CHAPTER 5

DISCUSSION AND CONCLUSION

This chapter includes four sections. Section one presents a theoretical description including a theoretical model, theoretical process, and definitions of the constructs and concepts. The second section compares the findings of this study to the findings of other studies. Section three discusses the implications and recommendations for practices, the disabled support system, and further research and section four addresses the limitations of this study.

Theoretical Description

A substantive theory, grounded in the perception and management of fourteen people with paraplegia, had been developed to account for the basic social process for those involved and a pattern of behavior which is relevant. The theory is derived from constant comparative analysis of the study answers of the two research questions stated in the specific aims of the study. The first aim of the study was to describe how Thai men perceived changes after paraplegia. The second aim of the study was to describe how Thai men with paraplegia managed everyday life.

The Theoretical Model

The theoretical model of making the best of paraplegia is illustrated at construct levels in Figure 6. and shows the constructs and the concepts in Table 6. Strauss and Corbin (1990) define concepts as a conceptual label placed on discrete happening events and other instances of phenomenon. Category is a classification of concepts which are grouped together under a higher order: more abstract concepts. In this model, an arrow moving in circle represents the hypothesized causal relationships in the direction pointed. The sign on the arrows indicate that the hypothesized relationships are positive. The straight lines with an arrow indicate the context and intervening condition, influencing the causal condition and action / interaction strategies. The circle shaped arrow also represents the direction of action / interaction strategies as a continuous moving process.

The theoretical model of making the best of paraplegia represents an interrelatedness of the constructs and concepts as follows. A positive relationship exists between the perception of self and life alteration construct and making the best of paraplegia construct. The three concepts of a perception of self and life alteration include the perception of the self as "being ill", the self as "being disabled", and the self as "being a disabled person". The three concepts of making the best of paraplegia include: learning self-care, learning the system of care and support, and learning to live in society. The self and environment constructs were influenced the making the best of paraplegia construct. The four concepts of the self include personal consideration, personal attribution, physical condition and past experiences. The three concepts of environment are composed of setting, physical environment and resources. Similarly, social norm, sociocultural attitude, and the hope constructs also influenced the making the best of paraplegia construct. The two concepts of hope included hope for maintaining life and hope for recovery.

A relationship developed between the learning self-care and physical function aspects, lifestyle / behavior modification, and social participation. The two concepts of learning self-care were maintaining physical function and controlling and preventing physical complications. The two concepts of the physical function aspects are comprised of existing limited physical functions, and limiting physical complications. The three concepts of lifestyle / behavior modification are composed of modifying lifestyle, being dependent on others and decreasing working capability. The one concept of social participation was maintaining social participation.

A relationship developed between learning the system of care and support, and psychological aspects, lifestyle / behavior modification, and social participation. The three concepts of learning the system of care and support were seeking and accepting necessary supports from significant others, seeking governmental support, and seeking alternative treatment and professional suggestions. The seven concepts of psychological aspects were a comfortable mind, morale, sustained self-worth, maintaining hope, low self-esteem, dissatisfaction with disabled support system, and feeling inferior. The two concepts of lifestyle / behavior modification were being able to self-care, and being dependent on others. The one concept of social participation was a change in relationships with significant others.

A relationship developed between learning to live in society and psychological aspects, lifestyle / behavior modification, and social participation. The four concepts of learning to live in society were avoiding having a sense of inferiority, controlling negative behavior, managing stress, and protecting dignity. The five concepts of psychological aspects were a comfortable mind, reducing stress, increasing self-esteem, sustaining self-worth, and satisfaction with what they have. The one concept of lifestyle / behavior modification was being more independent. The two concepts of social participation were maintaining and decreasing social participation.

Theoretical Process

The theoretical model of making the best of paraplegia is described as the effort of a persons with paraplegia to manage everyday life as well as they can in their limited conditions and situation. Suffering from paraplegia generates perceived substantial changes of the self, from the self as "being ill" to "being disabled" and to "being a disabled person" respectively. Persons with paraplegia responded to their perception of self and life alteration with three strategies; learning self-care, learning the system of care and support, and learning to live in society, which are grounded in the accounts of the informants as they discussed the process of rebuilding their lives. It was consistent with Blumer (1969) who stated that individuals interpret situations and take action (managing) based on their view of themselves. Thus, the model is constantly in motion as informants perceive their selves and life alteration with the influence of context and intervening conditions, on action in their world. Although the conditions, actions, and consequences were seen as a process that emerged naturally, the grounded analyst's viewpoint sees the linking of action / interactional sequences as a process (Strauss & Corbin, 1990). The authors stated that process is the change in action / interaction strategies.

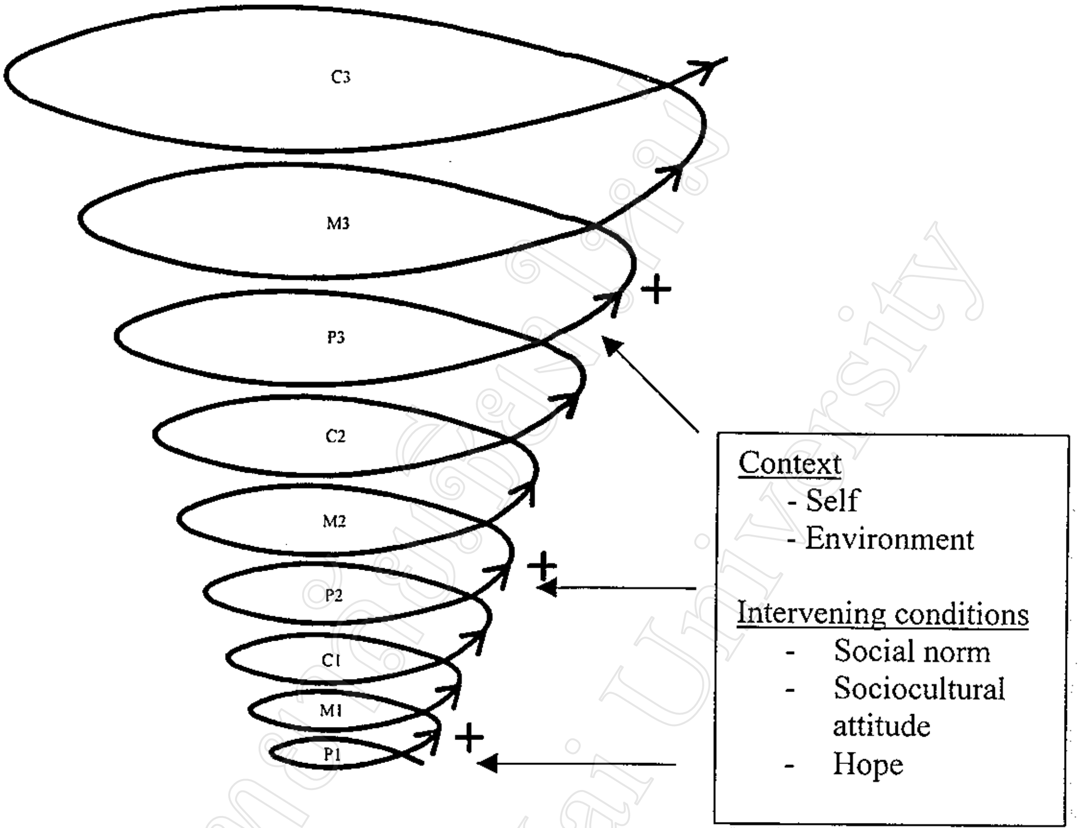
Based on interviews with Thai men with paraplegia, the model of "making the best of paraplegia" was conceptualized as a moving cycle originating from the center of self and gradually expanding out with every cycle of movement, as the movement of a Tornado. The pattern of flow depends on perception, managing strategies, and their consequences. Thus the model of "making the best of paraplegia" is always expanding gradually from inward to an outward direction. Although within the process the movements are repeated, the meanings of each repetition are never the same. Overtime, clear developmental coping process from self-center to other-centered, and inward to outward direction, was evidenced by the use of coping strategies by the study informants. Similar life experience was found in a study of 10 Thai adult with paraplegia where, during the early period of their experiences, living as lying only and under the supervision of a caregiver is prevalent (Chuenklin et al, 2000). During the transitional period, the paraplegics had experiences about seeking alternative treatment, confronting with complication and unpleasant symptoms, learning how to live, provision of facilities for living, being independent to decrease the family burden, and being isolated from the society. The living with paraplegia period, they could take care of themselves, return to be part of the society and contributing benevolence to oneself. Lyon (1993) wrote that the coping tasks for people with disabilities in first period focus on functional abilities such as controlling symptoms, managing medical and self-care routines, and preventing complications. However, Easton, Rawl, Zemen, Kwiakowski, and Burczyk (1995), in their study of follow-up care for rehabilitation clients by advanced practice nurses, found that clients' coping strategies had changed over time because it took time for people to fully realize the implications of their disability. Heinemann (1995) also stated that the passage of time appears to allow people to reframe their experiences of injury and disability in the ways that allow them to redirect psychological energy to the external world, relationship with others, and important goals.

However, Doka (1993) stated that throughout the course of disability people may cope at different points in disability in different way. Many time, they may feel like, sometimes up, sometimes down, others time flat. As Danielson et al. (1993) supported that the long-term course of spinal cord injury brings many unexpected secondary complication that can occur at any time. The characteristics of this chronic condition encompasses not only the physiological course of condition but includes family life transition and problems of living which take place over and over again. Therefore at each point of life movement, persons' own reactions and responses can be different. Throughout life, persons have developed a broad repertoire of coping abilities. As coping abilities develop over time, it is reasonable to think that persons may reframe their initial perception of stressful situation and that they may even "nourish the conviction that we are in some ways better off than we were before" (Affleck & Tennen, 1996, p.900). Therefore, the model of making the best of paraplegia as a repeated cycle continuous moving process which were expanding gradually in an outward direction. It can be applied to most of the paraplegics.

This model finding strengthens the arguments against stage models of adjustment that imply individuals must adjust prescribed as stages (Cairns & Baker, 1993). Trieschmann (1988) described that coping with SCI involves a variety of responses. Also, Yoshida (1993) found that the construction of the self and identity post SCI is a dynamic model and this process presents a swing back and forth like a pendulum between the nondisabled and disabled aspects of the self. Therefore, it is reasonable to assume that there may be other forms of self-identity reconstruction for young adult Thai males. It is formed through perception towards self and life alteration and influenced the informants in managing with their life changes. In this study, a model of making the best of paraplegia that considers both elements may increase the understanding of the nature of managing strategies which move or change to follow a transformation of self-identity in a more comprehensive manner. This process represents situations or contexts which informants define and take action upon.

Definitions of Constructs and Concepts

Definitions of the constructs and concepts in the theoretical model are illustrated in Table 7. Definitions of the concepts are derived from the study data. Definitions of the constructs are based on the definitions of the concepts.



P = Perception M = Managing C = Consequence

P1 = Perceived the self as "being ill"
P2 = Perceived the self as "being disabled"
P3 = Perceived the self as "being a disabled person"

M1 = Learning self-care
M2 = Learning the system of care and support
M3 = Learning to live in society

C1 = { - Physical function aspects
- Lifestyle / behaviors modification
- Social participation

C2 / C3 = { - Psychological aspects
- Lifestyle / behaviors modification
-Social participation

Figure 6. The Model of Making the Best of Paraplegia of Young Adult Thai Males.

Table 6.
The summary of constructs and concepts in the theoretical model

Causal condition	Context	Intervening condition	Action / Interaction strategies	Consequences
Perception of self and life alteration -Perceived self as "being ill" -Perceived physical function alteration. -Not able to walk -Not able to urinate and defecate -Having spasm -Having pain -Having pressure sores -Having urinary infection -Perceived self as "being disabled" -Perceived dependence on others -Perceived decreased working capability -Perceived self as "being a disabled person" -Perceived inferiority -Perceived discrimination from society -Perceived changes in relationships with significant others	Self -Personal consideration -Recognized own ability -Afraid of complications -Belief (health / religion) -Personal attribution -Developmental tasks -Male values -Physical condition -Past experiences Environment -Setting (place / time) -Physical environment -Resources -Disabled support system -Building / transportation -Health information -Social /Family support -Financial resources	Hope -Hope for maintaining life -Hope for recovery Social norm Sociocultural attitude	Making the best of paraplegia Learning self-care -Maintaining physical functions -Controlling and preventing physical complications Learning the system of care and support -Seeking and accepting necessary support from significant others -Seeking governmental support -Seeking alternative treatment and professional suggestions Learning to live in society -Avoiding having a sense of inferiority -Controlling negative behavior -Managing stress -Protecting dignity	Physical function aspects -Existing limited physical functions -Limiting physical complications Psychological aspects -Comfortable mind -Morale / reduced stress -Increased self-esteem / low self-esteem -Sustained self-worth -Maintaining hope -Satisfaction with what they have -Dissatisfaction with disabled support system -Feeling inferior Lifestyle/behavior modification -Modifying lifestyle -Altering life goals -Being able to self-care -Being more independent -Being dependent on others -Decreasing working capability Social participation -Maintaining /decreasing social participation -Change in relationships with significant others

Table 7

The definitions of the constructs and concepts.

Constructs	Concepts	Definitions
Perception of life alteration		-The informants perceived changes toward physical functions, capability to help themselves and ability to work, social status, and relationships with significant others.
	Perceived physical function alteration.	-The perception of the informants toward the change of physical functions involved mobility and elimination, and also being at risk for secondary complications.
	Not able to walk	-The informants perceived having weak or disused legs due to SCI. This impairment caused them to chose a wheelchair as their primary means of ambulation, and use their hands as a replacement for helping to move themselves.
	Not able to urinate and defecate	-The informants perceived a loss of control over elimination both bladder and bowel. They described it as "bladder and bowel retention" or bladder and bowel incontinence.
	Having spasms	-The persons with middle or high paraplegia perceived a sometime slight increase in the tone of the leg muscles and / or their legs moved in flexion or extension. It may occur while they changed position, coughed and had a urinary infection. The severity of spasm is different in each person. Mild spasms did not disturb the activities of daily living, whereas severe spasms cause discomfort and pain, interrupted normal sleep and threw them from the wheelchair.
	Having pain	- The informants perceived a great discomfort at the back or the lower part of the body. They felt back pain when they had prolonged sitting with severe spasms occurring. They perceived abnormal sensations like phantom pain at the lower part of the body. They described this feeling like a burning pain, tingling, shooting, stinging or tightness.

Table 7 (continued)
The definitions of the constructs and concepts.

Constructs	Concepts	Definitions
	Having pressure sores	-The informants perceived having an ulcer at the buttocks, coccyx, under upper legs, ankles, and toes. They thought the development of the ulcer came from them not having physical feeling at the lower part of the body. They described that it came from forgetting to lift-up, injury from the toilet, and had shearing force on the floor of the house. They seem to be the most concerned about it because the healing takes a long time.
	Having a urinary infection	-They perceived urinary infection from the signs and symptoms of the body including fever, abdominal discomfort, cloudy or red urine, a bed smelling urine and having more muscle spasms. Some informants who catheterized, got repeated urinary infection. This situation made them perceive the self as "being ill" and felt discouraged. They accepted that improper catheterization was a cause of their urinary infection.
	Perceived being dependent on others	-The informants perceived decreased physical capability which caused them to require more assistance from others in almost every aspect of their life, especially physical, mental, and financial support.
	Perceived decreased working capability	-The informants perceived their ability to work decreased because of physical limitations. They also perceived less chance to assume their previous job or seek a new job because they had architectural barriers, social attitude, lack of assistance and information. Their loss of job caused them to experience financial hardship.
	Perceived inferiority	-The informants perceived themselves as worthless, useless, or less important because they have less capability to perform activities or work as before. They also perceived a negative view of themselves as having a disability inherently makes their self different from an ordinary people in society.

Table 7 (continued)
The definitions of the constructs and concepts.

Constructs	Concepts	Definitions
Perception of self alteration	Perceived discrimination from society	-The informants perceived a negative social attitude toward themselves when they have interaction with other people. This attitude includes look down on, ridicule, curiosity, and pity. They perceived others treated them as underprivileged minority status.
	Perceived changes in relationship with significant others	-The informants perceived that relationships between themselves and family members, wife / girlfriends, and friends was decreased or lost because of their disability, being unable to do anything, being dependent on others, decreased capability to earn, no mutual activities together from transportation barriers.
		-The informants perceived self changes from perceiving the self as "being ill", to the self as "being disabled", and to the self as "being a disabled person". These self identities result from the perception of life alteration including: perceived physical function alteration, being dependent on others, decreased working capability, inferiority, discrimination from society, and perceived changes in relationships with significant others.
	Perceived self as "being ill"	-The disabled identity is seen as "ill" by the informants. It is revealed when they perceived a physical function alteration or had a recurring physical complication.
	Perceived self as "being disabled"	-The disabled identity is seen as one aspect of the person, or nearly encompassing the self by the informants. It occurred when they perceived being dependent on others, and perceived decreased working capability.
	Perceived self as "being a disabled person"	-The disabled identity is seen by the informants as the main point of their life. This identity view frequently manifested in the informants who perceived inferiority, discrimination from society, and perceived changes in relationships with significant others.

Table 7 (continued)
The definitions of the constructs and concepts.

Constructs	Concepts	Definitions
Self		-The dynamic of the situation of an individual is developed by 1) personal consideration (cognitive of self) i.e. recognized own ability, afraid of complications, belief (health / religious), 2) personal attribution (psychological self) i.e. developmental task, and male value, and 3) physical condition (physical self), and 4) past experiences (cognitive of self).
Environment		-A surrounding environment of an individual with paraplegia is comprised of setting (place / time), physical environment, and resources which include disabled support system, building / transportation, health information, social / family support, and financial resources.
Hope		-The data interviews found that the persons with paraplegia have hope in three aspects, including: a) hope for full recovery (can walk again); b) hope for pain to diminish and be able to stand; c) hope for not getting worse and being able to work. That is, they perceived hope in two aspects: hope for recovery (a-b); and hope for maintaining life (c). It was also evident that feelings of hope fluctuated throughout the course of disability.
Social norms		-The behavior that people in society consider normal and appropriate. Social norms of ordinary people towards people with disability is pity and providing help for them whereas social norms of people with disability is avoiding being a burden on others, mutually supporting others, and requesting help from others politely.
Sociocultural attitude		-Sociocultural attitude refers to the attitude of society towards disability and has historically been associated with stereotypes which portray disabled persons as inferior, regrettable, a tragic loss, and being a burden on others. General people seem to have an obsession with labeling them as "the disabled", useless, and not worthy of being in the community. These labels can attach a stigma which may be very harmful for a disabled person.
Making the best of paraplegia		-The persons with paraplegia tried to manage everyday life as well as they could within their limited condition.

Table 7 (continued)
The definitions of the constructs and concepts.

Constructs	Concepts	Definitions
Learning self-care		-The cognitive and behavioral strategy that persons with paraplegia attempt to learn to take care of their physical dysfunction, and control of complications. This strategy is done regularly throughout the rest of one's life.
	Maintaining physical functions	-The self-care strategy intended to achieve needs to fulfill physical function include: maintaining mobility, maintaining urination, and maintaining defecation. These strategies were performed by the persons with paraplegia in order to maintain existing physical functionality in daily life.
	Controlling and preventing physical complications	-The self-care strategy response to physical complications, include: maintaining skin integrity, control of spasticity, pain and urinary tract infection. These strategies were employed by the persons with paraplegia in order to maintain their health status.
Learning the system of care and support		-The cognitive and behavioral strategy which the persons with paraplegia have used for seeking and accepting help to compensate for their lost capability to meet life's demands.
	Seeking and accepting necessary support from significant others	-The strategy which the informants requested from family members to help them in aspects of physical, and financial assistance. They also received mental support from family members, and their friends.
	Seeking governmental support	-The strategy emphasized the search for the way to obtain an income, through claiming disability pension, and through vocational training for replacing loss of income after paraplegia.
	Seeking alternative	-The strategy which the person with paraplegia who has hope for recovery and cure, tried to search for cures from other

Table 7 (continued)
The definitions of the constructs and concepts.

Constructs	Concepts	Definitions
	treatment and professional suggestions	optional therapy, technology innovations, and health care professional consultation.
Learning to live in society		-When the informants re-enter a social setting, they perceived changes in the relationships with significant others and they may face with an attitude of others who responded to them with discrimination. This attitude supports their perception of the self as inferior to ordinary people. By this time, they tried to leave this situation if this stigma become salient. They also worked hard to achieve the highest level of functioning attainable. The individual consciously attempts to integrate the former self with the new self created by paraplegia. The optimistic informant sets realistic and future-oriented goals.
	Avoiding having a sense of inferiority	-The avoidance strategy was used to manage negative feelings such as uncertainty, being inferior and self-worthlessness by avoiding social participation, relating oneself with the same or lower one, and comparing with others.
	Controlling negative behavior	-The strategy which a person with paraplegia tried to do, forced themselves to do, or concentrated on doing. It was not their old behavior. However, they tried to do it by trying to control their emotions, and conforming to social norms, in order to be able to live in society.
	Managing stress	-The managing strategy focused on distracting and adapting psychological conditions in order to alleviate the emotional stress: these strategies are composed of releasing stress, recreation, living with the present, making their mind up, and religious practices.
	Protecting dignity	-The intuitive strategy responds to the situations which threaten their self-esteem by avoiding being a burden on others, maximizing personal role function in the family, attempting to work, and using full remaining capability to help or

Table 7 (continued)
The definitions of the constructs and concepts.

Constructs	Concepts	Definitions
		entertain others.
The consequence of physical function aspects		-The sustained physical conditions after the persons with paraplegia tried to manage their physical dysfunction as well as they could. These conditions include: existing limited physical function, and limiting physical complication.
The consequence of psychological aspects		-The kind of emotions or mind conditions after the persons with paraplegia tried to manage their life as well as they could. These conditions include: a comfortable mind, morale, reduced stress, increased self-esteem / low self-esteem, sustained self-worth, maintaining hope, satisfaction with what they have, dissatisfaction with disabled support system, feeling inferior.
The consequence of lifestyle behavior modification		Lifestyle and behavior changes after the person with paraplegia tried to manage their life as well as they could. These changes include: modifying lifestyle, altering life goal, being able to self-care, being more independent, being dependent on others, and decreasing working capability.
The consequence of social participation		-Interpersonal relationships of persons with paraplegia in the family or society was maintaining / decreasing social participation, and a change in relationships with significant others.

Comparison of the Findings

The findings of this study are compared to the findings of relevant studies in existing literature. The purpose of this comparison is to find similarities and differences between the findings and specific contributions of the current study. The discussion is divided into three sections including: theoretical discussion, perception of self- alteration and making the best of paraplegia, and the consequence of making the best of paraplegia.

Theoretical Discussion

The model of making the best of paraplegia illustrated the relationship between a construct and concept of: the perception of self-alteration, managing strategies, consequence of managing strategies, a set of conditions influencing perception, and managing strategies. This model presentation appears to be the clearest theoretical exposition of grounded theory approach, especially as given by the paradigm model of: a) causal condition → b) phenomenon → c) context → d) intervening condition → e) action / interaction strategies → f) consequences (Strauss & Corbin, 1990). This model can link to the metaparadigm level of theoretical thinking in client domain because it explained the relationship between person (action / interaction), environment (causal condition, intervening condition, context, contingency), and health (consequences) which this model led to nursing intervention, at last (Kim, 1997). Lancaster and Lancaster (1997) stated that descriptive model is aim to describe things either as they are or as they work and an explanatory model is one of descriptive model which describes the causal relationships among the elements in a system. That is, the model of making the best of paraplegia is an explanatory model which is the subgroup of descriptive model.

In this study, the findings also support many theoretical models and theories that have been used within the health profession. The model of making the best of paraplegia was seen as coping (Folkman, Moskowitz, Ozer, & Park, 1997; Danielson et al., 1993; Dimatteo, 1991). It also corresponds with two major functions of coping theory: problem-focused strategy, and emotion-focused strategy (Lazarus, 1999). With respect to the problem-focused strategy, a person obtains information about what to do and mobilizes action for the purpose of changing the reality of the troubled person-environment relationship. These coping actions may be directed at either the self or the environment. In this study, the strategy of learning self-care, and learning the system of care and support were consistent with the characteristics of the problem-focused strategy because the persons with paraplegia tried to take direct action to resolve physical and financial problems. The two actions in learning to live in society; controlling negative behavior, and protecting dignity, were also seen as problem-focused coping because the persons tried to change the person-environment relationship.

With regards to the emotion-focused strategy, it focuses on regulating the emotion tied to the stressful situation. This kind of strategy is congruent with the strategies of avoiding having a sense of inferiority and managing stress, because the persons use cognitive efforts that change the meaning of a situation, or regulate their emotion from the stressful situation without changing the environment. In this study, problem-focused coping was found more than emotional-focused coping, and differed from the findings in the coping literature, where emotional-focused strategies dominate (Lazarus & Folkman, 1984).

The cognitive adaptation theory (Taylor, 1983) described that coping with threatening events consists of three processes: a search for meaning, a search for mastery, and a process of self-enhancement. This theory was similar with the model of making the best of paraplegia as follows: a search for meaning involves identifying why the event happened in one's life and assessing what impact the event has on one's life. This process can compare with the perception of self-alteration; the search for mastery involves an individual attempting to adjust their behavior in order to prevent future occurrence of disaster and attempting through action or alteration of one's personal belief system. This process is similar to managing strategies in this study, the strategies of learning self-care, learning the system of care and support, and learning to live in society; a process of self-enhancement which involves individual attempts to build self-esteem. This process is congruent with the strategy of learning to live in society, especially the action of protecting dignity which the informants tried to manage in their situation to promote their self-esteem.

The acceptance of loss theory (Wright,1983) proposes that the four value changes to acceptance of disability involve: a) enlargement of the scope of value; b) subordinating of physique; c) containment of disability effects; d) transformation of comparative status values to asset values. This study found that perception of self-alteration is seen as the recognition of a variety of experiences that led the persons to enlarge their scope of value, whereas the strategy of learning to live in society, managing stress by making their mind up (Tum Jai) and religious practices involved subordinating their physique which means the person decreased the emphasis on physique as a measure of the self and worth is relative to actual ability. Making their mind up was also consistent with containment of disability effects which represent an important value change, including broadening the range of things that are cherished, that is, the acceptable limits or boundaries. The strategy of protecting dignity includes: avoiding being a burden, maximizing personal role function in the family, attempting to work, and using full remaining capability to help or entertain others also presents a transformation of comparative status to asset values. With an asset value, it is a focus on a person's ability to be evaluated rather than on a person's status.

The model of making the best of paraplegia is also compatible with the Roy Adaptation Model(RAM) (Roy & Andrews, 1999). RAM consists of three element: 1) environment stimuli; 2) coping mechanism; 3) adaptive response (Ducharme, Ricard, Duquette, Livesque, & Lachance, 1998). Roy stated that three types of environmental stimuli effect the person's ability to cope, including focal stimuli, contextual stimuli, and residual stimuli. Focal stimuli are those that immediately confront the individual and are the most critical in initiating behavior. This stimuli can be compared to causal condition or the perception of self-alteration. Contextual stimuli are all additional stimuli that contribute to behavior and provide meaning to the situation for the individual. This stimuli can compare to the context of making the best of paraplegia, self, and environment. Residual stimuli include values and beliefs that affect how the individual responds in a given situation. This stimuli can be compared to intervening conditions, including hope, social norms, and sociocultural attitude.

In RAM, the coping mechanism responds to the stimuli in two subsystems; a regulator subsystem (respond through neural, chemical, and endocrine processes), and a cognitor subsystem (response through channels of perceptual information). In this study, making the best of paraplegia is a coping process which is congruent with a cognitor subsystem because the informants managed their situation in response to the perception of self-alteration. The cognitor subsystem also responds through a process of learning, judgement, and emotion. Making the best of paraplegia is the coping process of learning self-care, learning to live in society and learning the system of care and support to compensate for their changes.

In RAM, the coping mechanism influences adaptive responses or maintains adaptation (Roy & Andrews, 1999). The authors believe that adaptive responses support health, which is defined as a state and a process of being and becoming wholly integrated. They also categorized behavior resulting from the coping mechanism into four adaptive modes: physiological-physical, self-concept, role function and interdependence. These adaptive modes may be similar to the consequences of making the best of paraplegia which includes: physical aspects, psychological aspects, lifestyle/behavior modification, and social participation.

There is one example of the research using grounded theory method which is both similar and different from this study. Dewar and Lee (2000), who studied how individuals with catastrophic illness and injury managed their personal and social world, found that there were three processes of bearing illness and injury: finding out, facing reality, and managing reality. The individual employed three principal strategies: protecting, modifying, and boosting, in all of the phases to help them endure their circumstance. Regarding different aspects, first, the process of bearing illness and injury did not progress orderly. The phases flowed together and were re-experienced continuously. Whereas, the process of making the best of paraplegia moves as the result of the perception of self-alteration with a cycle continuous moving process through three strategies of learning self-care, learning the system of care and support, and learning to live in society. They may have a re-experience in each of three strategies when they perceived self change in everyday life. Second, the process of making the best of paraplegia cannot be divided into phases because this study is a cross-sectional study.

There is only one point that is similar to this study, managing strategies. The strategy of protecting dignity, especially avoiding being a burden on others, is consistent with a protecting strategy which described how the informants tried to be as self-reliant as possible and to limit their requests for assistance. The strategy of learning self-care, and learning to live in society (all strategies of protecting dignity) were similar to a modifying strategy which involved learning new skills to adjust to physical limitations and learning to revalue the ability that they still possessed. Similarly, a protecting strategy, especially, attempting to work and using full remaining capability to help or entertain others, was similar to a boosting strategy which explains an informant's effort to enhance their self-esteem.

As is evident from this discussion, the model of making the best of paraplegia is an explanatory model, linked to the metaparadigm level of theoretical thinking. Moreover, many theoretical models can be used to explain the model of making the best of paraplegia which is coping in young adult Thai males with paraplegia. Although most theoretical models view the coping process as a unitary concept with psychological and social dimensions without physical dimensions, except in the Roy Adaptation Model, the theoretical perspective used for this study is a symbolic interactionism or social theory of disability which concentrates self-perception on obstacles imposed on disabled people who limit their opportunities to participate in society. Self-perception can be seen as the primary motivation behind human behaviors to maintain good physical and mental health (Dovey & Graffam, 1987).

Perception of Self-Alteration & Making the Best of Paraplegia

The informants in this study perceived self-alteration after paraplegia as: the self as "being ill", "being disabled", and "being a disabled person". They perceived the self as "being ill" as a result of the perception of physical function alteration. They perceived the self as "being disabled" as a result of the perception of being dependent on others and a decrease in working capability. They perceived the self as "being a disabled person" as a result of the perception of inferiority, discrimination from society, and the perception of changes in relationships with significant others. Seymour (1998) stated that persons with disability perceived self-alteration because the self and the body are inextricable; a disruption to the body inevitably disrupts the embodied self. They define their own self in terms of what they perceive to be the reactions of others and many perceptions pertain to the individual's role and relationship in the social environment (Dovey & Graffam, 1987). Therefore, the perceptions contribute to an individual's self-concept.

The self-concept is a dynamic process influenced by the person's current health status, past experiences, social relationship, and the previous view of self. In this study, the young male's perception of self-alteration after paraplegia was largely based on what they encountered with their own self. When disability has a significant impact on all of their life and when the associated changes are continuous, their perception of life is over a long period of time (Dewar & Lee, 2000). Since the demands on the persons related to the disability can never be completely eliminated (Miller, 1992), the way a person reacts to these changes may require coping throughout a person with paraplegia's life span.

Making the best of paraplegia was seen as a coping process as described before. It emerged as the core category or the central phenomenon of managing strategies. The attributions of making the best of paraplegia include: 1) making an effort to attentively and carefully take care of the self; 2) trying to seek and accept support as much as they are capable; and 3) trying to maintain normalization. Some of these attributes are similar to Barnes et al (1999) who stated that disabled persons adjust to their predicament presumably as an attempt: 1) "to make the best of things", and cultivate a cheerful, outgoing manner; 2) not to go too far in normalization lest these efforts appear abnormal, or be construed as an attempt to deny difference, and 3) to avoid self-pity or resentment.

The phenomenon of making the best of paraplegia is concerned with the strategies of learning self-care, learning the system of care and support, and learning to live in society. These strategies are also congruent with Barnes et al.(1999) who described the four levels in coping with chronic illness are: 1) the technical and practical management of the physical conditions; 2) the management of thoughts and feelings (about one's sense of self-identity); 3) the management of interpersonal relations (renegotiating long-established relationships, which perhaps involve new forms of support); and 4) interpreting and making sense of the condition (so that individuals can carry on with their lives and not submit to negative features).

Moreover, Livneh (2000) summarized findings based on over 30 empirical studies focusing on coping with SCI. The author classified coping strategies with SCI into engagement and disengagement strategies which offered a unique way of identifying these strategies. Engagement strategies include: a) problem-solving or problem-focused; b) seeking social support; c) maintaining hope; e) cognitive appraisal or restructuring; and f) venting emotion. The group of disengagement strategies commonly includes the following: a) denial; b) wish-fulfilling fantasy; c) self-blame; d) other-blame, and e) alcohol / drug abuse. Among the prominent findings, the engagement strategy group is congruent with the strategies of learning self-care, learning the system of care and support, and learning to live in society, whereas the disengagement strategy group does not appear to be concerned.

The following discusses simultaneously between each managing strategy which corresponds with each perception of self alteration.

Perceived Self as "Being Ill" & the Strategy of Learning Self-Care

In this study, the informants perceived the self as "being ill" as a result of the perception of physical function in the aspects of not being able to walk, not being able to urinate and defecate, having spasms, having pain, having pressure sores, and having urinary infection. They tried to learn self-care by focusing on observing, preventing, and caring for physical dysfunction in terms of maintaining physical function (maintaining mobility, urination, and maintaining defecation), and controlling physical complications (maintaining skin integrity, spasticity reduction, pain handling, and UTI prevention / care). These findings are congruent with those described by Davidhizar and Shearer (1997). The authors stated that chronic disability is an irreversible presence, accumulation, or latency of disease status or impairment that involves the total human environment for supportive care and self-care, maintenance of function and prevention of further disability. Similarly, Deloach and Greer (1981) indicated that the physical survival of disabled persons depend on two abilities: the ability to overcome life-threatening aspects of disabling conditions and the ability to perform the routine tasks of everyday life. In addition, Gage et al. (1997) who studied understanding the transition to community living after discharge from an acute care hospital in twenty-four physically disabled persons, described the occupational hierarchy model which emerged from the data analysis and was analogous to Maslow's theory that all human needs are motivations of behavior. The need at one level must be relatively well-satisfied before the person turns to satisfaction of the next level of need. If the first level of need, self-care which is related to one's ability to sustain the essential biological physiological functions and protect oneself from harm is not independent, the person must have a strategy to address the basic needs.

The perception of not being able to walk & maintaining mobility. Most of the informants perceived not being able to walk. This situation caused them to stay at home often, decreased their working capability and social participation. This perception is consistent with Widerstrom-Noga et al. (1999) who found that 430 men and women with SCI perceived a decreased ability to walk (86%), as being very hard to deal with, in the first of five consequences of SCI. This perception affected other aspects of life, as Bozzacco (1993) who studied the long-term psychological effects of spinal cord injury in five spinal cord injured men between the ages of 30 to 45 who had been injured at least 10 years, indicated that the impairment of mobility and position that resulted from SCI did have a significant impact upon the developmental task / expectations of adulthood. Mobility and position restrictions delayed and / or interfered with the establishment of close personal relationships and the development of a satisfying career.

In order to control existing physical functionality as normally as possible, the informants learnt self-care by maintaining mobility. They insisted that a wheelchair is a necessary piece of equipment for them to move in everyday life. This finding is congruent with Woodbury and Redd (1987) who stated that the most basic adjustment which often comes first is maintaining mobility. The newly disabled need to learn how to move in their house, transferring in and out of bed and maneuvering the wheelchair around the home. These people have used a wheelchair to improve mobility and functional skills, and a wheelchair is easily accommodated into the person's transportation and home environment (Yarkony & Chen, 1996). Moreover, Bozzacco (1993) also stated that mobility with a wheelchair permits a person to seek out a desirable environment and to avoid one that is unpleasant; this implies independence. However, some informants would like to stand with long leg braces or hope to stand on their own. Morris (1991) supported that standing upright represents the ability to achieve a sense of mastery over the environment and is an integral part of being an independent person. This posture allows face-to-face interaction and eye contact. Parsons and Lammerts (1991) also found that the persons with paraplegia who had a lower thoracic lesion, could ambulate only at a slow speed and with great energy expenditure. Finally, they turned to use a wheelchair for movement.

The perception of not being able to urinate & maintaining urination. The informants perceived that they could no longer feel when their bladder needed emptying. Some found that they had urine retention, whereas others described that they have incontinent urine. These findings were congruent with Cyr (1989) who found that 75% of the people who sustained SCI from 11 weeks to 5 years experienced bladder problems. From the worldview of 430 men and women with SCI, Widerstrom-Noga et al. (1999) elaborated that the second of five consequences of SCI that the informants perceived was very hard to deal with is decreased control of bladder (87%).

The informants tried to learn urinary care to maintain urination which included self-catheterizing, tapping and expression, and using a condom. Each of them may use one or two techniques to maintain urination differently. It was supported by Levi, Hultling, Nash, & Seiger (1995) who found that more than one method of urinary emptying was used by some subjects. Yarkony and Chen (1996) found that the persons with SCI have chosen to employ each technique depending on knowing the risks and benefits, their lifestyle, and financial resources.

The perception of not being able to defecate & maintaining defecation. Most of the informants perceived no sense of fullness and no control over defecation. This seems to be their major concern. This bowel problem includes: incontinent bowels, and constipation. This finding supports the study of sequelae of SCI discharge from the initial rehabilitation program (Cyr, 1989) which found that 85% of the people who sustained SCI from 11 weeks to 5 years experienced bowel problems. Similarly, Widerstrom-Noga et al. (1999) found that the third of five consequences of SCI that the informants perceived was very hard to deal with is decreased control of bowels (86%). Stiens et al. (1997) also reported that more than one-third of surveyed subjects with SCI (149 spinal cord injury patients) rate bowel dysfunction as having the most significant effect on their lives after injury, and many reveals that the risk and occurrence of fecal incontinence and difficulty with evacuation are particularly significant life-limiting problems.

In this study, the informants tried to learn self-care the maintenance of defecation by unison enema, pressing on their stomach, stimulation around the anus, and manual evacuation. However, it was found that they used manual evacuation after each of the strategies. This finding supported Levi et al. (1995) who found that persons with SCI used various methods of bowel emptying; both reflex (digital stimulation) and passive (suppository, enema, digital evacuation) emptying. In the study of bowel care practices in chronic SCI patients, Kirshblum et al. (1998) reported that bowel program characteristics were that: alternate-day programs were the most common and most subjects performed their programs in the morning. The result of an effective bowel program is regularity to avoid complications such as constipation and diarrhea. Bowel complications or an ineffective program affects virtually every aspect of the patient's life, including physical, psychological, social, vocational, as well as the ability to maintain an activity level, functional independence, and social interactions. Seymour (1998) concluded that management of bladder and bowel dysfunction is a life-long preoccupation and never-ending problem.

The perception of having spasms & spasticity reduction. The informants perceived that they had leg spasms, but the frequency and severity was different among them. The severe spasm caused them to feel discomfort, and interrupted normal sleep. This finding was consistent with Cyr (1989), and Levi et al. (1995) who found that the person with SCI experienced spasticity 58-93% of the time. More than 41% of the subjects with spastic paralysis reported that excessive spasticity was associated with additional functional impairment and / or pain.

In this study, the informants tried to control spasticity through prevention by carefully changing position, taking medicine, restraining their legs in bed, and through care with massage, exercise, flexing the feet, and stretching their body. It was consistent with Maynard et al. (1990) who indicated that treatment of spasticity must be based on the individualized clinical decisions of physicians and the person with SCI. Treatment usually is indicated if the spasticity interferes with the performance of self-care tasks, gait, wheelchair positioning or transfer activities, disrupts sleep, or causes pain, discomfort, or deformity. In addition, spasticity can contribute to skin breakdown and joint contractures (Yarkony & Chen, 1996). However, regardless of spasticity treatment options, a daily routine of prolonged muscle stretching should serve as the foundation for management of all patients with spasticity. The reduction in spasticity that follows stretching can last for several hours. It could also be due to mechanical changes in the musculotendinous unit and a decrease in spindle sensitivity and gamma activity (Yarkony & Chen, 1996).

The perception of having pain & pain handling. The informants perceived that they had pain at the back and pain like burning, numbness, tingling, cramps, stinging, and needles or diffusely at lower parts of the body. This finding was congruent with Levi et al. (1995) who studied a 379 SCI population by interviewing using semi-structural protocals, and found that many subjects had experienced neurogenic pain (51%), and non-neurogenic pain (22%). Almost two-thirds of the subjects reported significant pain, with a predominance of neurogenic-type pain. Widerstrom-Noga et al. (1999) found that the last of five consequences of SCI which the informants perceived as being very hard to deal with was pain (77%). Similarly, Rintala, Loubser, Castro, Hart and Fuhrer (1998) studied chronic pain in a community-based sample of men with spinal cord injury, and found that 75% of the men reported neurogenic pain was associated with more depressive symptoms, more perceived stress, poorer self-assessed health, and poorer employment compared with those without pain. However, Yarkony and Chen (1996) found that pain can be a minor nuisance that only intermittently interferes with daily activities. It can also affect sleep and prevent performance of activities of daily living.

In this study, neurogenic pain was the most difficult problem for the person dealing with SCI. They attempted to manage this pain with physical management (exercise, stretching, lift-up, lie-down on top of pain area, and apply pain area with cool water), taking medication, and toleration. Bedbrook (1985) reported that it was difficult to manage neurogenic pain. The author found that a person with SCI who became a healthy, vigorous member of society, usually with busy recreational and sporting activities, rarely complained of neurogenic pain of an intensity requiring treatment. If they sustained any additional illness or complication then they too can complain of pain. Thus, treatment for the prevention of complications is vital in pain reduction. However, Stiens et al. (1997) stated that the goal of pain management is a reduction of suffering rather than the complete elimination of pain. The method to reduce pain is composed of a promotion of a high level of activities, normalization of social function and maintenance of general health. Significant discomfort may require medication. However, medication is usually avoided because of concerns about the lack of long-term effectiveness, the length of treatment required, tolerance, addiction, escalating dosages, sedating effects, and visceral effects.

The perception of having pressure sores & maintaining skin integrity. Eight out of fourteen informants perceived that they had pressure sores. Most of them cited pressure sores as their main concern. This finding supports the study of Cyr (1989) who found that 63% of the people who sustained from SCI 11 weeks to 5 years experienced decubitus ulcers. The author also found that pressure sores are a leading cause of morbidity for SCI patients and non-healing pressure sores may be related to infection (e.g. osteomyelitis). Since pressure sores can affect the psychology, occupation and lifestyle of the informants in this study, they have to use the methods of both prevention and care of pressure sores. This finding supports Zejdlik (1992) who emphasized that prevention is most important. The author stated that maintaining adequate nutrition and good personal hygiene is fundamental to maintaining the protective function of skin and preventing skin breakdown. Prevention also includes learning to shifts weight, turning and padding when in bed, and awareness of environmental threats to skin integrity. The author also stated that disabled persons need to be increasingly watchful during period of depression, illness and / or fever. Regarding the care of pressure sores, Bergman, Yarkony, and Stiens (1997) stated that the general approach to caring includes the elimination of the pressure sore, debridement, and optimization of the wound healing environment. This includes relief of pressure and avoidance of overly dry or overly moist conditions.

Uveges (1996) described that the true cause of recurrent pressure sores in many disabled persons is as much psychological, social, and behavioral, as it is physiologic. Thus, caring should include psychological intervention.

The perception of urinary infections & UTI prevention and care. The informants perceived that they had a urinary infection several times after being discharged from the hospital. They perceived that urine retention and improper catheterizing was a cause of urinary infection. This finding supports Gallien et al. (1998) who studied the influence of urinary management on urologic complications in a cohort of 123 patients with sustained SCI of 8 years, and found that urinary complications had developed in 75% of the patients. The most common complication was urinary infection. Liguori et al. (1997) who studied social and functional variables associated with urinary tract infections in persons with spinal cord injury, also found that UTIs were negatively associated with functioning and productivity (number of hours worked per week), but were not associated with life satisfaction scores.

When the informants perceived they had UTI, they tried to learn self-care by controlling UTI with prevention and care. To prevent UTI, the informants used the method of observing the characteristics of their urine, drinking a lot of water, doing catheters carefully. To care for UTI they observed the characteristics of their urine and took medicine. These findings support Zejdlik (1992) who stated that one can inhibit bacterial growth by preventing an overdistension of the bladder, thus ensuring regular and reliable emptying. A person managing UTI should be alert for signs of UTI (fever, cloudy or foul-smelling urine), clean catheterizing, drinking a lot of water.

Yarkony and Chen (1996) described that one should treat it initially with antibiotics. Recurrent asymtomatic bacteria is generally not treated to avoid the development of resistant organisms, but in the case of symtomatic bacteria with fever, leukocytosis, or increased spasticity, it is treated, and the catheterization schedule is increased to reduce bacterial concentration and remove the urine that serves as a culture medium for bacterial growth.

Perceived Self as "Being Disabled" & the Strategy of Learning the System of Care and Support

The informants perceived the self as "being disabled" as a result of the perception of being dependent on other and decreasing their working capability. Under the domain of the perception of being dependent on others, the informants perceived that they had to depend on their wife, parents or elder sisters because they were unable to do anything and were unemployed. Some felt that they had to depend on family members in all aspects of physical, mental and financial support. Consistent with this study, Rammasoota, Pramanpol, and Taveesit (1994) who studied the community self-help the disabled, found that disabled people and their family perceived disability as a burden more than those of the community. Furthermore, Gill (1999) supported that it is common for spinal cord injury persons with such a reduced level of independent functioning to "give up" or be a burden on others. These persons may perceive that receiving support places them at a disadvantage, which may reduce their self-esteem. This literature seems similar to some findings in this study. Some informants who had depended on his mother or his sister perceived that they felt uncertainty and fear for the future, if some day they may lose the support of their family member.

Similarly, Williams (1987) stated that the relationship between dependence and family members was implied by the respondent referring to the dependence in terms such as “being a burden to others”, “being an encumbrance” and “not wanting to interfere in the lives of others”. However, disabled men were always extremely grateful for the sacrifices their wives had made. Caring by women was seen as being a “natural” extension of their normal role. Although disabled men did feel undermined by an inability to perform certain activities in the household, there was no mention of a general sense of guilt but only occasional ‘embarrassment’ or ’humiliation’ when they failed in some task (Williams, 1987). This information was similar to findings in this study. Although some informants thought that they were a burden to their wife, and wished to die, they still thought that they received love and encouragement from their wife.

Regarding the perception of decreased working capability, most informarts perceived that it was difficult to return to work in the same manner as before getting paraplegia. This finding is supported by the study of Setsathien (1997). In her finding a sample of persons with mobility handicapped who registered in Udon Thani province was as having an employment rate of 12.5% which is low. Among these, the disables worked as employee 5.3% and self-employment 7.5%, respectively. The informants also perceived that the barriers to returning to work include: inadequate assistance from institutes, physical condition, difficulty in traveling, and a lack of information about employment opportunities. These findings are supported by Crisp (1992) in the study of vocational decision making by 60 spinal cord injury patients.

The author identified problems related to vocational decision making, i.e. lack of vocational identity, lack of occupational information, and the presence of environmental or personal barriers to a chosen career. Dijkers, Abela, Gans, and Gordon (1995) stated that there is much variation in the factors, both pre-injury (education, employment) and post-injury (neurologic category, receipt of vocational rehabilitation services, etc.), reported to be associated with unemployment.

When the informants perceived they were being dependent on others and decreasing working capability, they learnt the system of care and support from significant others, health practitioners and the government. This finding is consistent with Jonsson, Moller, and Grimby (1998) who found that during the adaptation process when disabled persons integrated their changed capability into their self-concept, they moved from not being able to ask for help, even if they wanted and needed it, to asking for help, informing others about difficulties and making demands. Gill (1999) supported that the support system plays a vital role in helping a person to adapt, adjust, and cope with SCI.

With the perception of being dependent on others and decreasing working capability, they tried to manage their life through learning the system of care and support with the strategies of seeking and accepting necessary support from significant others, seeking governmental support, and seeking alternative treatment and professional suggestions.

Seeking and accepting necessary support from significant others. In this study, the informants sought and accepted assistance from family members in the aspects of physical, mental, and financial support. They also accepted mental support from their friends. This finding was consistent with the qualitative study of managing the personal and social world in 28 males and female with catastrophic illness and injury, in which Dewar and Lee (2000) found that significant others were valuable sources of instrumental, social, and emotional support, and provided comfort, encouragement, hope, and inspiration to the person. Brillhart (1988) described that the disabled person often relies on family member for physical care, social contacts, emotional support, and financial aid. The author found that the parents, the mother especially, were very supportive of the disabled adult family member. Davidhizar (1997) concluded that for a disabled individual, social support serves as a buffer against the stressors caused by the disability. This information supported the findings in this study that some informants accepted that they forgot unhappy matters, had hope and morale after they received mental support from their friends and their family members.

However, Rintala et al. (1996) stated that receiving support may seem to place the recipient at a disadvantage or may reduce the recipient's self-esteem. Other studies indicated that perceived support leads to support-seeking, which in turn is associated with higher depression or distress (Thoits, 1995). One informant who was unemployed and only stayed at home, stated that he accepted physical, mental, and financial support from his wife until he felt he was a burden on his wife, felt discouragement, and wished to die. However, De Jong (1983) stated that dependence on others or accepting support does not imply that the individual is incapable of responding to demands. Some people may choose to accept help from their family in order to maintain autonomy in other areas of life. In this sense, accepting support from family members indicates autonomy rather than dependence, and autonomy is something that can only be understood in relation to the interaction between individuals and social contexts in the course of daily life.

Jacobson (1986) stated that cultural context influences the decision to accept support. The author described how the ideas about autonomy, dependency, and reciprocity shape the ways in which individuals define support as well as, give, get, accept or reject support. Social support is assessed in the sense of feeling accepted, loved, self-worth, and a sense of social integration (Heinemann, 1995: Elliott, Herrick, Witty, Godshall, & Spruell, 1992). However, in current Thai culture, accepting a lot of support or being dependent on family members in a disabled condition is probably considered a problem because interdependence is valued more than independence or dependence (Limanonda, 1991).

Seeking governmental support. In this study, forty percent of the informants have low household income. All of them are not receiving a disabled pension, however, four of them rely on private insurance and one relies on work insurance. Therefore, their financial situation may be worse than before their injury. Moreover, they may have used some money for necessary things such as home modification, cost of living, repairing or replacing the wheelchair, the appliances associated with bladder and bowel management, and medication. Thus, the basics of survival as a disabled person require more money than for a non-disabled person. Setsathien (1997) reported that medical welfare, and disabled pension are the first and second priority of need from government that disabled persons need.

In this study, some informants tried to claim disability benefits as their right, but all were unsuccessful. Those persons for whom compensation claims were pending showed a significant dissatisfaction and felt hopeless with the bureaucratic system. It corresponded with the study on "a follow-up on the utilization of vocational right and benefit in accordance with the Rehabilitation of Disabled Person Act B.E. 2534" which showed that the informants are relatively dissatisfied with the service efficiency including that the process of requesting for service is complicated and time-consuming, and there is also irregularity and inconsistency in the follow-up of service. As for the officers of the Rehabilitation Center, they said that management and administration factors are responsible especially upon failure of policy implementation (Vimolkajana, 1998). Levi et al (1995) also found that it seems unrealistic, and probably inefficient, to rely on additional financial support to achieve further psychosocial or financial improvements in the SCI group.

Financial worries can have adverse effects and they felt powerless in their dependence on their family members. Some of them wished to get vocational training, however, all of them could not retrain because of their physical condition and inaccessible transportation. One informant in this study criticized that the location of the vocational center (in Chiang Mai) created a sense of discrimination from society. As Barnes et al. (1999) stated, the location of disability resource centers are often outside the city which represents travel difficulties and moreover, conveys a negative image. The author also described that the nature of work that is appropriate for a person with disability includes more flexible working hours, short-term contracts, increased reliance on information technology, home-based working, and an individualized and fragmented workforce.

Seeking alternative treatment and professional suggestions. Since most informants have a hope for recovery and they also recognized that they had other option of therapy which were suggested by others, they tried to seek alternative treatment and professional suggestions in order to increase their chances for recovery and correct dysfunctions. Kylma and Vehvilainen-Julkunen (1997) stated that hope exists at the center of a person and can act as a motivator to move people with an open attitude forward toward new options and alternative methods of coping. Hope is a sense of the possible. Hope springs from knowledgeable trust in an available and reliable source of help from outside the self, at a time of need. Hope related to the expectation of assistance from sources in the environment is based on past personal experiment. Hope provides protection for people against despair, gives them strength and motivation to live, as well as a light amidst the changing of their life.

For maintaining or increasing hope, the informants tried to seek alternative treatment, follow technological innovations, and health professional consultations.

In this study, the informants sought alternative treatments including: herbs, holy water, treading on the body, acupuncture, and yore. Farran, Wilken, and Popavich (1992) stated that alternative treatment related to a behavioral dimension that the person takes to make hoped-for events happen. Upayokin (1995) concurred that treatment seeking behavior depend on available medical resources in keeping with social discourse and culture. Hope for cure and suffering caused by disability were the important factors determining how person sought alternative ways to take care of their physical impairment. Singtipphun (2002) found that personal beliefs and interest, influences of family, relatives, friends, and other social network were among factors that led persons to seek an alternative therapy.

In addition, the persons who cannot be helped significantly by scientific modern medicine, because disability is considered incurable, try to seek attention and relief through an alternative practitioner (Farran et al., 1992). Wendell (1996) stated that non-western and non-traditional medicine practice defines healing not as a cure but as an improvement in the quality of the patient's experience, an approach that seems particularly well suited to helping those with chronic illness. The author also described that the context of any attempt at healing in a society indicates a culture that considers controlling one's body a criterion of full harmony and of social acceptability. However, Herth (1989) found that active informant in treatment and seeking health might signify continued hope and coping.

In this study, informants sought to imagine another way of dealing with their circumstance. They have demonstrated hope concerning an imagined future for the body of unlimited opportunity for choice and reconstruction from technological innovations which included: put a microchip inside the body, spinal cord transplant with tissue from cloning, omentum graft at the spinal cord, and robotics. Seymore (1998) stated that treatment for illness and disability accepts a range of pharmacological and surgical interventions to remedy the physical health problem, treatment with techniques that can extend the capacities of body far beyond thinking. Artificial organ transplants, pacemakers and prosthetic limbs have a common place in clinical medicine. Thus, it is possible that technological innovation is simply an addition or modification of regular bodily function to increase efficiency or to make a task easier. Technological innovation is not an aspect of the distant future, it is the all-encompassing here and now. It offers the hope for disabled persons to have greater human satisfaction and happiness. Therefore, it is possible for disabled persons to imagine that technological innovations may be present as the possible opportunity to escape from their stressful situation.

Similarly, health professional consultation is also a behavioral dimension of hope where the persons were seeking health information related to their problem. Health professionals serve as sources of hope by providing cues and information, taking action to assist the person to achieve a goal, or providing affirmation, listening, supporting, and encouraging. Health professional consultation can provide information about the condition and the beneficial way of practice toward the persons. It decreases a worrying physical condition and relationship with others. It decreases helplessness by receiving information about specific events and emotions which can be anticipated. With accurate information, goals can be better set. The act of seeking information from a health professional can reduce feelings of uselessness and helplessness, while increasing feelings of self-confidence (Lange, 1978).

Perceived Self as "Being a Disabled Person" & the Strategy of Learning to Live in Society

In this study, the informants perceived the self as "being a disabled person" after they perceived inferiority, discrimination from society, and perceived changes in their relationships with significant others. Regarding the perception of inferiority, they perceived themselves as useless and worthless because they couldn't help themselves in the aspects of daily living activities, travelling, and finances. Feeling different from others in society also caused inferiority. Moreover, society's attitude towards persons with disability added to the perception of inferiority. This finding is supported Devey and Graffam (1987) who wrote that "feelings of self-worth might be relative compared to those around them. That is self-esteem is dependent on social interaction. Paraplegia threatens their self-esteem because they perceive themselves as being looked down on, being inferior and worthless.

Bozzacco (1993) who studied the long-term psychosocial effects of SCI, reported that the loss of the ability to stand upright influenced many social situations for persons with SCI. Closely related to communication difficulties was the group's belief that they were considered inferior to others during interactions, assumed oneself as having less than normal intelligence, and felt having someone looking down on them during a conversation made it seem as though he were being given a command or an order. Friedman and Dimatteo (1989) who studied the wheelchair disabled persons, found that three basic factors interfered unnecessarily in the lives of persons in wheelchairs: first, the negative perception of society, which saw disabled persons as deviant and inferior; second the negative self-perceptions held by disabled themselves, which limited their willingness to venture into the public eye; and third, physical impediments to the mobility of disabled persons.

In addition, the informants perceived that they were discriminated by society. They experienced that others responded to them by looking down on them, ridiculing, teasing, and pitying them. Ramasoota et al, (1994) who studied the community self-help for disabled persons in Udon Thani province, found that community attitude toward disabled people is similar to that of normal people of 43.9%, pity and sympathize with them of 41.5%, looked down and dislike of 14.6%. Wendell (1996) who found that culture makes major contributions to disability. These contributions represent stereotypes of disabled persons as dependent, useless, non-productive, morally depraved, asexual, and pitiful. Albrecht and Devlieger (1999) described that people with disability are assumed to be limited in function and role performance and quite possibly stigmatized and underprivileged.

Morris (1991) stated that a man in a wheelchair is an easily recognizable metaphor for a lack of autonomy because this is how the general culture perceives disabled people. The outcome of this negative societal attitude toward disability can be an assault on self-identity. They become particularly sensitive to the forfeit of previously valued and taken-for-granted aspects of the self (Barns et al., 1999). They generally were summarized as self-recriminations of various sorts, and often involved feelings of inferiority. Many self-recriminations are related to the inability to maintain meaningful work and maintain physical health (Dovey & Graffam, 1987). Friedland and McColl (1992) point out that society's traditional view of disability has supported the disabled individuals view of themselves as unworthy and having lower social status. However, Wright (1983) stated that disability is not the only characteristic that places a person in an inferior status position. Master statuses, such as race, age, and gender, are those which have a great deal of social significance because others respond to a person in terms of his status rather than in terms of the person's individual traits. Therefore, the stigma of class is added or reduced to that of disability.

The last perception of alteration domain in this study was perceived changes in the relationships with significant others, which was characterized by strains on marital relationships, uncertainty to maintain or establish intimate relationships, and lost of their friends and neighbors. In regard to strains on marital relationships, Bright (1996) described that an acquired disability changes family relationships and the balance of power, and can lead to problems and disagreements, as when there is an exchange of roles between partners. A disabled person feels demeaned by their wives for taking over that power because of their disability. Similarly, with the high level of dependence that often results from SCI, the couples are under extreme pressure to adapt and cope following the injury. The partner must play many roles as lover, caregiver, and substituted breadwinner that its may create deleterious situations and additional strains in the couple's relationship (Barnes et al., 1999 ; Kreuter, 2000). However, Crewe and Krause (1988) found that those who were married after injury tended to be more satisfied with their living arrangements, social living, emotional adjustment, and sense of control over their lives than those married before injury.

Some interviewed persons with paraplegia reported difficulty in establishing and maintaining close or intimate relationships because of being uncomfortable from pain, dependence on family, concern about physical appearance, and social attitude. This finding is similar to the findings of Kreuter (2000) who studied SCI and partner relationships. The author indicated that individual attitudes toward persons with SCI and the injured person's own prejudices against physical deviance may make it difficult to develop a new relationship. Thus, a person with SCI may be handicapped not because it imposes actual physical limitations but because it interferes with social relations or is in conflict with the individual's value system. In a study of experiencing disability, Dovey and Graffam (1987) investigated barriers in establishing intimate relationships, and found that the reasons for this appear to be social and physical isolation, dependence on family / caregivers for basic mobility, low self-esteem, and poor social skills. Yoshida (1993) interviewed 27 men with SCI regarding intimate relationships and marriage. Some men reported concern about their level of attractiveness and had difficulty meeting interested women.

In this study, most informants perceived change in relationships with their friends and neighbors. In the study of relationship between neighbor and disabled people in one village of Udon Thani province, Ramasoota et al. (1994) found that most neighbors (65.2%) in rural area , are always talk with disabled people, whereas 22.9% and 11.9% of them are rarely and never speak with disabled people. In addition, informants identified causes of change in relationship including: no mutual activities together, long distance to meet their friends, difficult transportation, dependence on others to go with them and anxiety of bowel incontinence. Friedman and DiMatteo (1989) who found that social relationships are often disrupted because a disabled person was decreased energy, limitations in mobility, communication impairment, or time required for symptom control. In addition, a person with disability, in an effort to hide their disability, may avoid certain friends and associates. Woodbury and Redd (1987) said that their friends are lost when activities and recreational pursuits are no longer mutually shared. Cogswell (1977) also stated that the paraplegics maintained very few friendships that existed prior to their injuries because it was difficult to establish a new identity with those who view them from the pre-trauma frame of reference. These paraplegics mentioned a number of problems which ensued when they tried to maintain old relationships: frequent expressions of pity, contamination of the relationship, questionable sincerity of overtures made by old friends, old friends were inclined to offer unneeded physical assistance, and paraplegics felt that old friends made invidious comparisons between the pre- and post-trauma relationship.

Dovey and Graffam (1987) reported that friendships are restricted to other disabled persons because their inability to satisfy the criteria they associate with "normality" (i.e. marriage, having children, living independently, earning a reasonable income through a job) has negative consequences on their self-esteem. Their "different" and negatively perceived identity of "being a disabled person" is reinforced by their segregation from the general community. The authors also described that non-disabled persons tend to keep more distance between themselves and persons living with disabilities, terminate interaction sooner, and feel less comfortable in interactions than they do with other non-disabled persons. In short, social interactions or relationships are less frequent, of shorter duration, and less dynamic.

When the informants perceived inferiority, discrimination from society, and perceived changes in relationships with significant others, they tried to learn to live in society by employing the strategies of: avoiding having a sense of inferiority, controlling negative behavior, managing stress, and protecting dignity. They employed these strategies in response to their situation in order to sustain self-worth, increase a sense of autonomy, and maintain social participation.

Avoiding having a sense of inferiority This strategy was an important method which prevents inferior feelings about the self which emerge as a result of interaction with others. Informants used the method of avoiding social participation, relating oneself with those of the same or lower status, comparing with others, refusing unwanted help, and protecting personal rights. This finding confirmed the literature in which Wright (1983) described that most people with disabilities do not take inferior feeling views of others without struggling to protect their self or egos and affirm their own worth. They avoided social participation because they were uncertain of what the responses of others would be, and paraplegics tend to expect the worst. They quick to interpret any questionable response as derogatory and rapidly withdraw if they perceive the slightest strain in a social encounter. They understood that the attention of others may be focused on the disability and that other aspects of the self will be treated as irrelevant. Disabled persons rejected curiosity about their disability for several reasons: they viewed reminders of painful disability-connected memories as unwelcome and expressed a desire to keep their disability private. They were afraid of being considered different and had outright resentment of morbid curiosity (Marinelli & Dell Orto, 1999).

Informants perceived discrimination from society because of the sociocultural attitudes toward disability. Some Thai people may see a person with disability as useless, non-productive, and dependent on family members or others ("Thai society with disabled law, 1987). Therefore, many informants tried to avoid social participation. Dovey and Graffam (1987) stated that a person with disability chose to escape or withdraw from society because of no other means of coping with negative attitudes and behavior from others. Similarly, withdrawn behaviors then stems from the belief that having a disability inherently makes the person less desirable, less good, and useless, which was the outcome of a negative societal attitude toward disability. It can be generally summarized as self-criminations of various sorts and social isolation often involving withdrawal from both wider society and from association with their friends (Wright, 1983).

When informants acquired new friends, they tend to choose people of lower social status than their pre-trauma friends. This finding supported Smith and Mackie (2000) who described that social comparison is a common tactic employed to establish distance between oneself and those who are successful. The persons do this by either downplaying their own similarities to them or backing off from relationships with them. By choosing friends of lower status, persons with paraplegia are able to balance the negative definitions of disability against some negative characteristic of the other person. If in this relationship they become successful in projecting themselves as a person of worth and become skilled in eliciting this definition from others, they proceed to more difficult relationships, eventually forming successful relationships with new individuals of equal status (Marinelli & Dell Orto, 1999).

With the same status relationship, Joachim and Acorn (2000) stated that discredited people manage their stress in relationships by isolating themselves into subgroups in order to normalize their attributes and covering. Covering is an attempt to minimize the effect of the stigmatizing condition and decrease stress (Goffman, 1963). Zejdlik (1992) found that this relationship plays an important role in helping a disabled person learn the way to deal with situations, share information and experiences regarding disabilities. Similarly, Wheeler and Dace-Lombard (1989) believe that support groups provide emotional support, modeling, goal setting, insight, personal growth, and self-esteem raising. Moreover, Davidhizar (1997) found that the person with disability who learns from the optimal performance of another disabled person can both stimulate and provide hope that they can function similarly.

Comparing oneself with others was an important strategy of learning to live in society. It helped to protect the positive image of oneself and improve one's feelings.

This strategy corresponds with Taylor's (1983) theory of selective evaluation which argues that traumatic circumstance people selectively focus on aspects of their situation that make them feel better relative to other individuals. Comparison and selective evaluation appear to be a valuable strategy in managing inferiority. Every effort should be taken to preserve the individual's ability to make these selective evaluations and positive comparisons. Similarly, Jonsson, Moller, and Grimby (1998) stated that by comparing themselves with other disabled persons, they conceded that the present situation was preferable. This strategy helps them sustained morale during everyday life.

Refusing unwanted help was used when the informants were offered things, money, or suggestions. They disliked to receive some assistance which showed that they were inferior to others. This finding supported Wright (1983) who discussed how social interaction involving, for example, expressions of sympathy or offers of help, may be detrimental to the self-esteem of a person with disability. This may be because of the prejudiced or inappropriate way in which the able-bodied person acted and / or it may be due to sensitivities of the person with disability. Traditional masculine roles might assist the persons with disability to counteract the prejudice that they encounter (Westbrook, 1997). Zejdlik (1992) stated that it may be difficult for many disabled persons to refuse assistance for two closely related reasons: fear of discouraging potential sources of help that might be needed later, and the rationalization that it makes people feel good even if the help is not necessary. However, refusing unwanted help in an appropriate, assertive manner can make everyone feel good about the interchange.

In avoiding having a sense of inferiority, the informants also tried to protect their personal rights by accessing every place where others went, and ignoring others' stares. Goffman (1963) revealed that interaction between physically disabled and non-disabled persons is marked by discomfort, uncertainty, and inhibition. Zejdlik (1992) also stated that being stared at becomes a problem for some disabled people because of what they tell themselves about the staring. However, many of the problems which the individual with disability face stem directly from discriminatory practices and neglect on the part of the wider society. Davidhizar (1997) suggested that a person with disability should try to find a way to live with their disability while achieving as a normal life as possible to help protect their own rights. That is, the person with disability who had sufficient interpersonal skill can put the able-bodied person at ease, as well as persons with disability who are socially extroverted and self-confident enough can simply enjoy society (Goffman, 1963). Therefore, the social skill of protecting personal right would allow person with disability avoiding having sense of inferiority.

Controlling negative behavior. In perceiving discrimination from society and changing relationships with significant others, the informants learnt to live in society by controlling negative behavior in communication with significant others. They learnt to use this strategy because they needed social acceptance and to maintain support from others. In this study, the strategies of controlling negative behavior are trying to control emotion and conforming to social norms.

DiMatteo (1991) stated that regulating emotional reaction and trying to maintain a sense of cognitive and behavioral control is the way to cope which functions effectively in the long run. Zejdlik (1992) also indicated that personal control is a critical factor in coping effectiveness. In Thai society, persons with disability are seen as useless, unable to help themselves, dependent on others, and inferior to others. In Buddhist religious teaching, emphasis has been placed on curbing angry feelings. The Thais are taught that anger is a prime disruptor of a good life and causes quarrelling (Tantipathananond, 1974). Therefore, a Thai person with disability tries to control their emotions by acquiescence in order to maintain support. Similarly, the persons with paraplegia employed the strategy of conforming to social norms in their peer group, reciprocity with other, and avoid drinking or drug addiction. Smith and Mackie (2000) described the two reasons that people conform to social norms include, people believe that the group is right and they want the group to accept and approve of them. The authors also described that agreeing with others ensures that people contact with a common reality, gives them the feeling of being valued and increases their confidence. Velde (1997) supported that friendly or proper manners can develop and sustain relationships with others. That is, it can influence social acceptance and maintaining support.

Managing stress. The strategy of managing stress involves releasing stress, recreation, living with the present, making their mind up and religious practices. Informants noted that their effort to manage stress depended primarily on themselves and what they learnt or received suggestions from others. Releasing stress to reduce stress used both active and passive ways that involved hitting a wall, listening to powerful music along with singing loudly, self-talk, staying with a pet, reading, and temporarily leaving a stressful situation. In Thai society, Thai people normally do not express anger or aggression directly nor are they ready to accept the angry feeling of others. In school, Thai children are taught to suppress anger. If it heats the heart, it may cause them to release the anger with a violent reaction (Tantipathananond, 1974).

In addition, Poompachati (1992) stated that rhythm and music script may help to release stress. The use of appropriate music can generate a good mood. Thus, music is a tool for creating positive emotion and decrease the feeling of social isolation. In the context of chronic stress, the person may relieve stress by distracting oneself from it with turning one's attention to reading material (Gottlieb, 1997). Self-talking is also a behavior in managing stress because it allows the release of unsatisfied emotions. Moreover, Davidhizar and Shearer (1997) stated that experiences that engender hope help to release stress by sharing the experiences of friends and watching the activities of animals. Willis (1997) found that relationships with animals can promote feelings of self-worth, help offset loneliness, reduce anxiety, provide contact, comfort, security, and the feeling of being need.

Regarding recreation strategy, Barnes et al. (1999) stated that a young man with disability spent more time engaged in passive, solitary activities such as watching television or listening to music. Especially, the television may be left on permanently, providing easy escape from unpleasant, intrusive thoughts, interactions, or other stressful demands. Gottlieb (1997) stated that active recreation such as gardening, cooking, or travelling provide the possibility of gaining a greater sense of control over one's circumstances. These activities demonstrate to oneself that the stressful context does not define all of one's life because other valued roles can be assumed that provide pleasure and self-satisfaction. Recreational activities that involve effort devoted to refreshing or entertaining oneself create positive and rewarding alternative experiences. Moreover, many of these active forms of recreation not only accomplish the function of tension reduction but also restore and enhance the energy needed to cope effectively with ongoing life pressures.

Living with the present is a way of emotion-focus coping that the persons with paraplegia used to deal with the stress associated with their event. This strategy is superficially similar to suppression but here they are trying to refuse to acknowledge, or to put out of their own mind, the fact of the disability and its implication (Ray & West, 1984). This strategy was support Fordham (1995) who studied health related behavior and changing perceptions of contemporary rural life in Chiang Mai province. The author found that many informants response to health conform to the broader logic of Northern Thai culture. A fundamental tenet of the Thai Buddhist world is that phenomenal reality is both illusory and that it is subject to change. Change is believed to impinge on each person's life in an unknown and unknowable way according to the law of Karma and from the perspective of the present the future is always unknowable. Thus, for many villagers there is an emphasis on enjoying the present rather than on making long term concrete plan for the future, as a very common saying in the North is that "(one) shouldn'think too much". The implication is that to worry too much about future negative consequences will cause sorrow at present, and it may tend to draw such ill to oneself.

Aldwin (1994) stated that a refusal to acknowledge an event or feeling is denial. Denial allows one to literally forget that something has happened. Ego psychologists view denial as a growth-inhibiting strategy, perceiving it to be "antithetical to psychological health". However, Ray and West (1984) stated that refusal to acknowledge their event does not necessarily imply a distortion of reality. It can be just a bias in the way that the situation is evaluated toward maintaining the status quo or maintaining emotional equilibrium in the short-term rather than making adjustment in the light of changed circumstances.

Making their minds up is one strategy of managing stress that the informants tried to employ in response to dissatisfaction with their disabled situation. Making their minds up is synonymous with "accepting", managing one's emotion or feeling (Domnern & Sathienpong, 2001). Martin and Weston (1998) stated that acceptance of reality (letting go) is a gradual awareness of the new reality which is one of the most important phases because it marks the point at which a person is detaching from the emotion of the past and is moving forward to the future. Acceptance can be a very complicated response to life threatening illness. In some cases it is considered the resignation. Martz et al. (2000) stated that acceptance of disability is viewed as an undesirable or negative state (resignation), but also an optimal, positive state and a process of continued coping with disability.

Informants in this study can also make their minds up by shifting their viewpoint and value or establishing their own viewpoint on other aspect in their life. They shifted their viewpoint by thinking: their injury was not more severe, the reason of male value, an accident may occur in anyone, and remaining capability is the same. This finding was consistent with Martz et al. (2000) who stated that the cognitive or intellectual type of acceptance as a state of cognitive reorganization and reorientation is demonstrated by: a) an acceptance of oneself as a person with disability; b) a new sense of self-concept; c) a reappraisal of life values; and d) a search for new meanings and goals. Wright (1983) also defined the three components of acceptance of disability which included the degree to which a person is able to: 1) find meaning in their circumstances, 2) value their selfhood, and 3) maintain positive beliefs about themselves. Walsh (1999) stated that a person with disability had a stigma attachment and their life was changed forever. Recovery is a deeply personal and unique process of changing one's attitudes, values, self-concept, and goals. Recovery involves the development of a new meaning and purpose in one's life. It is finding ways to live a hopeful, satisfying, active, and contributing life.

Some informants in this study used resignation as a strategy to reduce the stress from their situation. Ratanakul (1996) stated that chronic illness may stimulate a person value religion, have faith in God, and have a relationship with God. Spiritual beliefs may provide ways for disabled persons to cope with their fears, anxieties and frustrations as life changes and health problems develop. Dhammananda (1993) stated that Buddhists believe ideas about culpable behavior or accepted responsibility from the result of karma in their previous life by resignation. This is crucial in helping people overcome their misery and bringing equanimity and peace of mind. The informants believed that they were disabled because of their karma which was easy to resign with their disability. As Fordham (1995) point out, the use of Karma in "negative context" is a normative Northern Thai means of explaining the misfortune of illness or disability.

However, Gottlieb (1997) stated that resignation is not necessarily a passive mode of adaptation that involves surrender and defeat. Instead, it involves both the realistic recognition that certain aspects of one's self or one's circumstances cannot be altered and accompanies emotional calm. Noh, Beiser, Kaspar, Hou, and Rummens (1999) stated that Asian values are not passive resignation. It is simply tactical.

Stress is held to be best handled by indirection and internal change. That is, Asian people often make their mind up by resignation.

When the informants realized the law of karma and perceived that bad deeds bring bad results, they will then use religious practice including making merit (a food offering, donations of money), offerings dedicated to the Sangha, and praying. Merit ensures fortune in the present and the future by the accumulation of merit through the performance of good deeds (Mulder, 1990). The most common way to acquire merit and a better next life is to give by helping others, donations of food, and money. These merits act to get rid of attachment and to purify the mind with resultant happiness (Klausner, 1983).

Another way to make merit is not killing a living being. It is one of the five precepts. Some informants, including family members observed the first precept of not killing because they realized that their happiness and suffering are self-created through the operation of the law of karma. To minimize the occurrence of troubles and problem in their life, they make the effort to refrain from doing evil. They perform good actions because they know that these will bring them peace and happiness (Dhammananda, 1993). Moreover, most of the informants performed praying every night before sleeping. They gave the reason that praying helps them have a comfortable mind. Praying is one coping response that helped the persons the most in dealing with a serious personal problem (Pargament & Brant, 1998). Dhammananda (1993) stated that through prayer, the persons understand that "they become what they think, in accordance with the discoveries of psychology. When they pray, they experience some relief in their mind, that is, the psychological effect that they have created through their faith and devotion". Benzein, Norberg, and

Savemen (1998) also suggested that saying prayer should be essential for the persons' dialogue with God. The experience of prayers being granted also strengthened the experience of hope. Personal religious motivation and orientation that provides hope and meaning in life and disability has been found to be of more importance to increase life satisfaction and positive emotional adjustment than a more utilitarian, institutionalized, and less internalized form of religion.

Protecting dignity. In this study, most of the informants learnt to live in society with dignity by refusing unwanted help, avoiding being a burden, maximizing personal role function in the family, attempting to work, protecting personal rights and using full remaining capability to help or entertain others. It was consistent with Miller (1992) who stated that the ability to control environmental intrusion preserves personal dignity. Therefore, adjustment means more than self-acceptance and responsible behavior. The disabled persons should also develop social technique and psychological mechanisms to cope with the behavior of others (DeLoach & Greer, 1981). The strategies that the persons with disability use toward others would help them strengthen self-concepts, so that instead of being annihilated, they will be able to function in spite of negative social expectations.

Being a burden to others-in the sense of being helpless and subordinate- can be part of the disabled experience of living in the community. As well, oppression is almost unavoidable in the context of enforced dependence on family members for both material resources and assistance (Morris, 1991). Receiving support may seem to place the recipient at a disadvantage or may reduce the recipient's self-esteem. They may not wish to burden others and therefore may not want to request support. In this study, the informants tried to avoid being a burden on other, especially family members, by trying to help themselves including self-care in activities of daily living, working, and sharing the cost of living in the family. Seymore (1998) stated that when the person with disability can help themselves, they would reciprocate the favor which reduces being a burden with family members and restores the balance of family role. Feeling control over one's life, such as being able to help themselves in daily life and exchange support with family members, support a sense of mastery, maintain dignity, and encourage participation in their life (Danielson et al., 1993).

The findings in this study revealed that some informants tried to maximize personal role function in the family as father and the head of the household. This finding supports that of Bozzacco (1993) who stated that the role of working and love relationships has importance for men during young adulthood development. Goffman (1963) described that people with disability or stigmatized individuals attempt to manage the "spoiled identity" by managing tension involved in social encounters, and recovering their status and identity. Role, identity, and relationship are often the major issues in attempting to maintain a normal life. Buck and Hohman (1981) examined the relationship between spinal cord-injured fathers and their children. There was no evidence that the disabled fathers excluded themselves from discipline and other child-rearing aspects of parenthood or that disabled fathers lost control over their children. This research study supported this finding that two informants were able to look after their children by teaching them what they should do. Moreover, two informants who tried to help themselves both in their activities of daily living and earning for their family, felt satisfaction with their marital relationship. This finding supported Kreuter (2000) who studied SCI and partner relationships, and showed that an SCI person who strives to minimize the impact of his disability on a potential partner makes a more attractive candidate for a long-term relationship than an individual who has come to rely on others.

Regarding return to work after paraplegia, Gage et al. (1997) described that the occupational hierarchy model is composed of self-care (the lowest level), home management, work, satisfying leisure pursuits, and self-fulfillment (orderly high up to highest level). If a person with disability needs to return to paid employment, they have to fulfill the two primary needs (self-care and home management) adequately. This model is consistent with findings in this study which found that more than half of the informants attempted to work after they could help themselves in activities of daily living and some were able to travel by themselves or had family members support them. As Gething (1997) stated, the factors which affect the vocational potential of persons with SCI include: physical ability to work away from home, bladder and bowel management, education, level of family support, and availability of transportation and motivation.

Trieschman (1982) believes that a person needs two years just to become comfortable with the physical and social changes spinal injury entails, and the optimum time for reemployment is approximately two or three years after injury. The author also stated that employment may not be an appropriate goal for all persons with SCI, it depends more on the variables associated with obtaining employment including the intrinsic characteristics of the person (locus of control), timing of the vocational program, employer attitudes and discrimination, and the financial disincentives to productivity. Hall (1999) stated that the work or activities of the persons have empowered them to resist negative discourses and narratives of disabled identities by creating a different subject position for themselves. Through work and activities, they have re-defined some of characteristics of musculinity-developing their bodily competence and skills: and this sense of independence within the limitations of their impairment.

In this study, it was evident that most of the informants were self-employed. Palmer, Schrine, Getch, and Main (2000) found that the conditions led the person with SCI to choose self-employment including: a) chance event-led to the identifications of self-employment as an alternative when previously that alternative had not been deemed plausible, or even identified as an option; b) availability of resources-the availability of financial resources was an important factor in these individuals' decisions to enter self-employment.

While living in society, the informants tried to use their full remaining capability to help or entertain others by being a consultant in business, a mason, a coach of sports, by playing music in public and assisting in village activities. They did these activities in order to enhance their self-dignity. This finding supported the results of a study by Sawin and Marshall (1992) to identify the factors associated with feelings of self-competence and self-worth. An overall sense of self-worth was associated with social competence, close relationships, and job competence. Smith and Mackie (2000) described the two reasons that the strategies for creating and maintaining a positive view of themselves worked: 1) some of the ways people strive for high self-esteem really amounts to efforts at self-improvement; 2) self-esteem has value above its usefulness as an indicator of the level of success in society. Davidhizar and Shearer (1997) stated that a positive self-concept and feeling of self-worth involves enabling others to gain and use their own personal power. Feelings of empowerment allow clients to experience a sense of control and mastery over life.

The Consequence of Making the Best of Paraplegia

The consequence of making the best of paraplegia is composed of physical function aspects (existing limited physical function, and limiting physical complications), psychological aspects (comfortable mind, morale, reduced stress, increased self-esteem / low self-esteem, sustained self-worth, maintaining hope, satisfaction with what they have, dissatisfaction with the disabled support system, and feeling inferior), lifestyle and behavior modification (modifying lifestyle, altering life goals, being able to self-care, being more independent, and decreasing working capability), and social participation (Maintaining / decreasing social participation, and changing relationships with significant others). These findings suggest that young adult Thai males with paraplegia may have both good and poor adjustment or quality of life functioning. Crewe (1996) found that adjustment to disability is a complex process. It was unique to the individual. They had some loss due to SCI, yet they have experienced gain as a result of the disability experiences. Bozzacco (1993) stated that the outcome of the process of coping is part of the long-term adjustment to SCI or perceived quality of life.

Regarding perceiving a good quality of life, the informants perceived psychological well-being (comfortable mind, morale, reduced stress, increased self-esteem, sustained self-worth, maintaining hope, satisfaction with what they have), personal fulfillment (being able to self-care, being more independent, altering life goals, and modifying lifestyle), and maintain interpersonal relationships (maintain social participation). They perceive a good quality of life because of the following reasons: first, although they were disabled and limited in some physical and mental ways, they still had control over their bodies, mind, and lives (being able to organize personal activities, being able to drive cars, being able to help others such as, as a consultant or coach); second, they learnt what was possible and set goals; third, they developed or elaborated a value set that helped them make sense of their disability; forth, they conserved energy and searched for resources to manage their lives better and they had adequate supportive resources; fifth, they engaged in their social activities and remained in social contact, sixth, the longer the time they had to cope with stress, the more likely that they had repeatedly encountered opportunities to learn adaptive coping strategies. This finding supported Albrecht and Devlieger (1999) who stated that quality of life in a person with disability goes beyond activities of daily living and disease categories because it directs attention to the more complete social, psychological, and spiritual being.

In perceiving a poor quality of life, the informants perceived low self-esteem, feeling inferior, being dependent on others, decreasing working capability, and decreasing social participation. They perceived a poor quality of life because they put more emphasis on their body which caused them to think of themselves as useless or worthless and led them to social isolation and uncertainty to return to work again. They also had difficulty managing impairment, a lack of knowledge and resources and a disabling environment. Similarly, they had been disabled a short time (2-3 years) which gave them less experience to learn adaptive coping strategies. These conditions were a cause of reducing their quality of life.

In conclusion, the findings suggest that the theoretical thinking perspective, socio-psychological perspective and other various theoretical models adopted a broader interpretation of the model of making the best of paraplegia which emphasizes the perception of self-alteration, action / interaction strategies, and the consequence of managing strategies. Paraplegia commonly violates informants' sense of control, and their subsequent attempts to regain a sense of control may help to decrease the stress of the situation. They employed a variety of strategies depending on how they perceived their situation in order to cope as well as they could in their limited situations. Making the best of paraplegia represented a continual effort through using all three strategies to manage, reframe, and reconstruct their situation and social environment until they had achieved their demand. The similarities and differences between the findings of this study and other studies depended on the type of disability (paraplegia and tetraplegia), gender, the wider circumstances of disabling barriers and attitudes in society, and the impact of state policies and the welfare support system.

Implications and Recommendations

The findings of this study provide powerful information for implementation in nursing practice and the disabled support system. These issues will be discussed in the following. Further research is also recommended.

Implication and Recommendations for Nursing Practices

The findings of this study indicated that persons with paraplegia have to use various life and social skills while simultaneously taking physical care, and adapting with the role changes and family relationships. Based on the results of this study, the researcher recognized that a rehabilitation program should be designed individually after assessment for the patient's problems and resources has been done in order to provide appropriate intervention which meets the needs of each patient. Moreover, the findings could help inform nurses and health workers concerning informant's problems which they face in daily living, such as the problems of self-care, psychosocial (low self-esteem, feeling inferior), unemployment, social isolation, and claiming assistance from governmental support. Nurses should thus be alert to these problems. There seems to be a need to provide nursing intervention with emphasis on the aspects of increasing ability to self-care, promoting independence, enhancing self-esteem, and empowerment. The most important thing to provide nursing intervention is that nurses should be facilitators or resource people to help persons with paraplegia as the active persons in establishing goals and planning and implementing their own care. Nursing intervention can be developed based on the information in this study to provide support for a person with paraplegia as follows:

1) The nurse should establish the intermediate care unit for the paraplegia persons to prepare them in returning to their community. Its activities should be in the form of "Home Care" where it can be held both at the patients' home and the rehabilitation ward. First, there should be home visiting to give the useful and important suggestion and information to the patient's family in adapting and adjusting

the condition of the house and habitation to the paraplegia persons living condition. Next, the activities crucial to the patients daily life should be taught at the ward, e.g. self-care activity, pain and stress management, knowledge on optional curing methods, and social interaction skill program. This also includes information on the right of the disabled, and all resources available in the community. When the patients return to their home, there should be 1-2 times of home visit to follow up the problems and obstacles of the patients in their real life in the society. The intermediate care unit for the paraplegia should be the specific places where the patient can follow-up instead of going to the Out Patient Department (OPD).

2) The nurse should create the self-help group starts during rehabilitation period in the hospital. This should be done in order to let the paraplegia patient be able to learn from one another to develop coping strategies, to acquire a sense of control over their lives, and to develop network. This is also to make one feel less isolated by realizing that there are others who share similar feelings, reactions, problems and concerns. The nursing activities consist of:

2.1) Activities that create group relationship among the patients. The nurse will be in charge of stimulating the automatic group development without interfering the group. When the patients return home, a good connection among them, visiting, and a supporting telephone services will provide the person with paraplegia the opportunity to discuss common problems with peers and may eliminate some of the feeling of isolation and mitigate emotional loneliness.

2.2) The nurse should arrange the peer education activities in order to support the self-care ability and to enhance personal inner power of the paraplegia person. The activity can be done by choosing the paraplegia person with high potential and self-achievement to be a key speaker in teaching the patients in a hospital. The subject taught in the hospital could be on self-caring method, daily activities, how to call for the social welfare from the Government, the right of the disabled, their goal of life, and how to live their lives in the society with other people.

2.3) According to the fact that most of the paraplegia suffer difficulties in traveling from either dependency, cost of living, and inconvenience of road and street they take, therefore the distance care activity has come to be more necessary for them. The nurse should set up consulting unit or a hotline for crisis problem, a consulting service via telephone by the high-potential and achievement paraplegia volunteers. The volunteers can also come to work at least once a month.

3) The stereotype image is that people with the paraplegia is an asexual being. This stereotype can often affect to the expectations of people with paraplegia. It may take some time for the person to realize that he is still a man, despite not being able to carry out some of the traditional roles associated with that gender. Sexuality and finding new ways of sexual expression are now regarded as important components of rehabilitation and readjustment. According to this matter, presently, a doctor in one hospital in Chiang Mai province has opened the section for consulting and educating the spinal cord injury patients on sexual matter. Therefore, the nurse in charge of activity should have a contact with this specialist, so that the patient who needs the consultation on the sexual matter could be transfer to him. Prior to this, the nurse should create formal group to evaluate the patient's problem on sexual matter, then transfer him to the doctor specializing on sexual therapy.

Implications and Recommendations for Policy Development

The study on "managing everyday life among Thai men with paraplegia" collected information from fourteen persons with paraplegia. The findings of this study suggested that important practical issues which concerned the social policy development should be considered as follows.

1) The Rehabilitation of Disabled Person Act B.E. 2534 should be enforced by emphasizing public relations to general people or authorized persons for understanding clearly in detail and bring to practice in reality. For example, public facilities such as roads, pavement, and transportation, must not be overlooked, especially that new buildings are developed with ramps, wider doorways, flattened curbs, lower telephones and accessible restrooms and will be present everywhere. Also, the government should provide adequate budget for disability benefits such as medical assistance benefits and disabled pensions to cover all disabled people. In addition, disabled persons have to have access to all services and programs provided by the state or local government.

2) From the result of this study, it was found that the cause of injury of the group of persons who suffered paraplegia has changed from falling from a high place to vehicle accident on the road. The group of persons who suffered paraplegia has also changed from the poverty group to persons with a better economic status and education. This makes this group of people develop their own potential more than previous. Therefore the government should consider giving the society knowledge, and to change the attitude of people in the society towards the disabled. The society

should learn about the way disables live their life, and their attitude, without attaching to the same old social value that the disabled are a worthless, and dependent persons.

3) Government should assist the paraplegia people in term of legal matters, job training and occupation, and education as follow:

On legal matters, the Government should open an opportunity for capable disabled persons or rehabilitation professionals to act on behalf of individuals with disability to participate in political committees. This way may help persons with disability have access to government funds which helps to improve their economically and socially in daily living. The Government should also establish a legal service office for protecting disabled rights. This services will help disabled persons when they need help about claiming disabled benefits or other problems concerning their rights.

With job training and occupation, the Government should not locate a vocational training center outside the city center, separate or in an isolated area from the community. The center situated in a community gave a sense of regularity or normalcy and does not convey a negative image or the notion of difference. Moreover, the rules of a vocational training center or company should be flexible to adapt for helping disabled persons' work. For example, more flexible working hours, short training courses, home-based working, and fragmented workforce.

The Government should also employ the paraplegia persons in the governmental organizations and units especially in hospital. Those people could work in the job in or related to administration office, accounting, computer, and message delivery. This would help the paraplegia persons realize the value of their lives. It would also make them to be a role model for new disables as well as giving hope for a better life for the paraplegia patient group in the hospital that they are hired.

On education, the Government should support formal education as well as vocational training. All persons with paraplegia need not only vocational training like repairing electronic instruments or motorcycle repair. Some disabled persons who have intellectual capacity and are still young while injured, should be supported to continue their study.

Recommendations for Further Research

Based on the findings of this study, further research should aim to refine or test the process of coping in the persons with paraplegia. In order to increase its explanatory power, it was suggested that grounded theory studies should be taken with the persons with paraplegia in different contexts, such as those who live in a home for the disabled (some belonging to the Government and some to NGOs), those living in vocational training centers, and those who have been athletes.

To expand knowledge about coping with paraplegia, the next research should explore a different gender, because of the possibility that men and women cope with paraplegia differently and may require different nursing interventions to support their management.

One consequence in coping with paraplegia was psychological well-being. Thus, the researcher also needs to know more about enhancing factors that contribute to their ability to generate and sustain positive psychological states in stressful contexts. It will help the rehabilitation professional better understand how people get through extraordinarily difficult times and provide appropriate program help the clients preparing to re-enter their community.

For the impact of self-alteration on family members, longitudinal studies might explore how family members are affected by disabled family members, how they perceive changes from disability and how they manage their situation.

Action research should be done in the group of paraplegia persons who have shown abilities in adjusting themselves in term of physical, mental, and working, as well as appear to have a high achievement in the society. The situation analysis might be done to observe whether this group is prepared or is able to adjust themselves. This action research should be conducted in order to energize them as well as increase their inner power by modifying the group process which support them get to gather as a group. This group would help the paraplegia persons to be able to call for their rights in society.

Lesson Learned

The lesson learned from this study is a new experienced for the researcher. It made the researcher change concept and attitude. It might be considered as cognitive growth which will help to provide the next nursing intervention for SCI patients with more understanding than before. The change of concept or attitude occurred into two issues: first, professional issue, this study allowed the researcher to know an answers which accustomed to be a question before. The process of study helped to understand their barriers from physical function, circumstance and the feeling to society around them. The understanding occurred from seeing they slept in daytime because of injury and neurogenic pain which was difficult to effective treatment rather than lazy or depressed behavior. The way of their management was more wider than thinking. It might not be knew if the study is just only measurement. The result of study engendered more understood the person with paraplegia. Besides emphasizing on physical preparing, nursing intervention in the future should cover all preparing to re-enter to society.

Second, individual issue, the process of study, especially, data analysis, provide the way to interpret, compare, gather, and link among the data which later emerge to be categories and the characteristic of categories. It was an ingenious analysis which helped the researcher looked around all data and did not use to do before. Therefore, with having a chance to learn to do, it made the researcher impressed on this way of thinking. Besides answering the research question, this study provided learning experiences which might be worth the effort with giving rise to change attitude and the way to think and see life widely.

Limitations of the Study

The limitations of this study are related to the researcher's skills. In qualitative research, the researcher is the instrument. The quality of the data collected and the subsequent conceptualization that emerge during data analysis are limited by the researcher's skills. Questions developed for the broad framework of the interviews were generated from the literature, pilot work, the theoretical limits identified by the researcher. Since the researcher has experience in nursing care of persons with paraplegia, it led the researcher to create the ideas and the points of interest in selecting questions. However, the researcher tried to be aware of this issue. Whether these theoretical suppositions were accurate and complete and whether questions generated for this study produced data that can be used to expand and refine existing knowledge, determines the trustworthiness of the findings.

Data generated from this study were collected from fourteen informants, who were residents in two areas of northern Thailand, Chiang Mai and Lamphun province. Results from this study reflect the coping process at one period of time. Thus, findings cannot be generalized beyond the informants in this study.

Conclusion

The goal of this study was to gain a deep understanding of the perception of changes after paraplegia and the process used by Thai men with paraplegia to manage everyday living. Symbolic interactionism underpinned the grounded theory methodology and the research process of this study. A theoretical model, grounded in the perceptions and action / interaction strategies of fourteen informants was developed to illustrate the conditions and factors influencing the basic social process of making the best of paraplegia. Several implications for practice, the disabled support system, and further research were derived from the findings of this study. Limitations of this study are related to the researcher's skill.