

**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

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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