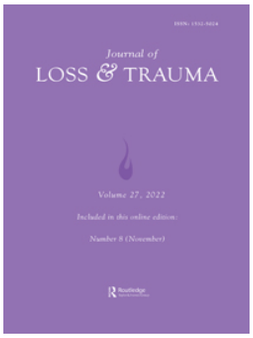

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The Ground Fell Away: An Autobiographical Study of Surviving a Fall From Height

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ABSTRACT

This paper explores the first author's experience of surviving a fall from height, as preparation for a small-scale phenomenological study with other fall survivors. In May 2018, I fell 20 ft (6.1m) from a mountain path and sustained multiple serious injuries. By exploring the experience using Interpretative Phenomenological Analysis, I was able to gain a deeper understanding of the trauma surrounding the fall itself, and reflect on the experience of sharing personal trauma verbally and in writing. Five superordinate themes were established from the data: "Through the medical machine"; "Identity"; "Support systems"; "Coping" and "Aftermath."

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Fall from height; iatrogenic trauma; interpretative phenomenological analysis; traumatic injury

Introduction

Wounded people tell their stories in order to "regain the voices that illness and its treatment often take away" (Frank, 2013, p. xii). Such storytelling is an act of resistance against events which interrupt the expected flow of life experience, moving the wounded toward integration of their injuries as part of the life narrative. Phenomenological research into the experience of falling from height seems to be entirely absent from academic literature. Survivor stories reside instead in the forums of trauma support organizations or charities such as the Spinal Injuries Association. Studies of falls from height focus on medical matters such as physical injury and mortality (Papadakis et al., 2020; Pascoletti et al., 2019) or address practical perspectives such as rescue strategies for emergency service personnel (McCurley, 2013), improvements to health and safety measures in the workplace (Chi et al., 2005; Ohdo et al., 2014) or in outdoor activities (Rugg et al., 2020). When searching for falls literature, I found only cold appraisal: calculations of fall trajectories and systematic analyses of injury patterns. As a survivor with an interest in scholarly examinations of falls from height, I could read

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that after motor vehicle accidents, falls are responsible for the most injury-related fatalities (Turgut et al., 2018). As a survivor of a 20-foot fall, I could read that I should not be alive to tell my story because "a combination of deceleration and impact injuries make survival unlikely when the height of fall exceeds 6.1 m (20 ft)" (Osifo et al., 2010, p. 544). I could not find accounts of survival, of personal growth, or any other meaningful examination of the experience itself. This paper is the first step in addressing the gap in qualitative explorations of the accidental fall experience and the physical, psychological, and social changes which affect those who have experienced this type of trauma. This study foregrounds the importance of hearing survivors' voices and is an opportunity to engage in written and verbal sense-making of the fall.

Methodology

The current paper is an autobiographical account of my fall experience analyzed as a reflexive starting point for a further phenomenological study with other fall survivors. Institutional ethical approval has been granted but at the time of writing, no data has yet been collected from other participants. Despite an increasing profile, autoethnographic or autobiographical studies are not yet universally accepted as a valuable methodological approach. However, as a tool for holistic sense-making and knowledge creation in the feminist tradition (Adams et al., 2015; McMillan & Ramirez, 2016; , autobiographical study is an ideal tool to explore the qualitatively unheard and unseen phenomenon of falling from height. When choosing to start with an autobiographical study, there was an appreciation of the potential for confirmation bias in the wider project, namely the possibility of inadvertently seeking to find themes from participant accounts that reflected my own experience. This informed the highly reflexive approach taken (Chang, 2021) and the use of individuals' written accounts as the sole basis for later interview questions.

Study design

Three qualitative written questions addressed three key aspects of the fall experience: an account of the accident itself; an account of the medical and other care received after the accident; a reflection on changes to health, perspective and lifestyle that occurred following the accident. My written responses to these questions were used by the interviewer (Che McGarvey-Gill) to devise a semi-structured interview schedule, and Interpretative Phenomenological Analysis (IPA) was used to analyze the responses. The current paper reflects only my analysis, with a second paper to follow from

the interviewer (McGarvey-Gill, in progress). IPA is a particularly apposite methodology to use when seeking to foreground personal meaning-making of idiosyncratic life-events (Smith et al., 2009). The written account and interview transcript were read and re-read, with notes on descriptive, conceptual, and linguistic elements made line-by-line. Notes were translated into themes and written on slips of paper which were physically moved around until the structure felt coherent. The theme structure was transferred to a master table of themes and passages of the account coded to each theme.

Results and discussion

Sharing the fall experience

On re-reading my written account, it seemed to be the detailed work of a completist. I took a hybrid medical and layman's tone when reporting the injuries, providing technical accuracy while ensuring a shared understanding of the reality of the harm caused:

> Endplate fractures of T8 and T11 vertebrae (the bit that pokes out the back snapped off), wedge compression fracture of L1 (vertebra was crushed and impinging on my spinal cord), six fractures of left ulna and radius, humerus surgical neck fracture (the ball bit at top of the arm bone near the shoulder was sheared all the way across diagonally).

Perhaps by listing my now invisible injuries, I felt I had validated myself as a survivor of something terrible. I may also have been conforming to the idea that the medical narrative is "The one against which other [accounts] are judged true or false, useful or not" (Frank, 2013, p. 5). Alongside factual elements, I observed aspects of storytelling such as scene-setting:

> It was a beautiful sunny day and we planned to walk up to Lingmoor Tarn. My husband had lost his mum to a stroke four weeks before and this was the first time we thought we could leave his dad. It felt good to get out in the mountains again and shake off the oppressive feeling we had for the last several weeks.

This highlighted the stark contrast between the idyllic setting and the contextual grief and loss, even before the accident destroyed the beauty of the day completely. It felt good to share my experience fully with someone, and as I sent the account to Che, I felt a degree of inquisitiveness: How would she react to my story? I had found the writing straightforward, but re-reading the account was difficult. I felt sorry for the person who had gone through the experience, as if it were not me. I was somewhat nervous before the interview, but Che put me at ease with her warmth and what felt like genuine interest in my experience. Part of me felt obliged to

present my professional self; a "coper" who solves problems. The personal self does not know whether, on a given day, I will find it upsetting to think about the accident. I was interested to discover what Che would ask, and someone else's perspective felt like a gift. She asked meaningful questions, but after the interview I was deflated. I felt we had not managed to get to the crux of the experience. I then realized that I did not know what the crux of the experience was, but that it was waiting to be found, if only I had the tools to find it.

Themes

I identified five superordinate themes regarding the fall: "Through the medical machine"; "Identity"; "Support systems"; "Coping"; "Aftermath." Key subthemes are illustrated with extensive use of quotes and a full list of subthemes is available on request.

Through the medical machine

This superordinate theme is notable in terms of frequency of reference and richness of detail. There were profoundly different experiences of care in the two hospitals where I was a patient. The first hospital was a spinal injury specialist center where I was placed in the major trauma ward. Dignity and choice were intrinsic to this caring and efficient environment, and independence was strongly encouraged:

> The second they saw I was able to do a bit for myself they started offering those choices and I said "I'll try and hold one of these cups with a straw and have a sip … ," and they were ready to catch it so I don't spill it all over myself. So it meant absolutely the world, it really did. The same with washing: Did I want to try to wash my top half? Is it okay if we wash round your catheter?

The person-centred approach to offering choice prevented a sense of dehumanization: "That made the difference between me feeling just like a lump of meat, basically, and a person. I just felt safe, totally safe." There was one negative aspect of the first hospital experience; a surgeon's lack of empathy for how traumatizing the injuries were:

> He seemed almost delighted and fascinated by how "interesting" my arm was. He called it a "swan-neck" fracture or a "dinner fork" fracture because of the weird shape it had gone into and asked me if I wanted to look at it, which I declined.

This seeming callousness was offset by other theater staff, who provided comfort by asking who my favorite band was so I could listen to their music throughout the operation. There was a powerful sense in both the written and verbal accounts that the experience of enduring substandard

and even actively harmful treatment in the second (local) hospital was worse than the accident itself, encapsulated in the subtheme "Iatrogenic trauma." This term, introduced to the social sciences by Ivan Illich in 1976, has been defined as the (largely unintentional) harm caused as a result of receiving medical treatment (Milligan, 2003). Unintentional does not mean unavoidable, and acts of harm by omission can be just as damaging as direct acts. Accounts of dismissive, detached or entirely absent healthcare professionals bring the reality of this harm to life. The first quote is from the night I arrived at the local hospital:

> There's this older woman with two broken legs trying to get out of bed as she's got some kind of post-operative disorientation. It was me and this other woman with a broken back who were desperately trying - like hostage negotiation – to talk her down, because we just kept pressing and pressing our buttons. Nobody ever came.
>
> A lady with learning disabilities needed help to use the toilet but they never came quick enough. Every time she soiled herself and they shamed her for it. It was so barbaric.

There was a clear sense that staff inattention and carelessness with medical equipment had the potential to cause permanent physical harm:

> The [health care assistant] took my back brace apart and put it on me with the back piece upside down. I asked her to put it right, but she acted as if I was being fussy, not the actuality of me being terrified that if my spine wasn't supported, it would collapse further.
>
> A couple of days later the other lady with the broken back was left to get in a wheelchair alone and she fell, because they had not put the brakes on. My husband and friend had to help her up because a nurse walked past the ward door looking but not helping.

The initial feeling of unsafety grew as time went on:

> When you feel unsafe, it's like anything can happen, and there isn't a clear way out of it. I knew on some level eventually I'll get to go home, but in what state, considering that woman was, like, just left on the floor? You know, they could have paralysed me.

The account of the second hospital contained another rich theme surrounding "Loss of control":

> My mind was the only thing I had going for me. You know, sort of minute to minute. I couldn't physically do anything and had no control. I was just in this machine of the hospital.
>
> What made it even more terrifying, being in a place where there was nobody there to help you or wanting to help you, was after I'd gone from [first hospital] which was super-efficient and they involved you completely in your care, to having none of that. It was such a horrible shock.

The first, devastatingly instant loss of control that epitomizes falling from height was reeexperienced in slow motion in the further losses cascading from it, such as the loss of bodily autonomy and function. Themes of abandonment and neglect were also significant:

> They slid me onto the bed and I was left there naked, covered with a sheet. I could not urinate, was left flat on the bed with bright lights shining in my face for nine hours without painkillers.

Given the importance of self-reliance to my identity, it is clear why I felt the iatrogenic trauma was worse than the accident itself; to have to plead for the minimum standard of care severely damaged my sense of self. Most frustrating was that the loss of control was not due to the prohibitive nature of the injuries. In the first hospital I had been able to hold a drink, use one arm to clean parts of my body and, with support, put on a back brace and walk several steps. It was only later that control was taken away, leading to a state of fear and the theme "Escape":

> I realized I was totally unsafe there, could not trust them to take care of me at all and had to get out of there as soon as humanly possible. So that's why I said "What do I need to do? Tell me *exactly* what I need to do to be deemed ready to go home" and that's what I worked toward.

This exemplifies a problem-solving approach to recovery; finding out the practical steps required (being able to put on the back brace independently and walk up and down a flight of stairs) and doggedly pursuing those goals. It was the fear of being further harmed that drove my desire to be discharged rather than my level of recovery, but the *appearance* of recovery using the two physical measures given could be achieved by a force of will. The image of home took on a talismanic quality, where safety and wholeness could be regained.

Identity

The fall account offers an intriguing insight into an experience of depersonalization caused by being given Ketamine, which took place when medical help first arrived on the mountain. This relates to identity in the sense that it involves feeling a loss of humanity:

> I felt myself losing the sense of being a living human being. I had a vague, wispy sense of being a person, but I was floating in a void of black and white chevrons. This became a tube of chevrons that I was rushing down; formless, not human, just a speck of something. I could just about perceive I was still a human and knew it was crucial to hold onto this thought, like mentally holding the tail of a kite as it rushes upwards into the sky. I felt that if I did not remember being a human I would never get out of the situation. I forced myself to open my eyes and it was to a beautiful blue sky with white clouds.

Here again is the stark contrast, this time between the beautiful blue sky and a hellish monochrome internal landscape. My reaction to Ketamine was one of the worst parts of the accident experience, possibly as it involves the ultimate loss of control; an almost complete loss of awareness of self. Particularly in the verbal account of the accident, the subtheme "Self-reliance and Independence" were paramount to my identity: "I don't like to have to be looked after, you know? I take care of myself and I've never really been dependent on anyone else." This explains the horror of dependence which occurred as a result of sustaining serious injuries: "To not be able to do anything for yourself is just horrendous and … I've never had that before." The physical helplessness drew out a high degree of fear as I was now "at the mercy of other people around me." This was much more prominent in my account than any consideration of pain or the trauma of the accident itself. A decision to mask my feelings, avoid talking about the accident with family members, and minimize the level of informal support required after discharge from hospital was partly to avoid being seen as dependent, but was also an attempt to alleviate pressure on others:

> I was just trying to get well, or at least to be able to do enough and have the appearance of being well enough so [my husband] didn't have to worry about it as much, and could concentrate on other things, like taking care of his dad.

Of interest is the word "appearance": Whether suffering or not, *seeming* to be well was crucial. The contextual trauma explained elsewhere may explain why, despite my own needs, I wanted to recover self-efficacy as quickly as possible. This theme is called "Other-focus" and it appears again when explaining why I made a joke ("Thanks for doing this, I just could *not* be arsed to walk back down") to the mountain rescue personnel before boarding the air ambulance:

> I know how horrible it must be for them to have to deal with people who are really badly injured … they're going to [see] really horrendous stuff, where people have already died in falls, or bad injuries and distress and stuff like that. So there was part of me which was like … I wanted them to feel okay.

These themes illustrate that crucial to an intact sense of self is the avoidance of pity and dependence, both to preserve self-esteem and to minimize the impact of my trauma on others.

Support systems

This superordinate theme illustrates problems which can occur with formal aftercare:

> They said an occupational therapist would come to the house and make sure I've got everything, and it just never happened. I didn't bother following it up. They can't

> bloody care for you when you're in there. They're not going to bother with you when you get out, are they?

My injuries also made it impossible to access specialist psychological trauma support:

> There was something offered that I couldn't access because, well, I had a broken back! In [first hospital] they offer you a specialist trauma person to speak to [after discharge]. I said yes but would have had to travel from home to [town sixty miles away]. That was pre-Covid: they wouldn't have thought 'we can do this over Teams or Zoom'.

It seems obvious that people with extensive physical trauma cannot be expected to travel to access psychological support. Given the surge in the use of online meeting platforms post-Covid, including for psychological intervention, perhaps this support can now be offered differently.

Another aspect of this subtheme was the potential role of peer support from others who have experienced a fall from height: "I do feel like reaching out for other people who have gone through the same thing. We might be completely different. Our experiences, our recoveries, you know? But that one thing connects us." "Not feeling alone in it. Feeling like, of everybody in the world, you get what I'm talking about." The therapeutic effects of meaning-making through commonality of trauma experience is not just the purview of formal therapy groups (Herman, 2015) but has also been found to be a benefit of participating in or co-producing phenomenological trauma research (McMillan & Ramirez, 2016; Whalen & Simmons, 2022). As the experience of surviving a significant fall from height is not addressed in academic research, the exploration of lived experience in the current study provides an opportunity for survivor voices to be amplified. Survival stories offer a connection to others who have fallen from height, and to the wider world of accident survivors.

Coping

As described previously, humor was used immediately after the fall as a way of avoiding pity and reassuring others. Humor was also used to leaven a potentially anxious moment when first venturing out of the house:

> There were a load of kids roughhousing around, and I went whoa, whoa, careful! Like kids do, [they said] "What's up with you? Have you broken your back?" And I said "yeah, that's right." They're like "Oh my God!" and I said, "do you wanna see a really cool scar?" and held my arm up, and they're like "Urghhh!" [laughs]. They were enjoying it, you know? In a gross out kind of way. And I remember that's the first time I felt a little bit comfortable being out, weirdly, because I was able to sort of [laughs] gross out these kids.

Communicating with people about the injuries for the first time through humor helped me to take control of the narrative of my accident and

navigate fears about being out in public. The main component of coping ability was defined in the theme "mental resources," where personal reserves of strength were used to psychologically survive the second hospital experience:

> It was just hell. I can't describe it in any other way. I thought I was gonna go mad, I honestly did that first night. I had to find a safe space [in my head] where as long as I kept my *self* – which I visualized as a gold glowing object - then I would make it.

This retreat into the mind and the visualization formed part of a defensive strategy to minimize the impact of the lack of medical care and being surrounded by the trauma of others. The importance of self-reliance in order to cope was very prominent in my account:

> Although it was good to have visitors, it was my relationship with myself that really enabled me to cope. Everything else can be stripped away: body or bodily function, familiar people and places, control over events and my "self" still remains. I have a refuge in my mind.

There were benefits to personal growth in having to access these mental reserves:

> I'm glad in a way that I had to do that, because like I say, it's *possible*. It's like you find little bits inside you that are a bit dusty, which you didn't really know were there, like a bit of an old office with filing cabinets in. And there's good stuff in there. You just gotta root it out.

The idea of finding reserves of strength in the mind during times of crisis is a common theme in recovery research (Lepore & Revenson, 2014; Harms & Talbot, 2007) and links to elements of post–traumatic growth explored in the final super-ordinate theme, "Aftermath."

Aftermath

"Aftermath" includes the difficult experience of remembering the fall, the physical and psychological sequelae of the accident, and changes to lifestyle and worldview which have occurred as a result. The core memory of the fall itself is as follows:

> The ground fell away and I tried to stop myself but could not. I remember shouting "no" and then kept falling, hitting a rocky outcrop about six feet down. I felt/heard bones in my arm and back break. I then somersaulted and fell another 12-15ft and hit the ground, sliding for a bit. I remember seeing my very badly smashed left arm still trying to grab at something to stop my fall. I did not know if there was another drop. It was totally useless, and I remember feeling sorry for my poor arm. I vividly remember thinking "please god, let that be it" as I knew if I fell any further, I would probably die.

The sense of dissociation from my arm could have been a psychologically protective measure, an attempt to separate my core self from the injury.

Dissociation from the arm recurred after the surgery: "When they finished [operating] I cried because I could not feel my arm and it did not feel like it belonged to me. They had put in a plate and several screws to hold the pieces together." There is a sense of the damaged part of the body being alien, and an unwillingness to accept the limb as part of myself. The written description of the accident introduced the concept of mortality, which linked to a new "survivor identity" some time after the accident:

> I said, "Oh, I survived a … .[fall]" and that's when it really, really hit me: That's what happened. I didn't just have an accident. Something happened where I could as easily have died as not, and that changes who you are, I think. It changed me, definitely. That's part of my identity now, just the same as every other thing that could be an identifier of someone.

While pain does not feature regularly in my account, there are some references to "agony" in the days and weeks after the accident, and the need to cope "moment to moment" in order to deal with it: "I don't know if you've ever been in that kind of pain where you just wish- you don't wish you were dead, you just wish you were unconscious so you couldn't feel it." There was also palpable fear about my physical condition worsening: "For the first few weeks of my recovery I was terrified every time I woke up about whether or not I could still move my legs." The seriousness of the injuries led to later physical consequences and changes to lifestyle:

> I have a lot of pain in my back and legs due to the nerve damage. I can't sit down for very long, and I cannot swim any more as my legs go dead. I am not allowed to run, jump, or otherwise exert any impact on my feet in case it collapses the vertebrae. For this reason, I am very scared of falling onto my backside, for example slipping on ice, and I tend not to go out if it is icy.

Traumatic stress symptoms (APA, 2013) were evident in reexperiencing parts of the accident, such as intrusive sounds and sensations of bones breaking, initially without any obvious triggers. After Eye Movement Desensitization Reprocessing (EMDR) treatment, reexperiencing only tended to occur mainly as a result of verbal or visual triggers, including walking on a path with a drop to the left: "Even when it's a small drop, even when it's like, a metre, it still goes through my head you know, I really don't want to drop off the edge of this." "I struggle to watch [things] now involving dangling from height. It makes me feel very anxious. I feel squeamish when people use expressions like 'fall off a cliff' or 'we broke the back of it'." Due to the relative rarity of falls from height, I realized that people could not be expected to know that they might trigger post-traumatic symptoms in survivors:

> If you're doing a lecture on suicide or on child abuse you know that this might affect [people]: "we need to be a bit careful about this." But the weird thing about

> having a trauma like a big fall is that it's so unusual, naturally it wouldn't feature in peoples' consciousness.

This formed part of the "Hidden trauma" subtheme, which exists in many different forms:

> It makes me think what's going on behind the surface for anybody I might meet. Anything I say or do might have an impact on them as I've got no way of knowing, and you can't walk on eggshells because you don't know what you're trying to tread around.

There is a wistfulness in my account as I struggle with the fact that my trauma is hidden: "It's like I almost want a little badge [laughs] which says 'This is what happened to me'. But we haven't got them, have we? It's all inside." This links back to the fear I experienced of people not being aware of my vulnerability when starting to remove the back brace for short periods:

> I was scared, and I remember thinking the first time I had to go out in public without it; 'I'm still hurt. People won't know I'm still hurt'. I'm hurt inside, as in inside my body where you can't see it, but also in here [points to head].

Frustration with the invisibility of trauma is a common component of the experiences of individuals who have survived other types of accidents (Harms, 2004). References to lifestyle changes, psychological consequences and the ongoing physical effects of the accident are balanced in my account by positive reflections, such as an increased sense of confidence in the mind's resilience. A source of significant pride was my focus on positive things to aid recovery, such as proceeding with my PhD transfer viva despite this being scheduled for around two weeks after leaving hospital: "The thought of not doing it never entered my head. It never entered my head not to do it. I was prepared to fight to do it." With the body broken, positively contributing using the still-capable mind was critical to recovery. When discussing how the viva went, humor was used to leaven the challenge of the process itself, which involved speaking over the telephone while wedged into a chair wearing a body and arm cast:

> I was proud because the [referee] said it's the best one he's ever done! [laughs] And I joke about that and say 'well there you go, that's the advice for doctoral students: liquid Morphine works like a charm!' [laughs]. It really, like, loosens up your thinking!

As well as the strengths-based approach to recovery, there was a general sense of gratitude in my account, where I reflected on how much worse the accident could have been:

> I feel grateful my injuries were not more severe: had I fallen a foot in either direction I would have smashed my head on rocks instead of landing on grass.

> Further along the path, it would have been unsurvivable as the drop was much greater. I was lucky not to be paralyzed as it is.

This sense of perspective is found elsewhere in IPA literature on near-fatal accidents, such as a participant in Wang et al. (2012) who in response to being called "brave" for dealing with his pain and injuries, said he had "stepped on the threshold of hell, and I realized that everything, compared to the marvels of life, could fade." Common to studies on post-traumatic growth (Kampman et al., 2015; Tedeschi & Calhoun, 2004) there was also reference in my account of the "small things"; not worrying about petty problems and being grateful for the beautiful things in life. Changes to relationships were also a significant part of the positive "aftermath" of the accident:

> My relationship with my husband is stronger, mainly because both of us went through utter hell at the same time, and just kept each other going. Going through something like that together is a make-or-break sort of thing really. Happily, we went the right way.

> Historically, my mum and dad - they never said I love you to me and I never said I love you to them. But since the accident we have started doing that. I initiated it at the end of phone calls, because I do love them and one of us has got to actually say the words.

The general importance of openness about feelings, whether positive or negative, also formed part of the post-trauma after-effects:

> I could have died. So, you need to just say what you feel, don't you? And for better or worse, you know? So, not having to tolerate crap from people because life is too short, and not forgetting to tell people how you feel about them because life is too short.

This epitomizes a significantly changed worldview, where opportunities for honesty should not be missed and time should not be wasted on the more negative aspects of life.

Conclusion

The process of analyzing my accident has allowed me to make sense of the trauma in new ways, such as the link between my sense of self and how I coped throughout the experience. Herman (2015, p. 195) claims that when the action of telling the trauma story is over, "The traumatic experience truly belongs in the past," but that each new stage of life can reawaken the trauma. By sharing the story of the fall and its consequences for the first time, these awakenings can be dealt with from a place of greater understanding and with a focus on learning rather than loss. Learning to take forward to the wider phenomenological falls study is that participants may have never written about their accident, and the process of writing, of re-

reading the account, and speaking about their experience will produce different emotional responses depending on their level of comfort in recalling the event. The length of time that has passed and the effect the accident has on their current lives are key factors in this regard, and the interview approach and debrief support must reflect this. As with all semi-structured interviews, rapport-building and ordering questions sensitively are essential. The "insider status" held by the researcher should help participants feel open to sharing their experience, and most importantly to experience a sense of true empathy (Wilkinson & Kitzinger, 2013).

Drawing together the themes from my account of the accident, it is apparent that personal identity and character traits play an important role in how individuals cope with the trauma of falling from height and the subsequent recovery journey. A strong sense of independence and self-reliance can both help and hinder, making any loss of control and physical dependence less bearable, while potentially providing the mental resources needed to strive for physical and psychological recovery. The account also evidences that assumptions cannot be made about which parts of a traumatic accident the survivor will find most challenging; physical injury and pain is not necessarily the worst aspect of the experience. Iatrogenic trauma (Illich, 2003) was the most significant harmful consequence of my accident, despite the severity of the injuries. My account can therefore help healthcare practitioners to understand the transformative effect of person-centred care in aiding physical and psychological recovery from traumatic accidents. Findings about hidden trauma are useful for trauma-informed practitioners from all disciplines, in order to continually develop an understanding of the diversity of trauma experiences that people live with.

Notes on contributors

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