The Fear of Living as A Cripple: A Study of Spinal Cord Injured Patients at the National Orthopaedic Hospital, Dala, Kano, Nigeria

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ABSTRACT

Background: Spinal cord injury (SCI) transforms lives in an instant, replacing autonomy with dependence, mobility with immobility, and hope with fear. Beyond the measurable clinical outcomes of mortality and neurological recovery lies a deeper, more pervasive reality: the existential terror of living as a cripple in a society ill-equipped to accommodate disability. This study explores the fears, anxieties, and psychological burdens of spinal cord injury survivors at the National Orthopaedic Hospital (NOH), Dala, Kano, Nigeria.

Methods: A mixed-methods study was conducted on 108 patients with traumatic spinal cord injury managed at NOH, Dala between 1st January 2018 and 31st December 2024, comprising 78 males (72.2%) and 30 females (27.8%). Data were collected through structured questionnaires assessing psychological impact and in-depth interviews exploring patients' fears regarding their future. The Hospital Anxiety and Depression Scale (HADS) was administered to quantify psychological morbidity. Qualitative data were analysed thematically.

Results: Mean age was 41.2 ± 13.8 years. Road traffic accidents accounted for 51.9% (56/108) of injuries, followed by falls (34.3%, 37/108). Cervical spine involvement occurred in 57.4% (62/108), with complete neurological injury (AIS A) in 61.1% (66/108). Clinically significant anxiety (HADS-A ≥8) was present in 68.5% (74/108), and clinically significant depression (HADS-D ≥8) in 72.2% (78/108). Qualitative analysis revealed five dominant fears: (1) fear of becoming a perpetual burden to family (81.5%); (2) fear of social rejection and stigma (75.9%); (3) fear of inability to marry or maintain marital relationships (68.5%); (4) fear of financial destitution (79.6%); and (5) fear of death from complications (63.0%). Women expressed significantly greater fear of marital abandonment (p=0.003), while men feared loss of provider role (p=0.001). Only 12.0% had received any form of psychological counselling.

Conclusion: The fear of living as a cripple among SCI patients at NOH, Dala is profound and multidimensional, encompassing family burden, social rejection, marital instability, financial ruin, and premature death. Psychological morbidity is nearly universal yet almost entirely unaddressed. These findings demand urgent integration of mental health services into SCI care and the development of culturally appropriate rehabilitation programmes that address not only physical recovery but the existential fears that define the lived experience of paralysis.

Keywords: Spinal cord injury, fear, psychological impact, depression, anxiety, stigma, Nigeria

INTRODUCTION

Spinal cord injury (SCI) is among the most devastating events that can befall a human being. In an instant, the injury transforms a walking, working, loving individual into a person confined to a wheelchair or bed, dependent on others for the most basic activities of daily living [1]. The clinical literature has exhaustively documented the epidemiology, surgical management, and physical outcomes of SCI [2,3,4]. Yet beneath these objective measures lies a subjective reality far more complex: the lived experience of the person whose world has been irrevocably altered.

In Nigeria, the burden of SCI is substantial, with road traffic accidents and falls from heights accounting for the majority of injuries [5,6]. Studies from Jos, Enugu, and Ibadan have documented the demographic patterns and clinical outcomes [7,8,9]. The psychosocial impact, however, remains underexplored. A recent study from NOH, Dala by Haddad et al. found that 66.7% of SCI survivors develop emotional problems including depression and anxiety, and 76.7% experience bouts of sadness [10]. Kwah and Abdullahi documented that 95% of SCI patients in Kano use religion as their primary coping mechanism, highlighting both resilience and the absence of professional psychological support [11].

The fear of living as a cripple encompasses multiple dimensions. There is the fear of physical dependency—of requiring assistance to eat, to bathe, to use the toilet. There is the fear of social rejection—of being stared at, pitied, or abandoned by friends and community. There is the fear of economic ruin—of being unable to work and provide for one's family. There is the fear of marital dissolution—of being left by a spouse unable to bear the burden of care. And there is the fear of death itself—from pressure ulcers, sepsis, or respiratory failure, complications that stalk the paralysed patient with relentless determination [12,13].

These fears are not abstract anxieties; they are grounded in the harsh realities of Nigerian society. Disability is often stigmatised, viewed as a curse or punishment [14]. Accessibility is virtually non-existent—public buildings, transportation, and even hospital facilities are rarely wheelchair-friendly. Family resources are stretched thin by the costs of care, and the social safety net is virtually absent [15].

This study aims to explore the fears, anxieties, and psychological burdens of spinal cord injury survivors at NOH, Dala, Kano, giving voice to the unspoken terror that accompanies paralysis and quantifying the psychological morbidity that remains hidden beneath clinical outcome statistics.

METHODOLOGY

This was a mixed-methods cross-sectional study conducted at the National Orthopaedic Hospital, Dala, Kano, Nigeria, between January and December 2025. NOH, Dala is a 260-bed federal tertiary institution serving as a major referral centre for spinal cord injury across northern Nigeria [16].

From a total of 538 patients with traumatic spinal cord injury managed between 1st January 2018 and 31st December 2024, 108 patients (78 males, 30 females) were purposively selected to participate in this psychosocial study, ensuring representation across age groups, injury levels, and time since injury.

Inclusion criteria were: (1) age ≥18 years; (2) confirmed traumatic spinal cord injury (ASIA Impairment Scale A–D); (3) minimum six months post-injury; (4) ability to provide informed consent. Exclusion criteria were: (1) significant cognitive impairment affecting ability to participate; (2) severe concurrent medical illness; (3) refusal to participate.

The Hospital Anxiety and Depression Scale (HADS) was administered to all participants. HADS is a 14-item scale (7 for anxiety, 7 for depression) validated for use in hospital settings and free from contamination by physical symptoms that might confound assessment in medically ill populations [17]. Scores ≥8 on each subscale indicate clinically significant anxiety or depression.

Demographic and clinical data collected included age, sex, mechanism of injury, level of injury, ASIA grade, time since injury, employment status, and marital status. Semi-structured in-depth interviews were conducted with 40 purposively selected participants (28 males, 12 females) to explore their fears and concerns about living with spinal cord injury. Interviews were conducted in Hausa by trained interviewers, audio-recorded, transcribed verbatim, and translated into English. Interviews continued until thematic saturation was achieved.

The interview guide explored: (1) immediate fears at the time of injury; (2) current fears about daily life; (3) fears about the future; (4) fears regarding family, marriage, and social relationships; (5) fears about economic survival; (6) fears about death and complications; (7) coping mechanisms and sources of support.

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Quantitative data were entered into SPSS Version 25.0. Descriptive statistics (frequencies, percentages, means, standard deviations) were calculated. Comparisons between groups used chi-square tests and independent t-tests.

Qualitative data were analysed using thematic analysis following Braun and Clarke's framework [18]. Two researchers independently coded transcripts, identified themes, and refined them through iterative discussion. Ethical approval was obtained and written informed consent was obtained from all participants. Confidentiality was maintained through anonymisation of all data.

RESULTS

Table 1 presents demographic and clinical characteristics of the 108 participants. Mean age was 41.2 ± 13.8 years. Males predominated (72.2%). Road traffic accidents were the leading cause (51.9%), and cervical spine injuries were most common (57.4%). Complete neurological injury (AIS A) was present in 61.1%.

Table 2 presents HADS scores and prevalence of clinically significant anxiety and depression. Clinically significant anxiety was present in 68.5% of participants, and clinically significant depression in 72.2%. Only 12.0% (13/108) had received any form of psychological counselling since their injury. Table 3 presents the prevalence of fears identified through the interview process.

Five dominant themes emerged from the qualitative analysis.

Theme 1: The Burden of Dependency. The fear of becoming a perpetual burden to family was the most frequently expressed concern, voiced by 81.5% of participants.

"Every time my mother lifts me to bathe me, I see the strain on her face. She is 62 years old. She should be resting, not carrying her grown son like a baby. I have become the child she never expected to raise again. Some nights I pray that Allah takes me so that she can have peace." (38-year-old male, C5 complete tetraplegia, 14 months post-injury)

"My wife now does everything—feeds me, cleans me, turns me in bed. She never complains, but I see the exhaustion in her eyes. She was my partner; now she is my nurse. That is not what she signed for when she married me." (45-year-old male, T4 paraplegia, 3 years post-injury)

Theme 2: The Sting of Stigma. Social rejection and stigma were feared by 75.9% of participants, with many describing actual experiences of abandonment.

"My friends stopped visiting after the first month. When I see them in the neighbourhood, they wave from a distance but never come close. It is as if paralysis is contagious. They do not know what to say, so they say nothing at all." (29-year-old male, L1 paraplegia, 2 years post-injury)

"At the market, people stare. Children point and whisper. Some adults look away quickly as if they have seen something shameful. I used to be a respected man in my community. Now I am just 'the cripple'." (52-year-old male, T10 paraplegia, 4 years post-injury)

Theme 3: The Ruin of Relationships. Marital fears were particularly acute, with significant gender differences. Women expressed greater fear of abandonment, while men feared inability to fulfil the provider role.

"My husband has not touched me since the accident. He sleeps in a different room. He says he is afraid of hurting me, but I know the truth—he no longer sees me as a woman. I am just a body he must care for out of duty. I am waiting for the day he brings another wife." (34-year-old female, T6 paraplegia, 18 months post-injury)

"I was supposed to marry next year. The bride price was paid, the date was set. Now her family says they cannot allow their daughter to marry a cripple. What woman would want a man who cannot work, cannot provide, cannot even stand beside her at the wedding?" (27-year-old male, C6 tetraplegia, 10 months post-injury)

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Theme 4: The Poverty of Paralysis. Financial destitution was feared by 79.6% of participants, with many already experiencing severe economic hardship.

"I was a farmer. I supported my parents, my wife, and four children. Now I cannot work. My brothers try to help, but they have their own families. We have sold our goats, then our land, now we are borrowing. When the money finishes, what will happen to us?" (42-year-old male, T12 paraplegia, 2 years post-injury)

"The hospital costs have exhausted everything. We spent our savings, borrowed from everyone we know. I have three children who need school fees, but the money goes to dressings and medicines. I lie awake at night wondering if my children will eat tomorrow." (36-year-old female, L4 paraplegia, 8 months post-injury)

Theme 5: The Shadow of Death. The fear of death from complications—pressure ulcers, infections, respiratory failure—was expressed by 63.0% of participants, often with vivid awareness of others who had died.

"I have seen three men in this ward die from bedsores. Good men, strong men. Their wounds got infected, then sepsis, then they were gone. I look at my own pressure sore every day and wonder: will this be the one that kills me?" (48-year-old male, C7 tetraplegia, 3 years post-injury)

"The doctor told me that people with my injury often die from pneumonia. Every time I cough, I panic. Every fever terrifies me. I am not living; I am waiting to die." (33-year-old male, C5 tetraplegia, 6 months post-injury)

Table 4 presents significant gender differences in fear expression.

DISCUSSION

This study illuminates the profound psychological burden borne by spinal cord injury patients at NOH, Dala, revealing that the fear of living as a cripple is as debilitating as the physical paralysis itself. With 68.5% experiencing clinically significant anxiety and 72.2% clinically significant depression, the psychological morbidity in this population is nearly universal, yet almost entirely unaddressed.

The fears expressed by participants encompass every domain of human existence: physical dependency, social identity, intimate relationships, economic survival, and mortality itself. This multidimensionality reflects the totality of disruption that SCI causes—not merely to mobility but to every aspect of personhood [19].

The predominance of fear of becoming a burden to family (81.5%) speaks to the centrality of family in Nigerian society. In a culture where interdependence is valued and family obligations are deeply internalised, the transition from contributor to dependent represents a profound identity rupture [20]. This finding aligns with the Haddad et al. study at NOH, Dala, where 60% of patients reported interference with family roles [10].

The fear of financial destitution (79.6%) reflects the economic reality of life with disability in a country with minimal social safety nets. Most participants were breadwinners before injury; after injury, they become economic liabilities. The East African study by Ikwuegbuenyi et al. found that 21.2% of discharged SCI patients had died post-discharge, often from preventable complications exacerbated by poverty [21].

The striking gender differences in fear expression reveal how SCI interacts with culturally prescribed gender roles. Men's near-universal fear of losing the provider role (92.3%) reflects the traditional expectation that men should support their families financially. Women's greater fear of marital abandonment (86.7%) reflects the vulnerability of women's status in marriage, particularly when they cannot fulfil domestic and conjugal roles.

These findings are consistent with the coping strategies study by Kwah and Abdullahi, which found that 95% of SCI patients in Kano use religion as their primary coping mechanism [11]. For men unable to provide, prayer may be the only resource remaining. For women facing potential abandonment, faith in divine protection may be the sole anchor.

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Perhaps the most disturbing finding is that only 12.0% of patients had received any psychological counselling. This silence of suffering represents a profound failure of holistic care. The Jos study by Alfin et al. documented clinical outcomes but did not address psychological needs [7]. The Southeast Nigeria study focused on epidemiology [8]. The Ibadan rural study highlighted surgical delays but not psychological sequelae [9].

This neglect persists despite clear evidence that psychological morbidity affects physical outcomes. Depression is associated with poorer wound healing, increased infection risk, and higher mortality in SCI patients [22]. Anxiety impairs rehabilitation engagement and functional recovery [23].

The fear of social rejection (75.9%) must be understood within the Nigerian cultural context where disability is often stigmatised and attributed to supernatural causes [14]. Participants' descriptions of being avoided, stared at, and treated as objects of pity or fear reflect deep-seated societal attitudes that compound the physical burden of paralysis with social exile.

The Islamic tradition, which is dominant in northern Nigeria, emphasises compassion toward the disabled and teaches that disability is a test, not a punishment [24]. Yet cultural practice often diverges from religious teaching, leaving patients caught between theological promise of dignity and social reality of marginalisation.

The fear of death from complications (63.0%) is not irrational. Pressure ulcers, urinary tract infections, and respiratory complications are leading causes of mortality in SCI patients, particularly in resource-limited settings [25]. The Jos study reported 24.7% mortality at six weeks [7]. The East African study found that of 212 patients contacted post-discharge, 21.2% had died, with pressure ulcers and sepsis as leading causes [21].

Participants who had witnessed ward mates die from these complications carried the traumatic memory with them, their fear grounded in reality.

These findings demand urgent action:

1. Integrated mental health services: Every SCI patient should receive psychological assessment and support as part of routine care. The near-total absence of counselling services at NOH, Dala must be addressed.

2. Peer support programmes: Connecting newly injured patients with long-term survivors who have adapted to disability could reduce fear and provide practical guidance.

3. Family counselling: Given the centrality of family in patients' fears, involving family members in psychological support and education is essential.

4. Vocational rehabilitation: Addressing economic fears requires programmes to retrain patients for alternative occupations compatible with disability.

5. Community education: Public health campaigns to reduce stigma and promote inclusion of persons with disability could address the fear of social rejection.

6. Spiritual support: Given the high reliance on religious coping [11], integrating spiritual care professionals into the rehabilitation team would honour patients' existing coping resources.

This study has several limitations. First, single-centre design limits generalisability. Second, the relatively small sample for qualitative interviews (40) may not capture the full range of experiences. Third, the cross-sectional design cannot track changes in fears over time. Fourth, social desirability bias may have led some participants to minimise certain fears. Fifth, the study did not include family members' perspectives, which would enrich understanding.

Longitudinal studies tracking psychological morbidity over time are needed. Interventional research evaluating counselling, peer support, and vocational rehabilitation programmes would identify effective strategies. Studies exploring family caregivers' fears and burdens would complement patient perspectives. Community-based research on stigma and inclusion could inform public health interventions.

This study of 108 spinal cord injury patients at NOH, Dala, Kano reveals that the fear of living as a cripple is profound, pervasive, and multidimensional. Clinically significant anxiety affects 68.5% of patients, and clinically significant depression affects 72.2%, yet only 12.0% have received any psychological support. Patients fear becoming burdens to their families (81.5%), financial destitution (79.6%), social rejection (75.9%), marital breakdown (68.5%), and death from complications (63.0%). Gender differences reflect culturally prescribed roles: men fear loss of provider status, women fear abandonment. These findings demand urgent integration of mental health services into SCI care, development of culturally appropriate rehabilitation programmes, and community education to reduce stigma. The physical paralysis of SCI is irreversible; the paralysis of fear, anxiety, and despair need not be.

REFERENCES

1. Craig A, Tran Y, Middleton J. Psychological morbidity and spinal cord injury: a systematic review. Spinal Cord. 2009;47(2):108-14.
2. Jesuyajolu D, et al. Burden of traumatic spinal cord injury in Sub-Saharan Africa: A scoping review. World Neurosurg. 2023;179:216-221.e2.
3. Darko K, et al. Presentation, management and outcome of traumatic spine injuries in Africa: A systematic review and meta-analysis. Neurosurgery. 2025;71(Suppl 1):167.
4. Lee BB, et al. The global map for traumatic spinal cord injury epidemiology: update 2011. Spinal Cord. 2014;52(2):110-6.
5. Nwankwo OE, et al. Epidemiological and treatment profiles of spinal cord injury in southeast Nigeria. Spinal Cord. 2013;51(12):898-901.
6. Obalum DC, et al. Profile of spinal injuries in Lagos, Nigeria. Spinal Cord. 2009;47(2):134-7.
7. Alfin JD, et al. Clinical profile and predictors of early outcome in patients with traumatic spinal cord injury in Jos, North-Central Nigeria. J West Afr Coll Surg. 2023;13(2):49-58.
8. Nwankwo OE, Uche EO, Okorie E, Nnezianya I. Epidemiological and treatment profiles of spinal cord injury in southeast Nigeria. Spinal Cord. 2013;51(12):898-901.
9. Oyemolade TA, et al. Neurotrauma: a burgeoning, yet understudied disease of rural areas in developing countries. J Neurosurg. 2022;138(4):1069-1076.
10. Haddad MM, Usman UM, Salis A, et al. Assessment of psychosocial impact of spinal cord injury among survivors in National Orthopaedic Hospital Dala-Kano, Northwestern Nigeria. Bayero J Evid Based Physiother. 2024;8(1).
11. Kwah SB, Abdullahi A. Coping strategies in people with spinal cord injury: a qualitative interviewing. Astroparticle Physics. 2018;20(1):195-202.
12. Kawu AA, et al. Complications and causes of death in spinal cord injury patients in Nigeria. West Afr J Med. 2011;30(4):245-9.
13. Ikwuegbuenyi CA, et al. Patients with traumatic spinal injuries treated in a low- and middle-income country: what happens after discharge? Neurosurg Focus. 2025;58(3):E2.
14. Gureje O, et al. The role of global traditional and complementary systems in the treatment of mental health disorders. Lancet Psychiatry. 2015;2(2):168-77.
15. World Health Organization. World report on disability. Geneva: WHO; 2011.
16. National Orthopaedic Hospital Dala Kano. About Us [Internet]. Kano: NOH Dala; 2025.
17. Zigmond AS, Snaith RP. The hospital anxiety and depression scale. Acta Psychiatr Scand. 1983;67(6):361-70.
18. Braun V, Clarke V. Using thematic analysis in psychology. Qual Res Psychol. 2006;3(2):77-101.
19. Dijkers MP. Quality of life of individuals with spinal cord injury: a review of conceptualization, measurement, and research findings. J Rehabil Res Dev. 2005;42(3 Suppl 1):87-110.
20. Hamzat TK, Olaleye OA. Family burden and quality of life of caregivers of stroke survivors in a Nigerian rehabilitation facility. J Rehabil Med. 2011;43(9):830-4.
21. Ikwuegbuenyi CA, Shlobin NA, Badejo O, et al. Patients with traumatic spinal injuries treated in a low- and middle-income country: what happens after discharge? Neurosurg Focus. 2025;58(3):E2.
22. Elliott TR, Frank RG. Depression following spinal cord injury. Arch Phys Med Rehabil. 1996;77(8):816-23.

23. Kennedy P, Rogers BA. Anxiety and depression after spinal cord injury: a longitudinal analysis. Arch Phys Med Rehabil. 2000;81(7):932-7.
24. Bazna MS, Hatab TA. Disability in the Qur'an: the Islamic alternative to defining, viewing, and relating to disability. J Relig Disabil Health. 2005;9(1):5-27.
25. McKinley WO, Jackson AB, Cardenas DD, DeVivo MJ. Long-term medical complications after traumatic spinal cord injury: a regional model systems analysis. Arch Phys Med Rehabil. 1999;80(11):1402-10.

Table 1: Demographic and Clinical Characteristics (n=108)

Characteristic	Number (n)	Percentage (%)
Gender		
Male	78	72.2%
Female	30	27.8%
Age group (years)		
18–30	34	31.5%
31–45	42	38.9%
46–60	24	22.2%
60 & above	8	7.4%
Mechanism of injury		
Road traffic accident	56	51.9%
Fall from height	37	34.3%
Other	15	13.9%
Level of injury		
Cervical 62 57.4%		
Thoracic 28 25.9%		
Lumbar 18 16.7%		
ASIA grade		
A (Complete)	66	61.1%
B–D (Incomplete)	42	38.9%
Time since injury		
6–12 months	38	35.2%
1–3 years	44	40.7%

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≥3 years	26	24.1%
Marital status		
Married 52 48.1%	52	48.1%
Single 46 42.6%	46	42.6%
Divorced/separated 10 9.3%	10	9.3%

Table 2: Hospital Anxiety and Depression Scale Scores (n=108)

Parameter	Number (n)	Percentage (%)
Anxiety (HADS-A)		
Normal (0–7) 34 31.5%	34	31.5%
Borderline (8–10)	28	25.9%
Caseness (≥11)	46	42.6%
Clinically significant (≥8)	74	68.5%
Depression (HADS-D)		
Normal (0–7)	30	27.8%
Borderline (8–10)	32	29.6%
Caseness (≥11)	46	42.6%
Clinically significant (≥8)	78	72.2%

Table 3: Fears Expressed by Spinal Cord Injury Patients (n=108)

Fear Domain	Number (n)	Percentage (%)
Becoming a burden to family	88	81.5%
Financial destitution	86	79.6%
Social rejection and stigma	82	75.9%
Inability to marry or marital breakdown	74	68.5%
Death from complications	68	63.0%
Loss of dignity/self-worth	62	57.4%
Never walking again	58	53.7%
Being alone/abandoned	52	48.1%

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Table 4: Gender Differences in Fears

Fear Domain	Male (n=78)	Female (n=30)	p-value
Fear of marital abandonment	48 (61.5%)	26 (86.7%)	0.003
Fear of losing provider role	72 (92.3%)	14 (46.7%)	0.001
Fear of social rejection	58 (74.4%)	24 (80.0%)	0.38