person while harmless to another, depending on an individual’s confidence in the ability to cope with challenges. Lev-Wiese (as cited in Gibson, 1999)

researched the impact of stress among 680 residents of the Golan Heights in Israel who lived under the constant threat of relocation. Results revealed that potency had a greater impact on reducing stress than factors like level of education or sense of community. Potency is thus a description of an individual perception of the self. In comparison, the construct fortitude comprises perception or appraisal of the self as well as of the environment (Pretorius, 1998). Potency appears to be predominantly an individual or intra-psychic model while fortitude includes the inter-psychic or relationship domains as well.

(v) **Resilience**

Resilience refers to a process by which one is able to bounce back from stress and adversity and continue with one's life (Dyer & McGuinness, 1996). Goldstein (1997) describes resilience as the attribute that "epitomises and operationalizes" what the strength perspective is all about (p. 26). He quotes Vaillant (1993) who defines resilience as a "self righting tendency, which is both the capacity to be bent without breaking, and the capacity, once bent, to spring back" (p. 248). There has been a great deal of research on the subject of resilience, particularly in the United States in the field of child psychology. Researchers have attempted to identify individual characteristics that could offer protection to children growing up under conditions of disadvantage and adversity (Masten, 2001). Walsh (1996) cites two studies identifying that contrary to predictions, children are able to rise above conditions of extreme hardship. He gives the example of a longitudinal study by Felsman and Vaillant tracing the lives of 75 high-risk males raised in a poor inner-city environment. The second example cited is a cross-cultural study by Coles among children from Brazilian shantytowns, informal settlements in South

Africa and American inner city children. Studies confirm that resilience derives from successfully engaging or overcoming difficulties (Rutter, 1987). An individual cannot be regarded as resilient if there have not been challenges to overcome (Masten, 2001). Although resilience is usually viewed as a personality trait residing within an individual, Masten (2001) describes the bi-directional nature of resilience as individuals influence and are in turn influenced by their environments. There is thus a close relationship between fortitude and Masten's description of resilience.

(vi) Coping

Dyer and McGuinness (1996), provide a simple definition of *coping* as “the behavioural consequence of having resilience” (p.277). Lazarus and Folkman (1984) include the appraisal process as an important component in coping. Their definition of coping is as follows: “constantly changing cognitive and behavioural efforts to manage specific external and/or internal demands that are appraised as taxing or exceeding the resources of the person” (p.141). Carver, Scheier and Weintraub (1989) further extended the ideas of Lazarus and Folkman (1984) in developing a multidimensional coping inventory. They distinguished between two processes:

The primary appraisal process, in which the threat is perceived.

Secondary appraisal, which consists of a response.

Although coping itself is regarded as the process of affecting a response, the cognitive-emotional and behavioural responses all make up the construct of coping (Lazarus & Folkman, 1984). Carver, Scheier and Weintraub's model (1989) was confirmed in a qualitative study by Naik (2001) exploring coping strategies among a group six physically abused women.

Individual interviews revealed that the women had used multiple coping strategies based on an appraisal of each situation. Furthermore, consistent with the above definition of Lazarus and Folkman (1984), Naik found that the meaning ascribed to the available resources, whether these were environmental or personal resources, influenced coping patterns among the women. Cultural beliefs were shown to play an important part in influencing meaning and in determining a coping response. In this context, coping may not necessarily result in a positive outcome as may be the case for women who remain in an abusive relationship for reasons specifically related to personal or cultural beliefs.

(vii) Social support

Johnson (2001) describes *social support* in terms of a stress-reducing resource. Social support has been found to promote psychological health (Elliott & Gramling, 1990). Research indicates that social support may either directly affect psychological adjustment or act as a buffer and moderate the negative effects of stress (Pretorius & Diedricks, 1993). However, not all research studies on social support have yielded positive results. In making sense of inconsistencies, Elliott and Gramling (1990) clarify that not all supportive relationships are positive. They cite Coyne and DeLongis who argue that social relationships may involve over protectiveness, intrusiveness and over involvement.

Elliott and Gramling (1990) undertook a quantitative study among 141 undergraduate college students on the relationship between personal assertiveness and social support. The authors conclude that the role of interpersonal factors is an important component of social support and depends

on characteristics of the giver as well as the receiver of the support. These conclusions are consistent with the work of Vaux (1990) who describes “an ongoing dynamic transaction between individuals and social networks” (p. 508). He conceptualises social support as a meta-construct consisting of three components, none of which are sufficient to describe the concept on their own:

Support network resources

Supportive behaviour

Subjective appraisal of support.

The importance attached to the appraisal of social relationships is similar to the process identified by Lazarus and Folkman (1984) on the subject of coping (as discussed immediately above). Likewise, the appraisal of the social support from others is also an important component in the construct of fortitude (Pretorius, 1998).

(viii) *Psychological well-being / wellness*

Although common sense suggests that *psychological well-being* must be the opposite of psychological illness, there is lack of clarity about the meaning of the term. It appears to be easier to describe problematic human behaviour than healthy behaviour (Christopher, 1999). There have been many different definitions of psychological well-being, each highlighting its complexity and multidimensional nature.

An early study by Blackburn in 1969 (as cited in Baker & Intagliata, 1982), utilised a balance model in which it was hypothesised that psychological well-being was related to the difference between positive affect and negative affect.

Witmer and Sweeney (1992) identified characteristics of wellness as being expressed through five life tasks including spirituality, self-regulation, work, love and friendship.

Ryff and Keyes (1995) identified the following factors: positive self regard, mastery of the environment, good relations with others, continued growth and development, purposeful living, and the capacity for self-determination. From the above one gains the impression that general wellness resembles a shopping basket of attributes. Christopher (1999) notes that theory and research on psychological well-being is substantially shaped by Western individualistic moral visions of the good or ideal person. He cautions that researchers need critical awareness of cultural understanding of psychological well-being so that our so-called norms are not discriminatory. This is an important factor to consider in a multicultural South Africa. This is particularly important in disability research in which one should guard against imposing discriminatory notions of so called normality (Brett, 2002).

A large-scale project on different manifestations of psychological well-being was undertaken by Wissing and van Eeden (2002). A quantitative research design was employed utilising questionnaires on a cross sectional South African population drawn from two universities, a number of organisations as well as residences for the aged all within a particular geographical area. Seven different factors were identified, namely general psychological well-being, personal actualisation and the capacity to love and work, constructive and social involvement and coping, multidimensional healthy lifestyle, relational well-being in close relationships and substance (in)dependence. The study confirmed the complexity of models of well-being.

(ix) **Protective Factors**

Protective factors are processes that interact with risk factors in order to reduce the probability of negative outcomes (O’Leary, 1998). All of the constructs mentioned above may act as protective factors.

2.7 The integration of the theory of fortitude into disability studies

Thus far, this chapter has presented theoretical models in the field of disability studies as well as certain criticisms of these and directions for change. The construct of fortitude as developed by Pretorius (1998) has been discussed within the broader discipline of psychological strength. Fortitude as a model of psychological strength appears to be a theoretical construct that may have application in the field of disability studies.

Like other salutogenic or fortigenic models, fortitude is not a theory of pathology or abnormality. In this respect it is suited to the subject of disability studies that has lobbied to disengage itself from labels of abnormality (Marks, 1999a). Although Fortitude is a theory of health or strength, the model is not concerned with strength alone but with courage or strength in the face of adversity. Consequently it is entirely possible for an impaired individual to have fortitude and manage to maintain psychological strength despite the hardships or limitations of the disabling experience.

Like other health models presented, fortitude is based on Antonovsky’s (1979) concept of the health or ill-health continuum in which there are degrees of health. There is no clear distinction between normal and abnormal, between healthy or unhealthy or able-bodied and disabled.

A continuum model suggests flexibility or change. Within a paradigm that acknowledges change there is less opportunity to relegate anyone to a single, static position, like normal or abnormal. For an individual with physical impairment, acknowledgment of the possibility of change is counter to a description of disability as a personal tragedy.

The personal tragedy perspective suggests dependency and disempowerment. In contrast, fortitude can be regarded as empowering of individuals. This is an important criterion for any theory that has application in the field of disability, given the history of the oppression of the disabled. It is impossible to bestow fortitude on anyone or indeed to remove a person's fortitude. Fortitude concerns the individual appraisal of the self and of others in which both individual and relationship factors are integrated and acknowledged. Thus, fortitude is not only contained in individual qualities (the positive appraisal of the self) but also in group, interpersonal or social qualities (the positive appraisal of the support from family and the environment).

In this respect, there are similarities between the theory of fortitude and current thinking within disability studies on the importance of integrating rather than separating individual and social factors in understanding disability. Fortitude is the sum of the various positive appraisals within the three interacting domains. Positive appraisal in one area may compensate for a less positive appraisal in another domain. As has been discussed earlier, disability can be stressful, with respect to personal experiences of impairment as well as in terms of the social responses or lack of adequate social responsiveness by others. It may easily be assumed therefore that an impaired individual could never be described in terms of positive psychological health.

However, although fortitude is a model of positive psychological health, the construct integrates both the positive and the negative. It is entirely possible to have a disability and to have fortitude notwithstanding difficult circumstances. In fact, a characteristic of the salutogenic/fortogenic paradigm is the presence of the positive in circumstances normality regarded as negative.

The objective of this research study is to demonstrate that the construct fortitude has application within the field of disability. Although the construct was developed among a heterogeneous group of undergraduate students, it is the contention of this thesis that fortitude has equal application among a group of students with physical disability. This is consistent with the approach of Marks (1999a), who encourages that disability studies should move in the direction of “dialogue and cross fertilization” (p. x). Marks is promoting the idea of moving away from only conducting research that relates to either medical or social matters relating to disability. In the present research, a small group of students with disabilities were interviewed to identify sources of strength. As will be discussed in the next chapter, results revealed dimensions of fortitude consistent with the general theory of fortitude as identified by Pretorius (1998).

Chapter 3

Research Methodology

3.1 Introduction

A qualitative research design consisting of unstructured individual interviews was selected for the present study. This chapter will commence with a discussion of the qualitative approach and its application in disability research. Thereafter, the question of disability research conducted by a non-disabled researcher will be presented. Information concerning data collection as well as details about the participants in the study will follow. A description of the method of data analysis will be given. The chapter will be concluded with a discussion of various ways of measuring the trustworthiness of qualitative research and with the limitations of the methodology of the current study.

3.2 The qualitative research design

Qualitative research consists of a range of philosophies and techniques (Parker, 1999). Barnes (1992) offers a brief definition of qualitative research as:

A tradition of enquiry concerned primarily with meaning and interpretation, compared to quantitative research that emphasises the importance of statistics (p. 115).

The following provides an overview of some of the essential characteristics:

Results are communicated in words rather than primarily in numbers as stories and dialogue become the medium of analysis (Stiles, 1993).

The researcher assumes a stance of 'empathic neutrality' (Patton, 1990, p. 45) in relation to the phenomena being studied. This is different from a sense of either objectivity or subjectivity. Instead, a researcher aims to understand the

other person's experiences or feelings and to use this as a channel of information in order to "provide the sense of what lies within". (Parker, 1999). Qualitative researchers are thus not passive observers, but participants in and an integral part of the research process (Parker, 1999). Being a partner in a process encourages empathy and helps to eliminate the sense of the other as an object (Denzin & Lincoln, 2000). Morris (1992), a disability activist, believes that a partnership approach to research breaks down boundaries and disconfirms negative images of the disabled.

As a consequence of the stance described above, interpretations are tentative and not fixed, since they are comments on meaning that is not directly observable (Mason, 1996). Qualitative research provides for non-linear causality; there do not have to be a direct cause and effect relationships (Stiles, 1993). This characteristic is evident in the current research that reflects the complex interrelationship between dimensions of fortitude.

Qualitative research is particularly sensitive to issues of power relations. It aims to reduce the possibility of the abuse of power and the disempowerment of the participant by regarding the participant as the expert on his or her own life and experience (Holmes, 1997). Qualitative researchers often advocate that the goal of research should be empowerment or emancipation (Stiles, 1993). This is consistent with the opinions of certain researchers within the disability liberation movement (e.g. Barnes, 1996, Morris, 1992; Shakespeare, 1994, 1996).

Qualitative research methods are common within the field of disability studies since they are seen as a way to guard against discriminatory practices (Barnes, 1992).

Shakespeare (1996) when commenting about his stance when researching disability, notes that although he accepts that he is the main author and the holder of the majority of the power, he strives to equalise the relationship to give the participants a measure of control over the process. To this end he rejects certain methods like the formal structured interviews and questionnaires. The unstructured interview method of data collection used in the present study was chosen with the aim of offering participants the opportunity to verbalise and explore their own experiences without setting these up against particular predetermined standards. The unstructured interview allows the interviewee to respond from within his or her personal frame of reference, allowing individual ideas and meaning to emerge (May, 1997).

Qualitative research offers the opportunity of obtaining exploratory data on a given subject (Patton, 1990). The qualitative design was chosen for the present study since it provides the best opportunity to explore the research question on identifying dimensions of fortitude. Qualitative designs are well suited to small-scale studies like the current one (Barnes, 1992).

3.3 Disability research and the non-disabled researcher

The question of the participation of a non-disabled researcher in disability research is relevant to this thesis. In the past disability research in general has been implicated in contributing to the oppression of the disabled (Morris, 1992). Disability activists have been highly critical of the legacy of disability research that exploited those with disabilities under the guise of helping or liberating them (Shakespeare, 1996).

People with disabilities often criticise disability research as not reflecting their own experiences (Barnes, 1992; Morris, 1992; Shakespeare, 1996).

On a much more serious note, critics (e.g. Finkelstein, 1993, Morris, 1992, Oliver, 1995, Read, 2000) have highlighted practices that completely disregard the needs and interests of the disabled while serving the individual requirements of the researcher or research institution.

As a result of the kinds of criticism alluded to above, there is a general wariness in respect of the non-disabled researcher conducting research among the disabled. The bulk of the critical literature on disability seems to have been undertaken by those with functional impairment (e.g. Barnes, 1996, Corker & French, 1999; Morris, 1992, Oliver, 1990, Shakespeare, 1996).

On the other hand, there are others who feel that it is unnecessary to have impairment in order to conduct good quality research in the field. The argument advocating that only the impaired individual is equipped for disability research suggests that disability is a single homogenous experience. Barnes (1992) contends that the range of different abilities within the disabled community is great. Thus, the presence of impairment does not automatically mean that an individual is able to feel an affinity for or is indeed interested in disability research.

Morris (1992) is in favour of collaboration between the (non-disabled) researcher and the (disabled) participant(s) in order to lobby against the oppression of disabled groups. In the final analysis, one could pose the question whether research among the disabled should be any different from any other research in terms of adhering to ethical principles.

3.4 Data collection

Initial data collection began in consultation the Unit for Special Abilities at the University of the Western Cape. The Unit provides assistance to a group of about 60 students with disabilities on the campus. A number of meetings were arranged with the co-ordinator of the Unit. The co-ordinator provided general information about the Unit and the affiliated students and agreed to discuss the proposal with the student executive body. The research proposal as well as a letter requesting permission to conduct the study, was brought before the executive and permission was granted in principle. Although it was originally proposed that interviews be conducted at the offices of the Unit, this proved to be difficult due to time constraints of the students and the constant use of the facilities. Since students with disabilities all reside in one particular residence on the campus, it proved to be easier to conduct interviews at the residence. Further liaison between the students and the researcher was conduct through the matron at the Chris Hani Residence. The matron arranged a meeting attended by the students and the researcher. The purpose of the meeting was to establish rapport, particularly since the researcher is not a person with a physical disability

At the meeting, the general purpose of the study was explained and questions were answered. This led to an informal discussion about courses of study and general life on the campus. Participants were informed that participation was voluntary and they were assured of confidentiality and anonymity. There were no incentives offered. Individual interviews were conducted during July and September 2003 at the student residence in the matron's office.

Prior to beginning the process, permission was requested and granted from the Registrar of the university to conduct the study at the student residence.

Individual interviews began with a discussion of ethical issues including informed consent, anonymity, the question of using direct quotations and the ability to withdraw at any time if they chose to do so. A statement of consent to participate was read to each participant and co-signed (Appendix B). In the case of blind students, this was read and agreed upon in the presence of a third party from the residence. Interviews were of about one hour in duration. Prior to the interviews, a short demographic questionnaire (see Appendix A) was administered verbally and completed by the researcher. Although none of the participants was a first language English speaker, the interviews were conducted in English, the language of tuition at the university and of the interviewer. Interviews were audio taped and later transcribed verbatim. All interviews began with the question “Where do you think your strength comes from”? The interviewer attempted to ask only clarifying and open ended questions and to avoid direct or leading questions.

3.5 Participants

The sample consisted of five males and one female, drawn from a group of students with physical disability living in residence at the University of the Western Cape. Participants were self-selected, having volunteered to partake in the study after an informal meeting with the researcher. Four of the participants present with mobility impairment, while two are visually impaired. Four of the participants have acquired impairment while two have congenital impairment. The participants range in age from 23 to 36 years of age and are involved in a number of different areas of study.

3.6 Data analysis

Marshall and Rossman (1995) describe data analysis as “the process of bringing order structure and meaning to the mass of collected data (p. 111). In the present study, data was analysed using qualitative content analysis.

May (1997, p. 173) quotes Ericson et al. describing qualitative content analysis as follows:

The analyst picks out what is relevant for analysis and pieces it together to create tendencies, sequences, patterns and order.

Data analysis began with a thorough reading of each of the typed transcripts in order to identify themes. Time was spent reading and rereading the transcripts to generate themes that reflected the meaning behind the participant's narratives. The rationale for using this approach was to allow themes to emerge naturally as a way of answering the research question on participant's perceptions of dimensions of fortitude. As each transcript was read, themes were marked off using coloured highlighters, a different colour for each theme. Each theme was given a two-letter code name. Codes provide basic label for assigning meaning to descriptive material. For example, the positive appraisal of the self was assigned the code ME, while disability struggles were coded DS. During this preliminary stage, themes were generated through inductive analysis. They were allowed to emerge out of the data without imposing the categories prior to collection or presupposing which categories would emerge (Patton, 1990). This approach may be contrasted with deductive analysis in which themes or categories are set in order to satisfy a hypothesis.

The analyst aimed at assuming a stance of ‘empathic neutrality’ (Patton, 1990, p. 54) or openness to understanding the participant’s world.

During the second stage of the process, provisional themes were written on a large piece of paper in the form of a mind map. Sub-themes were clustered together according to commonalities of meaning.

The third stage of the process involved decisions about final theme names. The analyst was guided by “sensitising concepts” or concepts that she had brought to the data that provide a general sense of reference or direction (Patton, 1990, p. 391). In this case, direction was provided within the general framework of psychofortology, by the theory of fortitude and particularly the three dimensions of fortitude as identified by Pretorius (1998).

The analyst decided on themes based on her judgment in interpreting and integrating the participant’s responses into the existing theoretical categories (Mason, 1996). Once themes are finalised, each transcript was carefully re-read in order to ensure that the participant’s meaning was not lost in the process of deciding on theme names.

After data analysis and prior to finalising the results, a brief summary of each participant’s response was written up and given to the participant for comment. This was to ensure that results properly reflected the participants meaning (Barnes, 1992) and allow the participants a sense of co-authorship (Winslade & Monk, 1998).

3.7 Trustworthiness of results

The concepts validity, reliability and generalisability are used as a way of judging quantitative research methodology.

* “*Validity* refers to the degree to which what has been measured corresponds with other independent measures obtained by different research tools” (Parker, 1999, p. 10).

* “*Reliability* is the extent to which the same results are obtained if the research is repeated” (Parker, 1999, p. 11).

* “*Generalisability*” refers to “the usefulness of one set of findings in explaining other situations” (Grbich, 1999, p. 66).

Qualitative research acknowledges what has been referred to as “awareness of the gap between an object of study and its explanation” (Johnson, 1999, p. 186). Thus, although qualitative research attempts to accurately capture the feeling or represent the meaning, it acknowledges the “sense of debate in research rather than a sense of aiming for a fixed truth” (Parker, 1999, p. 3). Consequently, it has been asserted that validity, reliability and generalisability are inappropriate terms in a qualitative paradigm that relies on interpretation rather than objective truth (Marshall & Rossman, 1995). Instead, the notion of “trustworthiness” has been proposed to measure the authenticity or “good practice” of a qualitative study. (Johnson, 1999, p. 186). Trustworthiness is measured by the concepts credibility, dependability and transferability.

3.7.1 Credibility

Credibility has been described as “confidence in the truth of the data” (Polit & Hungler, 1995, p. 427). For research to be credible it has to demonstrate that it was conducted in a manner that represents as accurately as possible the participant’s world (Marshall & Rossman, 1995). The present study aimed to achieve this by allowing participant’s to voice their own opinions during the interview process and through consultation with participants after data analysis.

3.7.2 Dependability

Dependability is similar to reliability from the quantitative perspective. Reliability assumes that it is possible to replicate a piece of research. According to the qualitative approach, it is impossible to replicate work. Repetition would entail a different piece of research; there would be a different researcher, different participants, differences of time and place that would result in a different meaning (Tindall, 1999). Instead of aiming for reliability, dependability is achieved by a “well documented, systematic approach to the process of collecting and analysing data...open to the scrutiny of the reader in line with acceptable principles and standards” (Johnson, 1999, p. 187).

3.7.3 Transferability

Transferability is similar to generalisability, or the extent to which results can be generalised to other populations (Marshall & Rossman, 1995). As discussed under dependability, qualitative research explanations are linked to only one particular time and setting and cannot therefore claim to be generalisable. However, findings may be transferable to other situations as a way of providing insight or information. According to Johnson (1999) transferability of research from one situation to another requires adequate detail about the theoretical focus, specifics about the situation and setting as this enables readers to judge for themselves and make links from one situation to another (Johnson, 1999). The present study investigates dimensions of fortitude among a group of university students with physical impairment. Results cannot be generalised to other populations of disabled individuals, but may be useful in contributing to the body of knowledge on disability studies and to the sub-discipline of psychofortology.

3.8 Limitations of the methodology of the current study

A number of methodological limitations that may impact on the trustworthiness of the results need to be considered. Since results were obtained from single interviews at a particular time and place, conclusions are limited to the present study and are not transferable. This is consistent with the theoretical understanding of qualitative research that acknowledges that meaning is altered as circumstances change (Parker, 1999). The small sample size of the present study may also affect transferability. Conclusions cannot be said to represent all students with physical disabilities. However, results have provided insight into the perspective of a small group of disabled students.

The third limitation concerns that of language. Given that all interviews were conducted in English and not the participant's mother tongue, meaning may have been lost, further compromising the credibility of results.

Finally, characteristics of the researcher-participant combination may have prevented the emergence of narratives that represented participant's true feelings. All the participants were black students who had been previously economically, socially and politically disadvantaged in the past. While one of the students hailed from a poor community outside of South Africa, all the others grew up under the apartheid system. In contrast, the researcher was a white woman who does not have a physical disability. Given that the researcher was a master's level student, compared to most of the participants who were undergraduate students, issues of power may have constrained participants from speaking openly. These differences may also have compromised credibility of results.

3.9 Conclusion

This chapter on research methodology commenced with a general discussion of qualitative methods and its application in disability research. The current debate on the role of the non-disabled researcher in disability research was highlighted and it was suggested that impairment is not a prerequisite for conducting disability research but rather that one should adhere strictly to general ethical practices.

Regarding specific details of the current research, participants consisted of a group of six students with physical disability all living in a student residence at the University of the Western Cape. Data was collected by means of unstructured individual interviews that were audio taped. These were later transcribed verbatim. Qualitative data analysis was used to generate themes that would provide clarity on the research question.

Since a qualitative research methodology was employed, results needed to be judged according to measures of credibility, dependability and transferability that together reflect on the trustworthiness of research results. Trustworthiness of qualitative results is a form of control comparable to the concepts validity, reliability and generalisability in quantitative research. Limitations of the methodology of the current study that may impact on the trustworthiness of the results were presented in the last section of this chapter. These include factors like the single interview process that occurred at a particular time and in a particular place; the small sample size and language and other differences, that may have constrained participants from speaking openly.

Chapter 4

Results

4.1 Introduction

This chapter details results obtained from qualitative content analysis of the transcripts from the individual interviews. The content reflects participant's response to the question "Where do you think your strength comes from"?

An overview of themes and sub-categories of themes is presented first. Thereafter, each of the themes is individually discussed. A discussion of results with reference to the research question, the theory of fortitude and current literature will follow. The subject of reflexivity concludes the chapter.

4.2 Six main themes and sub-categories of themes

Struggles and difficulties of the disabling experience

Situational limitations and difficulties

Interpersonal /the social construction of disability

Fortitude

Disability as something positive

The absence of depression

Giving something back to others

The evaluative appraisal of the self as a source of strength.

Positive appraisal of the self

A perception of the self as part of normal society

Personal drive and ambition

Evaluative appraisal of the support from the family

Evaluative appraisal of the support from others

Interconnectedness of the dimensions of fortitude

4.2.1 Struggles and difficulties of the disabling experience

Although participants occasionally mentioned general difficulties (e.g. financial constraints that prevented studying), the presence of difficulties unique to the disabling experience was prominent. Four of the six participants mentioned situational frustrations e.g.:

Difficulty of access, e.g. lectures that are upstairs.

Needing extra time to arrive at lectures.

Lecture notes or test that were not translated into Braille in time.

All the participants spoke of negative social perceptions and unpleasant experiences with able-bodied people that they found stressful. These ranged from insufficient incentives or information provided to the disabled about study options to more serious discrimination, underestimation or pity towards the person based purely on negative perceptions of impairment.

“A lot of people think that disabled people should be just sitting at home looking for the end of the month for their (disability) grant. They are just walking by and they say ‘Can I help you?’ Why does he or she need to help you? I mean if you need help you should just ask for help. People think that you are special when it comes to a love relationship. You find that people are not expecting you to be in a love relationship” (M).

“Problems make people like me feel that people are despising me; they don’t consider me a human being... my head, my brain, I walk, I feel just what other people feel” (Se)

“Immediately people bump into a blind person they think that you have a mental problem, that’s their perception” (Mp).

4.2.2 The theme of fortitude

In spite of the fact that the theme of struggles and difficulties with the disabling experience was a prominent one, none of the participants was overwhelmed or defeated by these experiences. All the participants believed that they had the ability to maintain strength in the face of adversity and rise above obstacles.

One of the participants lost her sight at age 18 and as a result had to give up her dream of becoming a nurse. While describing the difficulties in being the first blind student in her particular field, and the kinds of problems that she experiences, she nevertheless maintained a positive approach and a sense of joy and lightness towards life in general. (The latter was expressed in her non-verbal communication rather than in her verbal expression).

“Getting notes is also a serious problem. You cannot study without notes, they write a test today but you don’t have notes so you are to wait for 5, 6 days, 10 days before you can write. So everything comes late for you. What it is that motivated me, mme, I think its my desire to see myself finishing the degree because every time whatever happens, I tell myself that I want this degree. I want to finish my studies, though it is difficult”.

In spite of difficulties in moving from a special school into a mainstream university, M, was determined to pursue his dream of becoming a lawyer.

“If you want to achieve something you have to go outside. There is no tertiary school for people with disabilities...you can’t go to the labour market like other normal people that have no education, rather than getting this Disability Grant you have to further your education.”

Among many of the participants there was a sense that negative experiences have somehow driven them to achieve.

“(People) underestimate me...I don’t go off to prove them wrong but they give me a challenge” (Ro).

A conviction that disability had been a positive growth experience and that impairment had rendered the individual as a better person was directly expressed by half of the participants.

“When you don’t have any disability, when you are normal, whatever you are doing, you are just doing for the sake of ‘I’ve done it’. You’re not doing it for the sake of purpose” ... “I regard my blindness as quite useful in a way as I’m asking myself: Who would I be here if I wasn’t blind? ... ‘Would I have achieved what I’m having now if I wasn’t blind? I don’t think so.”(Pa).

“Many people say that I am an inspiration to them. People say that I live a different life somehow. So I guess if I was not disabled I probably would have lived life differently” (N., who is mobility impaired as a consequence of polio at the age of two)

“I believed in myself even more after the accident” (Ro).

“I don’t regret being blind.” (Pa).

One of the indicators of fortitude is the presence of only low levels of depression (Pretorius, 1998, p.23).

“There are times when you don’t feel good about yourself. It is part of life, sometimes you are happy, sometimes you are not and you just control these emotions...a person may feel a bit depressed but get out of it quickly...It doesn’t get to me...I’ve not sure that I even know what depression is.” (N).

A further indicator of fortitude was expressed in the desire to give something back to others. A student from outside of South Africa with acquired mobility impairment, expressed a desire to return to his country after completing his degree in order to pass on what he had learnt to uplift his own country.

“We don’t have things that side. If I go home I have to help those other people. It is not in keeping silent that things should become good”.

4.2.3 The appraisal of the self as a source of strength

All the participants expressed a positive sense of self albeit in different ways:

“Once you feel ashamed of yourself, you’ll never go anywhere...but it’s up to you. What are you telling yourself? What do you want to do with your life? I’m the kind of person who when I want to go somewhere I will, no matter what, nothing will stop me.” (Pa).

“I draw my strength from, my determination in making sure that the opportunities that I get hold of I make full use of” (Ro).

“I’m this kind of person, ...I don’t want to be a loser; I always want to compete for something. I always set myself a goal and say I want to achieve that goal no matter what happens...When I’m thinking about the goal that I set I have to achieve that” (Mp).

All of the participants regard themselves as being just like everyone else. While acknowledging impairment, they did feel that it was a significant part of who they are.

“As people in the world we all have something that is not 100%. I think that God gave me this that is not 100%. It is written in the bible ‘No one is perfect’. When it says that it means that none of us is perfect and I believe in that...I feel like a normal person” (Se. who acquired mobility impairment in an accident at 18).

The sense of being regarded as ‘normal’ by able-bodied friends and themselves and being part of everyday experiences was commonly spoken of.

“I’m the only blind person there. In most cases I’m always taking part in whatever they are doing. The way that they see me they don’t treat me as different, like sometimes they forget that I can’t see.” (Mp, describing the importance of his youth group, where he feels a strong sense of belonging and reports that he is never treated like a disabled person).

"When I grew up I matriculated in a sort of normal school where everybody is... what's the difference?' When I was with able bodied people they could learn from me and I could learn from them" (N).

Having personal ambition and goals was part of the positive sense of self. Since the participants were a group of university students, there was a sense of motivation and drive towards success in this regard.

"You should know what you want and you should know where you are going"(Mi., on the subject of his studies).

"It is important in life to have a job, a good job and that is something that drives me"(N).

4.2.4 Evaluative appraisal of the support from the family as a source of strength

One of the participants regards most of his family with the exception of his late mother as unsupportive and critical of his efforts. All the other participants described their families as contributing towards their strength and generally supportive of their endeavours.

"I have a brother who was studying, at Wits and is a lawyer today. He is also blind...At home they really supported me, especially my father because he is also blind...they would give themselves time to come and sit with me and show me and help me." (Pa).

"She was the person who always believed in me. From there I build my support base ... they always told me that I am able."(Mp)

"My family...they never really treated me like a disabled person"(N).

" My family was always very supportive, my mother...showed me that it does not matter if I'm disabled or not. She really believed in me and my family always gave me support"(Mp)

"Play(ing) the role of a cornerstone for me" (Ro. Describing his family).

4.2.5 Evaluative appraisal of the support received from others.

All the participants mentioned the importance of friends and others in their lives as valuable sources of strength.

“The lady used to tell us that whatever you want to do you can do, despite your blindness do not regard yourself as blind, regard yourself as a human being who want to pursue a career...put your desires forward and that’s how you will gain the strength to reach your goals” (Pa. describing the teachers at her colleague).

“They always motivate me and always give me hope. Made me to be the person that I am.” (Mp in speaking about the support he receives

The way that colleagues at university accept and treat the disabled person was commonly regarded as a source of strength. It is not the university itself, but the ethos of non-discrimination and acceptance as expressed through its people.

“Since I’ve come here people don’t mind, they don’t look at you like you are disabled...they take you as a normal person who can ask for help like any other person, not just that you need help because you are disabled”(M).

“They build me. What I need emotionally” (Ro describing university friends).

4.2.6 The interconnectedness of dimensions of fortitude.

Although the three dimensions of fortitude were described separately as three different themes, it was very clear from stories that participants had a sense of the interconnectedness of the dimensions in that evaluative appraisal in one dimension affects evaluative appraisal in another dimension.

One of the participants believes that his psychological strength comes from to the emotions that he experienced in seeing two of his brother crying for him after his accident. He has found it sustaining and supporting to know how much he means to his family.

“Those tears sort of drove me...I was faced with how bad my family felt when I was in that accident” (Ro).

One of the participants spoke of having a very strong sense of direction in life that he linked to the way that his family and others treated him.

“If the family don’t treat you like a person, people outside cannot. My family treat me like a very valuable person who can judge and do things like any other person. I find that people around me will not treat me ill because they know that my family stood at my side (M).

Examples from other participants include the following:

“They are really supporting me and I think what is really motivating them is seeing that I’m not failing. They see that my results are good and feel positive towards me and that help me to feel good” (Pa).

“There are people that believed in me that helped to motivate me. From there I build my support base” (Mp).

“They take it for granted that I am like them. That’s what made me realise that I am part of a community, a part of people around me, then I can be happy in the way that they are” (Mp).

However the interconnection should not be regarded as only functioning in a positive direction. One of the participants describes the interconnection as serving to reduce psychological strength.

“The family sometimes express self doubt, that holds me back” (Ro).

The connection between the evaluative appraisal of individual and family factors are evident in the family values as expressed by one of the participants.

“ It’s in my family as well. At home we are all goal orientated” (Ro).

4.3 Discussion of results

The first part of this chapter presented the themes that emerged from participant's stories in response to the question: "Where do you think your strength comes from"? This part of the chapter consists of a discussion of these themes relative to current literature and the theory of fortitude.

4.3.1 The presence of adversity in participant's lives

The findings revealed the presence of high levels of stress and adversity in the lives of all interviewees. As has previously been mentioned, the construct fortitude relates to the ability to remain psychologically well despite stress or adversity (Pretorius, 1998). Most of the stress spoken about was in relation to the disabling experience. On the one hand this is consistent with social model theory that disability accounts for the vast majority of the stress in the lives of those with impairment (Morris, 1992). However, there may have been other reasons that constrained participants from discussing more general stressors. The most obvious reason was the fact that participants were aware that the study concerned disability. Although this is a matter that may warrants further discussion, it must be born in mind that the present study aimed at identifying dimensions of fortitude in order to determine sources of psychological strength and was not specifically concerned with adversity.

It was the participants themselves who volunteered information about stressful experiences relative to disability. This theme is consistent with evidence from literature on the social model of disability in which disabled people report feeling marginalized or disempowered by virtue of environmental constraints as well as through the perceptions and actions of others (Corker & French, 1999; Read, 2000; Shakespeare, 1994; Thomas, 1999).

With respect to the research question, results revealed that all of the participants made a connection between adversity or stress and psychological strength. In effect, all were aware that they were able to maintain strength despite the presence of stressors. The participants made this link themselves without any prompting from the interviewer. The presence of strength in spite of stress is consistent with the salutogenic and fortigenic paradigm in general.

Antonovsky (1979) was very clear that stress is a normal part of life. He was concerned with how people respond to stress and was particularly interested in understanding the characteristics of those who did not succumb in spite of extreme stress. Similarly, Pretorius' (1998) research on fortitude identified a 'stress resistant group' who were able to maintain strength despite difficulties. Ryff and Singer (1998) emphasize the role of the negative in positive health. They argue that since positive health concerns actively engaging in life, "difficult experiences, pain and struggle are inevitable parts of such engagement: (p. 10).

4.3.2 The presence of fortitude.

Results revealed that in spite of the presence of negative experiences and particularly negative experiences relative to the disabling experience, all participants regarded themselves as having the ability to rise about their troubles and maintain strength. This ability has been described by Pretorius (1998) as 'fortitude'. None of the participants used the term 'fortitude' since it is a construct that is relatively unknown. However, all participants acknowledged qualities that fall within a strength/fortitude perspective.

These included the ability to regard disability as something positive which was consistent with research by Finkelstein and French (1993) alluded to earlier.

Another example of fortitude includes the absence of major depression, as identified by Pretorius (1998) in his stress resistant group.

While the above examples may be described as subjective evidence of fortitude, there are also examples that can be classified as objective evidence of fortitude. Research has shown how stressful student life can be for those with physical disabilities (Baron et al., 1996; Holloway, 2001). Thus, it would seem that the ability to persevere despite challenges and stressors provides objective evidence of fortitude. The desire to serve one's community and give something back to others as described by one of the participants is a final example that reveals fortitude or psychological strength.

4.3.3 The three dimensions of fortitude

Consistent with the theory of fortitude, participants believed that they obtained strength from an appraisal of their personal and environmental situations. In particular, sources of strength were identified as falling within the three dimensions of fortitude, namely the positive appraisal of the self, the positive appraisal of support received from the family and from the support received from others. Results also showed that the three dimensions had different importance for different people; for some the support from family was extremely important while others particularly valued the contribution of the support from friends or others. Although two of the participants mentioned religious faith as a source of strength, they both tended to regard faith as part of a family or personal ethos or support system rather than as a source of separate strength in its own right. The question of whether spirituality or religious faith should be regarded as another dimension of fortitude has been limited by the small sample size of the present study.

(i) *The interconnectedness of dimensions of fortitude*

Although the three dimensions of fortitude will be discussed separately below, the dimensions make more sense as an interconnected whole. Each of the individual dimensions can be explain on their own. However, somewhat analogous to members of a sports team, each of the three dimensions affects and are affected by each of the other dimensions to a greater or lesser extent to produce fortitude.

As has been stated in 4.2.6, participants stories revealed a sense that one dimension affected another. This part-whole characteristic has commonly been discussed in relation to other theories within the salutogenic and fortigenic paradigm. Witmer and Sweeney's (1992) model of wellness consists for example of five interconnected life tasks, namely: spirituality, self-regulation, work, love and friendship. While each of the five is seen as contributing in its own right, it is only as a whole that the model makes sense. Goldstein (1997), in his research on resilience, stressed that resilience was not located within a person or within the social support system but in the "mutuality's of interpersonal relationships" (p. 31). He was describing a two-way process between the individual and social systems. Similarly, Ryff and Singer (1998) describe the many facets of positive psychological health as going "beyond the separated layers into a synthesis" (p. 23).

Thus, although fortitude consists of three dimensions that are synthesised into a whole, these will be discussed separately in the following section for further clarity.

(ii) *The positive appraisal of the sense of self*

The theme of the positive appraisal of the sense of self was the dimension that was most prominent in participant's narratives. A positive appraisal of the sense of self has been shown to be an important component in many of the other constructs discussed in section 2.6.2. Hardiness for example has been described in terms of a personality characteristic that helps to reduce stress (Funk, 1992), potency refers to a confidence in one's abilities (Ben Sira, 1985) and sense of coherence is regarded as a proactive human quality (Ryff & Singer, 1998).

In view of the negative characteristics of the social construction of disability, disabled individuals who have fortitude would also require a strong sense of self. There has been much literature and research on the negative effects of the social construction of disability on the self-identity of the disabled (Hughes, 1999, Shakespeare, 1994). As mentioned previously, the subject of identity was investigated in a research study on the meaning of health and disability among a group of eight women with physical impairment at Syracuse university (Tighe, 2001). Results indicated that by virtue of the social response to impairment, disability was regarded as the person's "master status in society" rather than as a small part of the person's identity (p.526).

However, a study by Watson (2002) at Edinburgh university among 14 disabled men and 14 disabled women on self identify found that most of the participants did not see themselves as disabled in the way that society does and did not identify with other disabled individuals. It was not that participants denied impairment, but that they strongly rejected negative and demeaning stereotypes and had a clear sense of their own identities.

The above findings are consistent with the views expressed by participants in the present study. All six participants were very clear in rejecting a disabled identity in spite of accepting the presence of impairment. For all of the participants, a positive appraisal of themselves took the form of a refusal to accept negative perceptions of others. They were all very clear in defining themselves as 'normal' in contrast to 'abnormal' and expressing a positive sense of self. The ability to resist the social pressure to regard themselves as abnormal can be contrasted to the research by Brett (2001) and Tighe (2001) discussed earlier in which participants expressed a sense of abnormality.

Another manifestation of a positive sense of self was evident in participant's positive attitudes and motivation towards their studies. This was classified as a sub-theme titled 'sense of personal drive and ambition'. These findings are consistent with the positive relationship between work orientation and fortigenesis as identified by Strümpfer (1995) as well as with the study by Viviers and Cilliers (1999) among industrial and organisational psychology students at the University of South Africa as cited earlier.

(iii) *The positive appraisal of support from the family*

The positive appraisal of the support received from the family was generally regarded as an important source of fortitude. There was however one exception, a 36-year-old male who had lived apart from his family for many years. Although he acknowledged the positive appraisal of support that he received from his mother who is now deceased, he regarded his extended family as competitive and distrustful rather than supportive of his choices in life. Although this appears to be an example of a negative occurrence of one of the dimensions, this may be explained by broadening the definition of family.

This participant appears to have moved on with his life and has formed a new family in Cape Town who are supportive.

Another participant spoke a great deal about his family and although he found them extremely supportive he also acknowledged the challenges of trying to do things on his own. He felt that his family often wanted to do too much for him. This is consistent the conclusions of Coyne and DeLongis as discussed earlier, highlighting that social support is not only experienced as positive.

There are many examples in the literature of the importance of the family in the well being of an individual. Feetham (1997) quotes a World Health Organisation description of the family as the “primary social agent in the promotion of health and well-being” (p. 322).

A classic study on resilience was conducted by Werner and Smith (1982) in Hawaii. The study followed the progress of 600 children from infancy till the age of 18. In spite of being reared under very adverse conditions, many of the children displayed resilience. Family factors were shown to be a significant contributor in making the difference between the vulnerable and the resilient child. A study by Holmbeck and Wandrei (1993) among a large group of first-year college students in America, found that adjustment to college was related to personality factors as well as to elements of the family relationship. However, research by Schultheiss and Blustein (1994) among undergraduate students at a different American college found that the adolescent-parent relationship was related to adjustment in females but not for male students. It was also concluded that family relationship factors might function in different ways in different developmental stages.

(iv) *The positive appraisal of support received from others*

Results revealed that a positive appraisal of the support received from friends and others was regarded as another source of strength or dimension of fortitude. Research on social support has shown that it acts both in a direct way as well as indirectly in moderating the effects of stress and reducing depression (Pretorius & Diedricks, 1993).

Consistent with other research, results revealed that the support from others was regarded as complex or multidimensional. It was not simply that others bestowed support in a patronising manner; in fact participants were very clear that they did not require help or assistance from others. Instead the appraisal of support was part of a two-way relationship. It was sometimes mentioned by participants that they first needed to prove themselves to others (or visa versa).

This is consistent with a description of social support as provided by Vaux (1990) as “a complex process involving transactions between people and their social networks that unfold in an ecological context” (p. 512-513). Vaux’s model stresses the appraisal of support, recognising that social support cannot be measured quantitatively but is the qualitative component.

Research by Elliott and Gramling (1990) at Virginia University noted the relationship between interpersonal behaviour, social support and psychological adjustment. Elliott and Gramling conclude that social support is a process that begins with an interpersonal relationship. They regard one of the positive outcomes of social support as psychological adjustment.

4.4 Summary of results

In summary, the results reveal that participants in the study identify sources of their strength as originating from a positive appraisal of the self and a positive appraisal of the support received from their families and from others. This is consistent with the theory of fortitude as presented by Pretorius (1998).

Participants revealed awareness that they possessed fortitude in spite of the presence of stress in their lives and that the two were somehow linked. Most of the stress appeared to be attributable to problems with respect to disability.

The construct fortitude is made up of three dimensions. However, for this small sample of students with physical impairment, the positive appraisal of the sense of self appeared to be the strongest dimension. This result is not surprising given the negative pressures on an impaired individual by virtue of the social construction of disability. It would seem that a strong sense of self is required in order to show fortitude as an individual with physical impairment.

4.5 Reflexivity

A requirement of the qualitative methodology is that the researcher should reflect on her impact on the research process (Johnson, 1999). Reflexivity is the process of being critically and constructively aware of oneself as part of one's research (Banister, 1999). It is impossible for a researcher to step out of the social world in order to study it. By virtue of our mere presence in the research situation, we are influencing others as they influence us (Johnson, 1999). We enter a research situation with perceptions, understandings, interests and areas of bias that affect our perceptions and this in turn influences our explanations (Parker, 1999).

In spite of some of the negative implications of the above that may be termed a lack of objectivity, Parker (1999) explains that instead of wishing away “the gap between the object and its representation” qualitative researchers work with the gap or the problem (p. 4). He explains further that although qualitative researchers aim to become as close as possible to an objective account, “subjectivity is a resource not a problem” (p. 13). During the interview process, the researcher is required to engage in an ongoing internal dialogue about the reflective experience while simultaneously living in the moment (Fontana and Frey, 2000, p. 659). In writing the final report, reflexivity acts as a control, offering the possibility of other realities and encouraging one to question one’s assumptions, and to consider alternatives (Banister, 1999). Reflexivity is thus regarded as a useful tool in qualitative research.

4.6 Personal reflexivity

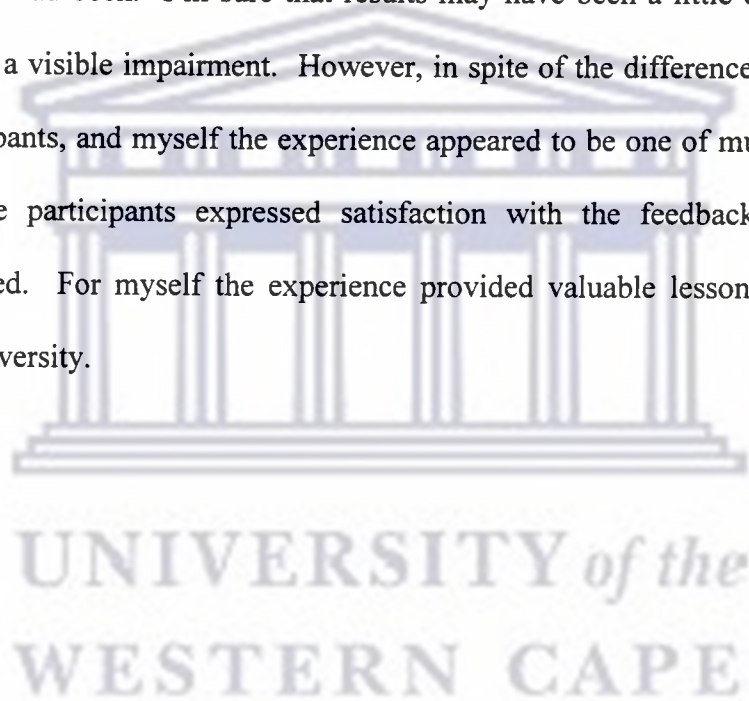
My interest in psychofortology had been sparked by literature on the alternative paradigm prior to registration for the Master’s degree in Clinical psychology. In spite of the vast amount of material that needed to be covered in the Master’s year, emphasising the pathological perspective, I was nevertheless drawn to the study of the strength model. The choice of studying fortitude from the perspective of disabled students came about as a result of a chance meeting with a blind student on the campus. The meeting took place at a time in which I was experiencing difficulty balancing the demands of being a wife and mother as well as a fulltime student and feeling somewhat sorry for myself. However, in discussion with this student, I was afforded insight into the difficulties of a world of which I was totally ignorant.

Although the subject of diversity was part of the curriculum for trainee psychologists, I realised that I was totally unaware of the experiences of disability. This sparked my interest and I began reading of the subject of disability and found that there was very little that did not reflect a medical approach. The paucity of disability research from a positive perspective provided further justification for the direction of the research.

I thus began my research journey from two purely selfish motives to study a subject for my own interest and because there appeared to be limited research on the subject. As I immersed myself in the literature on the social model in particular, I was forced to confront my own motives. However, an initial meeting with the disabled students prior to the individual interviews helped to build rapport in a relaxed atmosphere. I was able to overcome my initial sense of awkwardness about impairment and feelings of wanting to offer help.

The individual interviews were more challenging than I had expected. My research on the social model as well as my own feelings in the room elicited a sense of concern about the power dynamics that were operating across a number of levels. My position as an older, white, non-disabled female pursuing a post-graduate degree placed me in a position of power relative to participants. Clearly, these differences would impact on the results. During the interviews, I had a sense that with the exception of the subject of disability, there were many unspoken areas of conversation. However, I was also aware that many of the challenges that I faced were similar to those in the therapeutic situation for which I had been prepared during my training. This knowledge helped me to contain my discomfort and use it in order to build rapport with the participant by using emphatic listening skills.

I was acutely aware that I had learned from the participant in a similar fashion to the way a therapist learns from the patient (Casement, 1997). I found all the participants extremely open to speaking about themselves. After each interview I asked participants whether they had questions for me. I was sometimes asked how I (as an able-bodied person) experienced the disabled. While this was uncomfortable at first, this may perhaps have been a way of checking out my level of comfort and willingness to be an object of study just as they had been. I'm sure that results may have been a little different had I shown a visible impairment. However, in spite of the differences between the participants, and myself the experience appeared to be one of mutual learning. All the participants expressed satisfaction with the feedback that I later provided. For myself the experience provided valuable lessons on working with diversity.



Chapter 5

Conclusion

5.1 Summary and interpretation of results

This thesis was driven by an underlying belief that the theory of fortitude could be usefully applied in the field of disability studies. Critical disability literature reveals dissatisfaction with what is regarded as the medical model's over-pathologising of disability (Marks, 1999a; Pfeiffer, 2000). Opponents contend that the medical model has exaggerated differences between the impaired and so-called 'normal' society. In so doing, the disabled are marginalized and respond to with pity, a process that has been described by Oliver (1993) as the 'personal tragedy theory of disability'. Participants in the present study expressed views that concur with the above criticism. They voiced general unhappiness about the negative assumptions that other make about them based purely on impairment. In contrast and consistent with other findings (e.g. Hughes, 1999; Watson, 2002) all participants described themselves as quite 'normal' in spite of the presence of physical impairment. Participants made a strong plea to be judged or valued in the same way as everyone else and not according to labels of illness or pathology.

An alternative to the pathological paradigm has been offered by the salutogenic or fortigenic paradigm, interested in the subject of psychological health or strength (Wissing & Van Eeden, 2002). Within this paradigm, the construct fortitude, the subject of the present study, is concerned with understanding the origins of psychological strength in the face of stress or adversity.

Fortitude does not deny the presence of illness or pathology but aligns itself to the approach of Antonovsky (1987), conceptualising health as a continuum rather than in terms of a dichotomy. The concept of a continuum describes a process of heterostasis or change rather than homeostasis or balance (Antonovsky as cited in Pretorius, 1998). The literature reveals the struggle within disability studies to conceptualise the subject in terms of heterostasis rather than in terms of a fixed state as indicative of labels like disabled-able-bodied, healthy-unhealthy or 'kingdom of the well and the 'kingdom of the sick' (Tighe, 2001) p. 511).

A study of fortitude among the disabled is in no way intended to minimise the many stressors experienced as a consequence of impairment. Research has shown that impairment results in stress both as a consequence of environmental limitations as well as negative social perceptions (Swain et al., 1993). The present research revealed that participants attributed a significant proportion of the stress in their lives to problems with respect to disability. This is consistent with results of other studies conducted among students with disabilities (e.g. Holloway, 2001; Marinez & Sewell, 2000; Preece, 1995).

However, in spite of the stress in their lives, participants showed evidence of psychological strength or fortitude. As fortitude is not a commonly known construct, none of the participants used the actual term. Nevertheless, all acknowledged that they did not feel overwhelmed or defeated by the stress in their lives. All the participants believed that they had the ability to maintain strength despite adversity. Many expressed the view that negative experiences have somehow driven them to achieve. Half of the participants reported feeling that disability had been a positive growth experience.

Consistent with Pretorius' research on fortitude, none of the participants experienced depression in any significant form.

In response to the research question: "Where do you think your strength comes from?" participants attributed sources of psychological strength to the three dimensions of fortitude as described by Pretorius' (1998). These include a positive appraisal of the self and a positive appraisal of the support received from families and from others. Of the three dimensions, the positive appraisal of the sense of self appeared to be the strongest and the one most spoken of. This result is not surprising given the negative pressures on an impaired individual by virtue of the social construction of disability. It would seem that a strong sense of self would be required in order to show fortitude as an individual with physical disability. Disability literature contains many examples of disabled writers reflecting a positive sense of self in spite of pressures from society to regard themselves as less than others (Barnes, 1999; Oliver, 1990). One such writer, Corker (as cited in Swain and Cameron, 1999), refers to the need to accept impairment without describing oneself only in terms of disability. This concurrent with views expressed by participants in the present study.

To return to the subject of fortitude, it is extremely important to stress that fortitude consists of the sum of the positive appraisals of the three different domains. Although each of the three domains is important in its own right none can stand alone, since that would not describe the construct. Since fortitude consists of three parts, the total is made up of different proportions of each dimension in different individuals. In the present study it appears that the positive appraisal of the self has been stressed.

However, all participants mentioned all three domains as well as an interrelationship of the three domains. This point has been stressed in order to counteract a sense of exaggerating the positive or valorising individual's with impairment.

None of the participants regarded themselves in heroic terms and it would be a grave injustice to suggest otherwise. The nuances of having a positive sense of self as compared to being described as a hero are difficult to put to paper. The literature reflects criticism among disabled activists in the way that the media portrays an exaggerated, romanticised view of disability (Shakespeare, 1994). Camillieri (1999) a disabled academic writes about his battle with breaking through into normal society and how he was set apart and seen as different. Participants in the present study did not regard themselves as in any way special in spite of acknowledging that they could be described as having fortitude. This is the essence of the health or strength perspective in general. Masten (2001) describes resilience as 'ordinary magic'. She explains that resilience develops out of ordinary rather than extraordinary processes and speaks of 'the power of the ordinary' (p. 235). She reveals her excitement and optimism in terms of the implications of ordinary magic in promoting human well-being. Fortitude can also be described as ordinary magic in that it does not require ingredients that are only accessible to a limited few but is made up of ingredients of ordinary life. The results of the present study have suggested that the construct fortitude has application within diverse groups.

5.2 Limitations and recommendations

The results of this study were generated by means of single individual interviews, conducted in English during a particular period in time.

The interviews took place between a non-disabled researcher and six participants, all students from UWC with a physical disability. Results are limited to the conditions mentioned and are not easily transferable to other groups of physically disabled individuals.

The very small sample size was a limitation that may have prevented the exploration of the research question on a deeper level.

A further limitation concerns possible oversimplification. Social aspects such as race and gender that may have impacted on the results were not included in the analysis. There was only one woman in the sample and in fact most of the students on the campus with physical disabilities are males. The subject of gender and fortitude warrants further investigation.

This study was just a beginning; its purpose was simply to explore dimensions of fortitude among students with physical disability. The following recommendations for future research are made:

Further research on the subject of fortitude among people with disability is advised. According to van Niekerk (1997), South Africa has one of the largest populations of trauma related spinal cord injuries resulting in physical disability. Confirmation of the presence of fortitude among more disabled members of our society helps to challenge negative social stereotypes.

Further research is required in order to gain a deeper understanding of fortitude in order to develop primary and tertiary preventative programmes. Research within a salutogenic and fortigenic paradigm has the potential to make a useful contribution in terms of future planning. This concept is well described in the words of Barnard (1994) "Pathological focus is geared towards the past in contrast to elements of resiliency and on the future" (p. 143).

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APPENDIX A

Demographic Details

First name: _____

Age: _____

Gender: _____

Home language _____

Degree: _____

Year of study: _____

Marital status _____

Country and area of origin: _____

Special Ability: _____

Was the disability acquired or present at birth? _____

Special education: _____

The logo of the University of the Western Cape, featuring a classical building facade with columns and a pediment.

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APPENDIX B

Consent Form

I, _____
hereby declare that I was not coerced into participating in this study. Ethical issues were discussed with me, with regard to confidentiality and anonymity. I was informed of the nature of the study and its purpose. I am also aware that I am free to decline from participation as well as to withdraw from the research study if I so choose.

Participant's signature _____

Researcher's signature _____

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