

EMPIRICAL STUDY

## Vulnerable, but strong: The spinal cord-injured patient during rehabilitation

SANNE ANGEL, PhD

*Department of Nursing Science, School of Public Health, Aarhus University, Aarhus C, Denmark*

### Abstract

A traumatic spinal cord injury affects the body to an extent that the patient requires the assistance of others to survive and recover. The rehabilitation phase puts the patient in a vulnerable position and involves a considerable amount of strength on the patient's part. The aim of this paper is to explore the vulnerability of the spinal cord patient and how this vulnerability connects to the necessary strength, as the patient struggles to survive the injury and get through the rehabilitation.

The circumstances of 12 traumatic spinal cord-injured patients were observed in the rehabilitation unit and after discharge.

A phenomenological-hermeneutic narrative approach applying Ricoeur's theory was used. Data were collected by field observation and interviews during the first 2 years after the spinal cord injury.

The patient's strength during the rehabilitation was portrayed by their endurance and from their narratives of how they handled difficult situations. The patient's perception of vulnerability varied, and strength was mobilised as a response to the vulnerability to overcome the imbalance between demands and resources. Vulnerability should therefore refer to a person's experience of the situation rather than the person, as it may hinder the professionals' open, explorative approach towards the person.

**Key words:** *Phenomenological-hermeneutic, narrative, rehabilitation, Ricoeur, spinal cord injuries, vulnerability*

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This paper presents the perspective of becoming vulnerable after a spinal cord injury. A longitudinal study of the patients' circumstances investigated the first 2 years of rehabilitation after a traumatic spinal cord injury. The narrative approach to the data collection provided extensive material open for analysis that can contribute to our knowledge of the patient's situation after a spinal cord injury from different perspectives, in this case vulnerability. The data has previously been analysed to investigate the spinal cord-injured patient's struggle to get on with life (Angel, Kirkevold, & Pedersen, 2009a, 2009b, in press).

### Background

Being vulnerable is a human condition (Henriksen & Vetlevsen, 2000). Human life is frail and exposed to numerous risks, necessitating precautionary measures. Other people play a significant role in these

measures, either directly or on a societal level. The dependency is most obvious in regard to the child and the individual who are unable to take care of themselves. The experience of independency increases with the extent the individual manages to take care of him/herself and takes precautionary measures (Henriksen & Vetlevsen, 2000).

Sellman (2005) argues that all humans are vulnerable as they can be harmed even though vulnerability is not apparent in a well-functioning everyday life. Sellman (2005) describes three categories of vulnerability; Type I risk of harm in which a person through his/her action has a chance to protect him/herself; Type II risk of harm in which a person's security depends on the actions of others; Type III harm is the unavoidable event against which the person is powerless. This means that vulnerability can be understood as a cause/effect. This receptiveness may be great or small. In some cases, self-protection is possible, in others the protection depends on other peoples' help,

and some cases are out of reach. This risk theory implies a demand/resource reasoning as the person may or may not be capable of handling the situation and eliminate the risk. The demand of the risk must be met with adequate resources. In a well-functioning daily life—even when the person’s own ability to keep the balance between demands and resources means it is maintained with the help of others—the vulnerability is often unperceived and may subsequently elapse. Then, if injury and illness occur, the person is reminded of his/her vulnerability. Therefore, Sellman (2005) defines the patient’s vulnerability by choosing the term “more-than-ordinarily” vulnerable.

Leffers et al. (2004) look at the relationship between risk and vulnerability, which often have been used as synonyms in nursing literature. In six empirical studies they show that in spite of a person being judged vulnerable from an external view as an attribute of the individual by the society, vulnerability is not static and the actual risk will be met with more or less resilience (Leffers et al., 2004). This means that a person’s actual vulnerability will first be revealed by the level of strength they manage to mobilise as they meet the risk.

Spiers (2000) explores this understanding of vulnerability from an objective and a subjective perspective. The objective perspective is an external assessment of whether a person is capable of self-protection based on normative social values like physical, mental, and social disadvantages in regard to self-care. The subjective assessment is from the perspective of the person who is actually vulnerable and requires that the vulnerability is perceived. This means the person meets challenges that call on their capacity to withstand, integrate or cope, and have the potential to disrupt the person’s integrity. These assessments may point at different levels of vulnerability. Thus, a person may perceive him/herself as strong, while he/she is assessed as being vulnerable and vice versa.

Henriksen and Vetlevsen (2000) point out that nursing builds on attitudes and actions of care dedicated to supporting and protecting the vulnerable patient and reducing his/her vulnerability (Henriksen & Vetlevsen, 2000). From a study of 12 persons with experiences from rehabilitation after acute or chronic illness, Sigurgeirsdottir and Halldorsdottir (2008) report that the vulnerability of the patient in rehabilitation is connected to the existential struggle to change everyday life due to the injury or illness. This implies the challenges of changes in self-identity and clinging on to old aspects of self and life. The participants described the vulnerability as being thrown off balance and imposed an even heavier burden of rehabilitation (Sigurgeirsdottir & Halldorsdottir, 2008).

The study by Perry, Judith, and Anderson (2006) describes how vulnerability is associated with the illness, its significance and related concerns. They found that the patient’s vulnerability was reduced when the patient met with competent, accessible professionals. On the contrary, the vulnerability increased if the patient felt neglected (Perry et al., 2006). The fundamental influence of the professionals on the patient’s balance is sustained by Angel, Kirkevold, and Pedersen (2009a), who report how the professionals support promoted the rehabilitation process and the patient’s well-being. This support obviously connected with the patient’s perspective. Otherwise, the patient would either give up the expectation of support from the professionals or suppress themselves to adapt to the professional perspective. In both situations, it had negative consequences for the rehabilitation process, and increased the patient’s agony in unbearable circumstances (Angel et al., 2009a, in press).

By combining the relative risk between external and internal demands and resources, and the accident of dependence, this study has been based on the following understanding of vulnerability: objective vulnerability appears when challenges a person faces surpasses his/her resources (own and even those supplied by others) and requires the mobilisation of extra resources. If own capabilities are exceeded, they should be supplemented by the help of others. Perceived vulnerability appears when the person him/herself realises that his/her resources, even supplemented by others cannot be mobilised or can only be mobilised with great difficulty.

In relation to the post-traumatic situation, an association between vulnerability and strength has been reported. As Calhoun and Tedeschi (2006, p. 5) cite, this connection is often expressed as “I am more vulnerable than I thought, but much stronger than I ever imagined”. Other studies have recognised this connection (Lohne & Severinsson, 2004). But, how are strength and vulnerability connected when being vulnerable is related to lack of resources in regard to the challenges? How does this relate to the expressed feeling of being vulnerable while at the same time feeling as strong as never before? Is vulnerability then a cognitive assessment and strength the experienced feeling? The statement does not tell us anything about the coexistence; does the feeling of vulnerability stop when the feeling of strength begins? Perhaps the patient experiences a feeling of great vulnerability, but also at the same time an unexpected amount of strength. To offer the patient adequate support, we need to know more about this relation between vulnerability and strength. Thus, the aim of this paper is to explore

the vulnerability of the spinal cord patient and how this vulnerability connects to the necessary strength to survive the injury and get through the rehabilitation.

## **Method**

The present study is phenomenological–hermeneutic with a narrative approach applying Ricoeur’s (1983, 1985, 1988) theory of man’s way of understanding himself and his world and interpretation (Ricoeur 1976, 2008). In a Ricoeurian (1983) approach, the vulnerability originates from the lack of the person’s understanding of him/herself and his/her world. Caused by the overwhelming event, he struggles to re-orientate as this event is beyond him. As long as it cannot be understood, it is not bearable either (Ricoeur, 1991). From the patient’s narratives towards an understanding of the spinal cord injury and what it means to him and his life, we learn about how the vulnerable situation was perceived and managed.

### *Setting and subject*

In Denmark, spinal cord-injured patients are assessed early on in the acute care unit before referral and admission to the rehabilitation unit. Their stay lasts between 2–12 months. Twelve spinal cord-injured patients were included consecutively as they were admitted to the rehabilitation unit. One man declined—giving the reason being beyond thinking just putting all his strength into walking again. The participants were all Danish-speaking adults, aged 17–71 (mean 43.75) without documented health problems prior to their injury. They were observed for more than 2 years after the accident at the rehabilitation unit and after discharge (2005–2007).

### *Data collection*

Seven interviews and nine field observations were conducted following the accident to uncover the patient’s interpretations of the situation and their attempts to create understanding and coherence in their experiences over time.

Data was collected more frequently in the beginning because of the assumption that the patients’ experience would be closely related to the experienced physical progress (Kirkevold, 2002). In the interviews (after the first, second, third, sixth, ninth, twelfth month and after 2 years) a narrative approach was encouraged by inviting the patients to talk freely about their situation, including any experiences and thoughts (Cicourel, 1988; Kvale, 1998; Pedersen, 1999). The questions were open-ended and included

the following: “Would you please tell me about what has happened?” And in the subsequent interviews, “Would you please tell me about what has happened since the last time we spoke?” In contrast to a retrospective perspective of storytelling, the prospective collection of their stories gave the researchers material to interpret and illuminate personal experiences and processes. The interviews (50–120 min) were conducted at the rehabilitation unit and later in the informant’s home, and were accompanied by field observations. Field observations were conducted three times (3–4 h) prior to the first interview and subsequently in connection with each interview. The focus was daily life during rehabilitation in the rehabilitation clinic and at home after discharge. The interviews were recorded and transcribed in full, and field observations were noted down immediately afterwards. The two data sources provided a broad data basis and interplay between external and internal experiences. Although Ricoeur is clear about pre-understanding never being eliminated, his intent is to meet the text as openly as possible. This approach extends to include the meeting with the participants. From a thorough analysis where the researcher’s intention was both to understand and explain the final results, our knowledge about the subjective will be expanded to show a general knowledge about the world.

### *Data analysis*

The data analysis was based on Ricoeur’s (1976, 2008) theory. All interviews were initially read separately and interpreted naïvely, and then generally with the transcribed field observations and notes; so, what did the text convey to us in general (Pedersen, 1999; Ricoeur, 2008)? The overall impression from both interviews and field observations was the spinal cord-injured patients’ loss of function and their struggle to regain some function. The conjectures from the naïve interpretation were substantiated using a structural analysis; what did the text convey with respect to semiotics; what did the text inform us about the narratives of vulnerability (Ricoeur, 2008)? These narratives dealt with perceived vulnerability and the existence of strength to understand the association. In the critical interpretation, the results of the structural analysis were used to challenge the naïve interpretations. The aim was to reach highly significant and coherent interpretations.

## **Ethical considerations**

The Ethics Committee of the County of Aarhus expressed no necessity for examining the study (21 December 2004). Permission was obtained from the

Head Nurse and the Medical Consultant at the rehabilitation clinic in West Denmark. The nurse who had prior contact with the eligible patients presented written information for the patients, as they were found capable for participation in the study. At the first meeting, the researcher informed the patient about the study, that their story would be only be used for the research, and they would be anonymous, although they may recognise elements of their own stories. The participants were informed that they could withdraw their consent at any time. Because of the early stage of the injury, the psychologist at the rehabilitation clinic was informed when the researcher had talked to the patient, and whether there was anything to report, so that she could subsequently attend to the patient's condition.

### Findings

The spinal cord-injured patients' narratives showed varying perceptions of vulnerability resulting from their experience of the balance between resources and demands. Strength was mobilised as a response to the vulnerability. The analysis revealed signs of being strong despite the vulnerability. This could be the result of an inner resource, often promoted by others' support. Signs of being strong could also be the result of a reduction of demands. However, mobilised strength could also be lost again, which reminds us of the fragile existence of strength when vulnerability is an objective condition.

### Substantial vulnerability

The spinal cord injury had a comprehensive influence. Vulnerability of the spinal cord-injured patient resulted from the paralysed body and the mental distress caused by the situation. The magnitude of this vulnerability can be illustrated by the Rober-Logan-Tierney Model of Nursing (Rober, Logan, & Tierney, 2000), known for its thoroughness in regard to capturing the complexities of living. The model categorises living activities: maintaining a safe environment, communicating, breathing, eating and drinking, personal hygiene and dressing, controlling body temperature, mobilising, work and play, expressing sexuality, sleeping, dying. During a lifespan, these activities are under the influence of biological, psychological, sociological, environmental and politicoeconomic factors, and managed in a continuum of dependency-independency (Rober et al., 2000). The basic issue is to achieve a balance between demands and resources. The findings showed that in the acute state of the spinal cord injury, all living activities were affected except for controlling body temperature, and for most patients, breathing. The

spinal cord-injured patient's demands, physical as well as mental, required increased attention, while at the same time their personal resources, both physical and mental caused by the paralysis, were small. Kate (44-year old, unable to walk, problems with her hands) spoke of her experience of the imbalance between demands and resources caused by the paralysis:

... and this is probably why all the hope I had is gone, because I didn't really have any great expectations. Well, I can see that I am improving, but not where I am paralysed, though ... This is still the big question whether I can be rehabilitated. (2 months post injury)

To Kate, the situation was substantially vulnerable bordering on hopelessness. Still, she had no intention of giving up. She was a mother and a wife, and her children and her husband relied on her. Despite a situation close to hopelessness, she was not even thinking about giving up: "no no, I wouldn't dream of it because of my husband and children. My husband often asks me if I have done my exercises properly" (2 months post injury). This demonstrates the power of being in a significant relationship. The strength seemed to have roots in the social identity. So, her family's needs gave her extra strength.

Strength existed even in the extreme situation of vulnerability. In urgent need of self-protection, a passenger in a car accident, Cindy (64 years of age with problems in walking and with her hands), managed to ask for the right help:

The police came and they started to drag me out of the car. I protested because my head dropped to one side and I couldn't hold my head. I was paralysed from my chest down. I told them not to do it. I know all about the spinal cord. (1 month post injury)

Cindy was strong, despite her inability to protect herself. She recognised the situation she was in and had the strength to use her knowledge to help the professionals to provide her with the right help. Cindy's story underlined the importance of help from other people because demands could be met from the surroundings only. The nurses' have an important role in protecting the spinal cord-injured patient who would not otherwise survive. When this happens, they relieve the patient. As in Belinda's case (60 years of age, problems with walking and hands), she felt safe despite her lack of physical and mental resources:

Some of the professionals were absolutely marvelous. They were so caring and knew just how to handle you as a person and could go in and do things for you without you having to ask. They just did it. They were just fantastic. (2 months post injury)

As the nurse supported the patient's efforts to rehabilitate, she supplied the patient with the resources the patient did not have herself. Consequently, the vulnerability of menacing and exposed demands decreased. Belinda's strength showed her ability to deal with her situation searching for resources. As an example she asked to see her vicar:

I spoke to our local vicar when I was in hospital, because I was devastated . . . I told him, I didn't feel as though this was God's punishment. If this is how you practice your faith that this was God's punishment—well, I don't believe in that sort of thing. My faith was a comfort to me. (2 months post injury)

Belinda knew enough about herself to know that her religion could help. Although in this severe situation she needed the vicar's support to reach an understanding. This indicates that knowledge and knowing oneself may encourage strength when the vulnerability was substantial, in addition learning to adapt to the new situation could promote strength. To Edward (17, unable to walk) this meant that he could handle the feeling of depression related to exhaustion:

When you realise oh well, it is just the same again; you have a bad day; then you have a good day and then you become better at tackling the bad days by reminding yourself that you will get better after feeling bad for a few hours and then I put on a film and let my thoughts wander until I go to bed and think that tomorrow I will be able to manage better. (2 months post injury)

For Cindy, Belinda, and Edward, these resources appeared when they needed them, promoted by the circumstances. For some, this did not happen without the help of others as in the acute state where the patient perhaps was unable to do anything to help himself. Then, the only way to overcome this vulnerability was to trust the professionals' willingness and ability. But, this was not enough for George (31 years of age and unable to walk) when he recognised that he would never be the same working person he used to be. He resolved that there was no life, and death was the best solution. He experienced

regaining his strength through the support of his wife who helped him to imagine a possible future:

. . . my wife said well, let us wait and see how much work he can manage before we decide to sell—that helped a lot . . . it gave me the incentive to get better. (1 month post injury)

Thus, imaging a valuable future was central in reducing the feeling of vulnerability. It gave reason to mobilising strength at all.

Mental images could make all the difference. As Hank (41 years of age, unable to walk) perceived, he had regained life because he survived in the first place: "Of course I am unhappy sometimes, . . . but I have difficulty staying unhappy, because, as I say hey, I have my life" (1 month post injury). Focusing on life as a gift instead of paralysis from the waist and down made Hank so strong that he managed to stay focused on positive thoughts.

### **Strong because of increase in resources**

In spite of the vulnerability, the patients' strength surfaced as they got more mobile with support from the professionals, the rehabilitation programme, and the facilities at the rehabilitation clinic. If a patient could not do anything by him/herself physically, the experience of doing something could be achieved if other people took over. The focus was on the bodily changes and progress was the core discourse, where even small improvements gave rise to hope and the strength to go on. Debbie's (27, problems with walking and hands) good progress led her to believe that she could return to her old life. This encouraged her to train happily and become full of energy. Debbie related how her progress effected her: "I feel so happy that it makes me want to work out even more" (1 month post injury). The improvements increased the resources and could simultaneously decrease the demands.

### **Strong because of decrease in demands**

A reduction of demands could also happen by avoiding confrontation with them. Debbie (27, problems with walking and with her hands) tried to protect herself. She did not want to participate in an arrangement with the other patients because she could not handle being confronted with all the other disabled people: "I don't see any reason to take part (in a lecture about the consequence of spinal injury) and listen to a lot of problems, that I may or may not will get" (2 months post injury). Thus, Debbie tried to perceive strength by avoiding confrontation. This was necessary because she could not manage facing

her own potential disability. When the professionals insisted she join in, they also hindered her unconscious attempts to reduce her vulnerability.

Another example of how the patients tried to reduce their feeling of vulnerability was when patients tried to camouflage their vulnerability. As Isabel (49 years of age, problems with walking and with her hands) managed to have a positive and smiling attitude as she entered the room for physiotherapy, even though she was frustrated and sad because she felt she didn't get enough training: "The days are very long and I have a lot more energy. I get depressed if anything stops me from training the little time I have to do it" (1 month post injury). This action was grounded in her attempt to protect herself in relation to the professionals. She could not handle a confrontation and needed their help to gain the best result from the training that she had. Although the professional actually aimed at protecting her, she experienced something else due to a disagreement about the amount of training she needed.

### Loss of strength

In contrast, slow progress and stagnation promoted further vulnerability. Although everyone knew that progress would stagnate, it also caused a deep crisis. When this happened to Belinda (60 years of age, problems with walking and hands), she feared that she had developed a depression. She could not imagine a future without an active life despite her supportive family and friends, who took good care of her:

No great progress anymore ... I still have a lot of problems ... I know I am lucky as I can manage on crutches, but I have got to a point where I can't see anything positive at all. (9 months post injury)

From a professional perspective it could be questioned whether it is possible to protect the patient from experiences like this by keeping the patient's hope down. Unfortunately, the professionals cannot do this without impeding the progress causing an important impact on the rehabilitation process.

Another situation that reduced the mobilised strength was when complications surfaced. For example, Larry (38 years of age, unable to walk) just as he thought everything was functioning, he developed a bladder infection, which encumbered his social life again:

When it was worst, I was thinking about it all the time ... because otherwise you can't feel it any other way, and you are constantly monitoring

whether your trousers are dry. We have both been invited to different things, but in the end my wife went alone. I just didn't want to get caught anywhere with wet trousers and having to drive home again. A lot of bother, although this is not the way I usually react—staying at home. (2 years post injury)

Thus, a spinal cord injury means being more than normally vulnerable for the rest of one's life because of the biological and physical imbalance of the body. The extra vulnerability has to be dealt with and further measures taken. This is a life condition which has far-reaching significance, also on the general outlook. For example, Adrian (44 years of age, problems with walking) worried about old age and senile decay, because he already needed all his strength just to manage his everyday life:

This has changed my life no doubt about it. Sometimes I think what it will be like when I get old, where most people have difficulty walking and moving around. What will it be like for me? I have realised that I need to move around as much as possible and for as long as possible to postpone this ageing process of getting old and having to walk with a stick. But I will need more than a stick though! (6 months post injury)

Adrian worried about whether old age would come prematurely and deprive him of the ability he had just regained. He therefore took precautions and tried to counteract this unwelcome effect. Thus, he mobilised strength towards this extra vulnerability.

Society's organisation of life for disabled persons stimulated vulnerability in many situations, although often seeming unjustified. One thing was to deal with an unalterable situation like a spinal cord injury; a totally different thing was if the situation could be improved with the relevant facilities. In spite of our welfare system, it was a struggle for the patients to get even what a spinal cord-injured person was entitled to. The very organisation of society made the dysfunction even worse. For example, when Frank's (37 years of age, unable to walk) wife had arranged a little trip and had tried to think of everything, the bus, nevertheless, turned out to be too narrow for his wheelchair:

I nearly went ballistic. They know all about the width of a wheelchair ... I mean, what are they thinking about? ... You think, well, this won't stop me. I got really stubborn. There are six steps up into the bus and I will bloody well get up them ... (2 years post injury)

Frank simply crawled up to a seat in front of all the other passengers. This was a sign of the strength he was able to mobilise while simultaneously exposing his vulnerability.

### **Comprehensive understanding**

Even though the spinal cord-injured patient could feel both vulnerable and strong at the same time, the vulnerable situation was incontrovertible; the patient's physical impairment challenged the patient's balance between needs and resources. This could apparently remain a lifelong condition with the label objective vulnerability, and inferred that the patient's network and surrounding society were considerate and did not unduly challenge these persons' situations any further. In spite of this objective vulnerability, the patient could feel strong. Thus, the objective vulnerability did not automatically mean subjective vulnerability, although the likelihood was a good occasion to explore a possibly feeling of vulnerability. Therefore, vulnerability should refer to a person's experience of the situation rather than the person, as it may hinder the professional's open, explorative approach towards the person.

### **Discussion**

Sellman (2005) suggests that the concept of the necessity of defining the patients' vulnerability as more-than-ordinarily vulnerable should be applied, but I believe it can be debated. Being a patient already indicates elements of vulnerability and after a spinal cord injury, the patient was invariably in an incredibly vulnerable situation; being paralysed and needing his/her strength as never before. My findings point at a vulnerability at all Sellman's (2005) three levels; first the patient experienced powerlessness in relation to an unpreventable injury (III), and during the rehabilitation the patient's security depended on the actions of others (II). However, as the findings of this study showed the patient had to some extent a chance to protect him/herself mentally (I) and with the help of others. The spinal cord injury patient's narratives revealed how vulnerability was reduced or increased due to the balance between resources and demands. Because of the paralysis, the strength primarily was exhibited mentally. Thus, the patient's resources increased as a result of relatives' positive impact, knowledge, insight, religion, a positive attitude like perceiving the glass as being half full rather than half empty, envisaging a future life. This strength was still often mobilised by the help of others.

Dependency was inevitable and when it was met, the patient's demands decreased and/or their resources increased. From the moment the patient relied on others' aid, a new reason for vulnerability arose. The impact of others managing the patients' dependency was significant also when the patients shared their visions and hopes (Simpson, 2004). Simpson (2004) argues how hope itself produces vulnerability by stating and by sharing something of real importance. If their trust was deserted, the situation would be even worse. Also, Strandberg, Norberg, and Jansson (2003) find in their study of patients' experience of dependency that dependency is very difficult for the patient, and the reason for increased vulnerability. However, Angel, Kirkevold, and Pedersen (in press) report that it could be managed in a giving and positive way if the professionals' focus was the patient's perspective, and if the patient was in charge as much as possible. During this interplay, reciprocity develops, characterised by acknowledgement and respect in spite of the patient's dependency of the professionals. This is supported by Perry et al. (2006) who find that skilled, available professionals had a decreasing effect on the patient's experience of vulnerability.

It could be questioned whether camouflaging vulnerability is the way to reduce it. Although, when a person with an extended vulnerability behaved as though this was not the case, the person may feel very vulnerable, but intended to avoid to be seen as such. The explanation was to avoid an increased feeling of vulnerability caused by the experience of fellow patients' vulnerability or by being met as a vulnerable person themselves. This may explain why Laskiwski and Morse (1993) discovered that young men who had been injured, swore when they felt like crying.

Vulnerability and strength coexisted. The vulnerability could be managed when strength was gained as the findings show from; being part of a significant relationship; getting the help they needed; having knowledge; ability to imagine their future; mental images from positive thoughts; experiencing progress; self-protection; and meeting an inclusive society. The regained strength made it possible for the patient to engage in rehabilitation in spite of the overwhelming loss of ability. Because the patient did not show or appear vulnerable all the time, it may be more appropriate to refer to a vulnerable situation rather than labelling the patient. This could create an understanding that the patient from time to time and in some situations felt weak, but in other situations, felt strong. Here, Lohne and Severinssons' (2004) study showed that vulnerability was most dominating in some situations; on the days the patient experi-

enced as bad days. Simultaneously, the vulnerability was increased with the dependency for help with intimate hygiene, like assistance for bowel and bladder function (Lohne & Severinssons, 2004). The understanding of vulnerability and strength as being closely associated means that the professionals need to know the patient's perception of vulnerability from situation to situation.

When Vladeck (2007) asks "How useful is vulnerability as a concept?" in the political arena, his question can be repeated in the care circle. According to this study, the answer is: if the concept was used when the professionals should take special care it was very useful. Not as a label characterising the individual's qualities, but to sharpen the professionals' awareness of navigating on fragile ground, and consequently, more due to the difficult situation than to the person. This was accentuated by Spiers (2000) as a point of discrepancy between vulnerability as being objective or subjective. From an objective perspective, the spinal cord-injured patient would be vulnerable for life. However, although the patients' narratives confirmed that they were aware of this vulnerability, they focused on how they mobilised strength. This distinction points to the issue of labelling entire groups of people as vulnerable. This may be useful for political resource allocation mindset in order to give special consideration to these groups. However, this challenges the necessity of judging the person's experience of vulnerability in the concrete situation and acting accordingly. Otherwise, we may overrule and suppress the strengths that the person succeeded in mobilising.

The contrasting situation, being vulnerable as never before and feeling stronger than ever before, may be the patient's recognition of the potential vulnerability combined with a successful handling of vulnerability. The needs and resources were balanced through recognition of the accentuated vulnerability, other people's help, and the patient's optimisation of resources.

## Conclusion

The understanding of vulnerability and strength as closely associated is decisive for the professionals' recognition of the patients' perceived vulnerability. Otherwise, there is a risk that the professionals misrecognise the patients' need for help; overlook the vulnerability, or suppress the courage the patient has mobilised. If vulnerability refers to a person's experience of the situation rather than the person, it invites the professional's open, explorative approach towards the person.

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