

**Diverging Life Paths: Understanding the Journey of Friendship
Following Spinal Cord Injury**

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Diverging life paths:
Understanding the journey of friendship following spinal cord injury

by

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A thesis submitted in fulfilment of
the requirements of the degree of

Doctor of Philosophy

School of Human Services, Faculty of Health

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REMEMBER

As I sit alone
With the warm sun on my back
I realise something's missing
A part of me which lacks

Could it be the trees
Reaching for the sky?
Or could it be the children
Walking home, who pass me by?

Perhaps, I miss the birds,
Chirping sweetly above my head
All I feel is restlessness
A part of me is dead

I know now what it is
Now I realise what is wrong
It's the feeling they call solitude
All my friends are gone

Of course I know
That as we grow
We have to make our way
We all must plot a different course
To go by everyday

I always thought my friendships
Would be round
Just like the moon
But you see
I am not ready
For it all to end so soon

I miss their happy laughter
Floating on the wind
I miss the many secrets
That circulate within

The only way to keep
Our friendships woven tight
Is to keep in contact always
And then we'll be alright

Claire (1996)

Accessed 3/9/2007 from www.friendship.com.au

ORIGINALITY OF THESIS

I hereby certify that this work has not previously been submitted for a degree or diploma in any university. To the best of my knowledge and belief, the thesis contains no material previously published or written by another person except where due reference is made in the thesis itself

Melissa Kendall

November 2008

Publications and Resources Arising from or Related to the Thesis

Kendall, M. Through my rose coloured glasses: When disability strikes a health professional. In C.A. Marshall, E. Kendall, M. Banks & R.M.S. Gover (Eds). (2009- in press). *Disabilities: Insights from across fields and around the world*, Volume 2. Westport, CT: Praeger Press.

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Abstract

The outcome of this study is an integrated theoretical framework for understanding friendship processes following spinal cord injury (SCI). A constructivist grounded theory approach was adopted to inductively explore the challenges that friendships faced following injury and how, within the context of hospital and community settings, people with SCI and their friends met these challenges. A total of 60 interviews formed the basis of this study. The sample consisted of 19 people with a SCI, 8 of their friends and 3 family members (1 wife, 1 sister and 1 mother) as well as 10 hospital and community-based rehabilitation staff. Written documents from published and internet sources were also analysed. Simultaneous data collection and analysis was utilised to develop the theoretical framework presented (Glaser & Strauss, 1967).

The primary concern identified for friendships following SCI was the divergence of life paths for injured individuals and their friends. Diverging life paths were defined by the concepts of *enforced separation* and *priority drift*. Specifically, following injury, friendships were separated at a physical, social and cognitive level through processes of *environmental separation, role separation, identity separation and interactional separation*. From the time of injury, friendships started to experience *priority drift*, in that friendships declined in priority because of *immediate need, the vulnerability of the new world, facing the unknown and reality shifting over time*. The diverging life paths presented an ongoing challenge for friendships.

To address the challenge of diverging life paths, people with SCI, their friends, family members and rehabilitation staff employed a variety of strategies (including *working* and *redefining the friendship*) aimed at reconnecting life paths. The purpose of these strategies was to reduce enforced separation and realign the

priorities of the friends. Working consisted of behavioural strategies that were principally aimed at reducing enforced separation by *breaking the ice, negotiating old and new roles and responsibilities, moulding the environment, and recruiting peer and staff helpers*. Redefining consisted principally of cognitive strategies aimed at changing perceptions of self, others and friendship through the concepts of *redefining friendship and priority setting*.

The processes of diverging life paths and reconnecting life paths occurred on a continuum for different friendships. Although some friendships experienced extreme divergence of life paths, others only experienced subtle divergence. Thus, some friendships did not utilise the processes of reconnection to a large degree whereas others required substantial transformations through working and redefining.

Previous research has typically explored social support and friendships in terms of network size, type of support and adjustment outcomes. The current study extends previous research through its focus on friendship processes, providing a basis on which to design future research and clinical practice.

Chapter 1

Spinal Cord Injury and Social Support

Introduction

The number of people living with spinal cord injury (SCI) in Australia has been steadily increasing and is predicted to reach 12,000 by the year 2021 (O'Connor, 2005). SCI, whether acquired through traumatic or non-traumatic means, almost always results in significant neurological impairment (Sullivan, 1999). The ensuing disability, whether accompanied or unaccompanied by altered cognitive function, affects both movement and/or sensation, limits control of certain bodily functions and, in some cases, creates a need for respiratory assistance (North, 1999).

The complications inherent in SCI range from the obvious physical (e.g., immobility, incontinence) losses, to a broad range of both social (e.g., limited participation in leisure activities) and occupational (e.g., restricted vocational choices) losses (Craig, Hancock, Dickson, Martin & Chang, 1990; Hollick et al., 2001). Indeed, changes in an individual's life may encompass, but are not limited to mortality, health status, occupation, physical function, autonomy and personal control, personal relationships, psychosocial adjustment, leisure participation and quality of life (Charlifue & Gerhart, 2004a; Charlifue & Gerhart, 2004b; Charlifue & Lammertse, 2004; Charlifue & Weitzenkamp, 1999; Riis & Verrier, 2007). Regardless of the level of disability experienced, Dijkers (1997) suggested that most people would perceive SCI as a 'significant challenge to an individual's quality of life' (p. 829), with emotional, social and economic consequences emerging over many years following injury (Dudley-Javoroski & Shields, 2006).

Although the SCI population is heterogenous across age, level of injury, and education (North, 1999), the majority of individuals sustain their injury during early adulthood. With current medical advances, (e.g., better resuscitation rates and improved long-term care), people with SCI are now living many decades with their disability (Charlifue & Lammertse, 2004). Riis and Verrier (2007) suggested that outcomes following SCI have been associated with demographic (e.g., gender, age) and injury factors (e.g., level and completeness of lesion, cause of injury) as well as psychological and emotional characteristics of the individual (e.g., coping style, adjustment to disability, personality).

There is an increasing awareness that SCI has ramifications beyond the individual who is injured. Physical, social and psychological consequences exist for the injured person, their family, friends and the communities in which they live. For example, Harvey and colleagues (Harvey, Wilson, Green, Berkowitz & Stripling, 1992) found that up to 73% of the personal care services provided to people with SCI are provided on a voluntary basis by family and friends. Indeed, the current cost estimates for SCI rehabilitation are likely to underestimate the real costs to individuals with SCI, their families and the community (Putzke, Richards, Hicken & DeVivo, 2002; Riis & Verrier, 2007).

Traditionally, SCI rehabilitation has been provided in an inpatient setting, driven largely by a medical model of treatment. Although necessary during the acute period following injury, the medical model becomes less relevant as the individual moves into the rehabilitation setting in the community (Hochstenbach, 2000). Recent theoretical advances, such as that provided by the International Classification of Functioning, Disability and Health (ICF - World Health Organisation, 2001) have suggested that it is essential to consider a broad range of personal and environmental

factors in addition to body structure and function. Specifically, the ICF has highlighted the importance of activity and participation in valued life and social roles. Rehabilitation professionals, both generally and within specialist SCI rehabilitation, are becoming more aware of the complex nature of disability and are placing greater emphasis on psychosocial (Boschen, Tonack & Gargaro, 2003; Martz & Livneh, 2005) and environmental factors (Whiteneck, Harrison-Felix et al., 2004; Whiteneck, Meade et al., 2004).

In recent years, specialist community-based rehabilitation providers have emerged, with a focus on decreasing length of stay in hospital, and reintegrating people with SCI into their communities using goal-setting and client-centred approaches (Kendall, Ungerer & Dorsett, 2003). Despite these advances, SCI rehabilitation continues to be plagued by theoretical, clinical and empirical gaps. Indeed, Siegert and colleagues (Siegert, Ward, Levack & McPherson, 2007) suggested that theory development should be at the forefront of contemporary rehabilitation. There is a pressing need for us to identify how it works. In a parallel way, research needs to focus more specifically on the processes of adaptation (Kendig, Browning & Young, 2000).

Although the concept of outcomes has broadened over the last decade to include social, emotional and cognitive aspects (Dijkers, Whiteneck & El-Jaroudi, 2000), the consequences of SCI for daily life situations are rarely evaluated. In particular, a paucity of research on social processes continues to exist despite the fact that social participation has been identified as an important aspect of long term health (Noreau & Fougeyrollas, 2000). Isaksson, Josephsson, Lexell and Skär (2007) suggested that maintenance of health status and participation following SCI is dependent on the development and enhancement of social relationships. Indeed, there

is widespread recognition that social support is an important environmental variable for people with chronic health conditions, disability and a variety of life challenges (Arora, Rutten, Gustafson, Moser & Hawkins, 2007; Beal & Stuijbergen, 2007; Gil & Gilbar, 2001; Isaksson, Skär & Lexell, 2005; Michael & Jenkins, 2001).

Despite knowledge about the importance of social processes, rehabilitation professionals often focus on assisting people with SCI to become as functionally independent as possible. The literature on SCI is predominantly focussed on medical management of the initial injury and secondary complications, depression and life satisfaction (e.g., Krause & Coker, 2000; Meade & Cifu, 2004; Meyers, Mitra, Walker, Wilber & Allen, 2000; Putzke et al., 2002; Quigley, 1995). There is a paucity of research investigating the changes that occur in relationships, the implications of SCI for relationships and the post-injury processes associated with relationships (Pearcey, Yoshida & Renwick, 2007).

Friendships, in particular, remain largely unexplored by all health and welfare professionals (Himes & Reidy, 2000), including rehabilitation providers in clinical settings and rehabilitation researchers. Little is known about how people with disabilities, including those with SCI, perceive the changes that occur over time in their social network and how these changes affect their ability to participate in their communities. Indeed, Chronister, Johnson & Berven (2007) suggested that there is a need for researchers to explore the concept of social support more fully in relation to a wider social network (i.e., extended family, close friends, acquaintances, neighbours, and work colleagues).

In the context of social support, friendship offers something unique because, unlike other relationships, it is not task-specific or based on formal attachments. Rather, it exists solely on its own merits and for its own purpose (Wiseman, 1986).

'Friendship is a thing most necessary to life, since without friends no one would choose to live, though possessed of all other advantages' (Aristotle, 1962). Friendship has been viewed as one of the most important of all relationships because friends help us understand the purpose of life (Knickmeyer, Sexton & Nishimura, 2002). Indeed, having friends is considered to be a normal and desirable part of life (Boydell, Gladstone & Crawford, 2002; Vandell, 2000).

Friendships are, therefore, a key area requiring attention if people with disabilities are to experience quality of life as valued members of the community. However, considerable work is yet to be done to understand and facilitate friendships among people with disabilities (McVilly, Stancliffe, Parmenter & Burton-Smith, 2006). Although friendship patterns and interactions have been examined in a limited sense within adult populations, the majority of research on friendship has been conducted with children, and is unlikely to translate to the SCI population. Furthermore, the current body of evidence about adult friendships suggests that friendship patterns and the needs of people vary across the life cycle (Mohr, Averna, Kenny & DelBoca, 2001).

In their landmark work, Adams and Blieszner (1994) concluded that we know relatively little about the nature of adult friendships. Furthermore, Carbery & Buhrmester (1998) suggested that a broader lifespan perspective needed to be integrated within theory and knowledge about adult friendship to address our current disjointed and fragmented understanding of the area. Friendships for people with disabilities have been even more neglected as a research topic, especially for those people who acquire disabilities in adulthood. There is recognition that opportunities for close, mutual and ongoing relationships are often lacking in the lives of people with disabilities (Matheson, Olsen & Weisner, 2007). By enhancing these social

networks, health and rehabilitation services can improve community integration and quality of life for people with SCI and, in turn, decrease reliance on acute healthcare services. Consequently, friendship is a topic of importance for all rehabilitation professionals.

There is clearly a need for investigation into friendship beyond the general research that focuses on social support or community integration (Boydell et al., 2003). The aim of this study is to inform the rehabilitation community about friendship processes following SCI through the development of a theoretical framework that can guide clinical practice. An understanding of friendship will be developed by viewing friendship as a non-linear process wherein each person is unique, every relationship is different, and each situation faced offers new experiences for the friendship (Amado, 1993). The study aims to identify the challenges that are faced in friendships following SCI and the ways in which people with SCI meet these challenges in their friendships, the strategies they use to maintain those friendships and the ways in which others, including families, rehabilitation professionals and the community in general can facilitate those friendships.

This chapter introduces SCI, providing a brief overview of the incidence of SCI, the nature of the population, and its physical and psychological sequelae. The participation and community integration difficulties experienced by people with SCI are discussed, highlighting the importance of environmental factors such as social support. The concept of social support is then explored in terms of the range of definitions available and its effect on physical and psychological health in general populations, people with disability and people with SCI specifically. Finally, the challenges associated with examining social support after SCI are highlighted. The

following chapter will explore the special social support that is derived from friendship.

Spinal Cord Injury

Incidence and Demographics

In the early part of the 20th century, up to 90% of people with SCI died within a few weeks of injury or within a couple of years as a result of secondary complications (North, 1999). In contrast, data collected more recently suggested that 94% of people with SCI survive the initial injury (Dittuno & Formal, 1994). DeVivo and colleagues (DeVivo, Rutt, Black, Go & Stover, 1992) suggest that about 95% of individuals are discharged to the community rather than institutional settings. Further, there is now an expectation of a relatively normal life span (DeVivo, Richards, Stover & Go, 1991). Indeed, since this time, survival rates following SCI are the highest they have ever been (DeVivo, 2007).

Over 15 years ago, Berkowitz, Harvey, Greene and Wilson (1992) reported that the incidence of SCI in the United States was between 30.0 and 45.0 per million per annum. More recently, the incidence of SCI worldwide has been reported to lie between 10.4 and 83 per million inhabitants per year (Wyndaele & Wyndaele, 2006). In an Australian cohort study, the prevalence of SCI was reported in the range of 8096 to 9614 cases in 1985. By 1997, this figure had increased to nearly 10,000, a prevalence rate of more than 681 per million of population. It was estimated that by 2021, the prevalence of SCI could increase to nearly 12,000 (O'Connor, 2005). Several trends have suggested that there will be a growing need for specialised support services for people with SCI in future. For instance, the ageing of the general population, increasing survival rates following SCI and the emergence of a trend

towards older onset of injury (Barrett, Putzke & Richards, 2002; Kemp & Krause, 1999; Liem, McColl, King & Smith, 2004), all suggest that there will be more elderly people with SCI who have significant support needs (Amsters, Pershouse, Price & Kendall, 2005).

The average age of persons at the time of injury has been reported to be between 30 and 35 years (Wyndaele & Wyndaele, 2006). Barrett et al. (2002) reported that an estimated 7 to 20% of the SCI population is 60 years or older (Krause, 2000; Menter et al., 1991; Menter & Hudson, 1995) where the average age of all persons with SCI has been reported to be in the late 40s (Kemp & Krause, 1999). Individuals who sustain their SCI in later life are much more likely to have incomplete injuries predominantly affecting the cervical spine (Barrett et al., 2002) despite the fact that during more recent decades a higher percentage of tetraplegia and complete lesions have emerged (Wyndaele & Wyndaele, 2006). DeVivo (2007) did however find that there was a trend towards a higher proportion of neurologically incomplete injuries.

In the past, SCI has typically been the result of motor vehicle accidents in individuals younger than 50 years of age and falls in older individuals. This pattern was reported to change during the 1990s, with a decline in the proportion of injuries due to motor vehicle accidents and sporting activities, but an increase in the percentage of injuries caused by violence (Waters, Adkins, Sie & Cressey, 1998). Recent data has shown a downward trend in the proportion of injuries caused by violence (DeVivo, 2007), whereas motor vehicle accidents have re-emerged as a principal cause of SCI (Asher, 2003; DeVivo, 2007). Despite these changing etiological trends, the majority of people who sustain SCI continue to be male, with a male-to-female ratio of 3.8:1. SCI also occurs primarily among young adults with the

16 to 30 year age range accounting for 56% of all new injuries (Wyndaele & Wyndaele, 2006).

Sequelae of SCI

SCI has a major impact on physical, cognitive and emotional function and hence on quality of life. Adjustments in lifestyle after SCI typically range from moderate to extremely severe, with significant costs to the individual, their family members and the community in general. Indeed, Murray et al. (2007) cited research suggesting that SCI is one of the most expensive hospital diagnoses. SCI is a complex physical condition that disrupts a wide range of bodily functions, life activities, and social roles. Responses to SCI are both physical (e.g., mobility, bowel and bladder control, sexual functioning) (Amsters et al., 2005; Anson & Shepherd, 1996; Asher, 2003; Benevento & Sipski, 2002; Young, Webster, Giunti, Pransky & Nesathurai, 2004) and psychological (e.g., anxiety, body image, vocational and financial) (Boschen et al., 2003; Dijkers, 1998; Fougereyrollas et al., 1998; Galvin & Godfrey, 2001; Hulse, 1997; Kennedy & Rogers, 2000; Krause, Kemp & Coker, 2000; Murray et al., 2007; North, 1999; Scivoletto & Petrelli, 1997).

The physical and psychological losses associated with SCI also commonly produce major social difficulties (Hampton, 2001; Isaksson et al., 2005). The social and family lives of people with SCI are drastically affected (Chan, 2000a; Kreuter & Butt, 1999) sometimes preventing participation in sporting, recreational, and leisure activities that individuals previously enjoyed prior to injury. Where participation is possible, it is often restricted or altered in nature (Carpenter, Forwell, Jongbloed & Backman, 2007; Ditor & Latimor, 2003; Kennedy, Lude & Taylor, 2006). The ability to participate in social, vocational and family roles is often significantly impacted,

adding to both the psychological and financial stress experienced (Larsson Lund, Nordlund, Nygard, Lexell & Bemsprang, 2005; Targett, Wehman & Young, 2004).

It is increasingly being recognised that, although the physical and psychological sequelae of SCI are important, it is the ability to participate in valued social roles and integrate into their communities that is the ultimate goal for many people following injury (Carpenter et al., 2007; Isaksson, Lexell & Skär, 2007; Isaksson et al., 2007). Participation and community integration are related terms that have been variably defined in the literature. However, most discussions of community (re)integration do not provide a definition of the concept or operationalise it (Dijkers, 1998). The term community integration has a number of meanings. Dijkers (1998) has described it as ‘a process, a state, a goal for individuals, a social principle, and an objective of policy’ (p. 3). Indeed, it is suggested that it is the key objective of the rehabilitation process (McColl, Davies, Carlson, Johnston & Minnes, 2001).

Community integration has been defined as the acquisition or resumption of roles that facilitate decision making and productive involvement within multiple relationships in the community (Dijkers, 1998). The needs of people with SCI living in the community relate to social participation, the reduction of handicap and involvement in areas of life (roles, activities and relationships) that are comparable to peers of the same age, gender and culture (Kennedy et al., 2006).

People with SCI experience extensive social challenges (Galvin & Godfrey, 2001). An individual may be unable to perform many tasks as competently as he or she could before the injury. This, in turn, impacts on the individual's participation in work, family and social roles. Successful rehabilitation involves maximizing the ability of the individual to ‘participate in community life activities, remain active in family and recreational events, and access local activities and resources’ (McKinley &

Meade, 2004, p. 79). Researchers investigating aging following SCI have found that community reintegration may decline over time due to changes in physical independence, mobility, occupation, social integration and subsequently life satisfaction (Charlifue & Gerhart, 2004b; McKinley & Meade, 2004; Rodgers & Marini, 1994).

In one Australian study, Dorsett (2004) found the highest levels of satisfaction within the domains of family relationships, general health, perceived control over life, and social support whereas life opportunities, access to recreational pursuits, and emotional adjustment were identified as issues of lower priority. Post and colleagues (Post, de Witte, van Asbeck, van Dijk, and Schrijvers, 1998) reported, in their study of 318 community-living persons with SCI and 507 inhabitants of a large city in the Netherlands, that the mean scores of general life satisfaction and of satisfaction with self-care ability, leisure situation, vocational situation, and sexual life were lower in persons with SCI than in the normative population group, but satisfaction with family life was higher. Tasiemski and colleagues (Tasiemski, Kennedy, Gardner & Taylor, 2005) found that the numbers of hours participating in sports decreased significantly after injury, particularly in team sports where social interaction is one primary benefit of participation. The value of leisure as a context for the establishment of social contacts, friends and community integration has been supported (Dattilo, Caldwell, Lee & Kleiber, 1998).

Despite the general findings in the SCI literature outlining that the highest levels of satisfaction existed within social domains such as family life and contacts with friends (Carpenter et al., 2007; Tasiemski et al., 2005), the fact remains that subjective well-being among persons with physical disability is often higher among those with active and meaningful social pursuits (Krause & Crewe, 1991; Loy, Dattilo

& Kleiber, 2003). This finding underscores the importance of research in this area. Further, regardless of these high levels of satisfaction generally, there remain individuals whose satisfaction within social domains of participation is extremely low. Theoretical and clinical developments in the area must be able to account for the differences among individuals whose social participation spans the entire spectrum from socially isolated to well-integrated.

The degree to which we can predict and explain these differences will determine the ways in which rehabilitation professionals can assist individuals following injury. Social and emotional adjustment and participation after SCI varies significantly from person to person (Larsson Lund et al., 2005; Mackelprang & Hepworth, 1987) and this involvement is often predicted by a complex range of personal and environmental factors. Indeed, Noreau and Fougereyrollas (2000) suggested that the quality of social participation may be seen as ‘a situational result generated by the interaction between the characteristics of the person and his/her environment’ (p. 171). However, May and Warren (2002) suggested that it is the social relationships of people with disabilities that are best related to participation of a person within his/her own life context.

Current evidence has suggested that participation and community integration are indeed variably predicted by a number of demographic, physical, psychological and environmental variables. Barrett et al. (2002) found that individuals who were elderly with late onset of injury had higher levels of handicap than those individuals who were younger with early life onset of injury. In terms of injury factors, severity of injury has been linked to participation, with individuals with complete tetraplegia experiencing lower levels of participation, especially within the social roles in the community that required the individual to have access outside of the home (Noreau &

Fougeyrollas, 2000). Related to severity of injury, Dijkers et al. (Dijkers, Yavuzer, Ergin, Weitzenkamp & Whiteneck, 2002) found that motor ability was predictive of participation levels. Duration of injury on the other hand was found to have no association with participation (Charlifue & Gerhart, 2004b; Noreau & Fougeyrollas, 2000).

Psychological variables of perceived personal control (Boschen et al., 2003) and cognitive appraisal of life events and situations (Noreau & Fougeyrollas, 2000) have been independently found to be predictive of participation and enhanced community integration. Some researchers have suggested that emotional distress does not impact on participation (Charlifue & Gerhart, 2004b) yet perceived life satisfaction and quality of life have been significantly related to community integration (Charlifue & Gerhart, 2004b; May & Warren, 2002). Noreau and Fougeyrollas (2000) found that, despite identifying severity of injury as a predictor of participation, the attainment of various life habits is variable among people who have the same type of injury, reflecting the subjective nature of appraisal of life habits. Given similar contexts, what one person may only achieve with extreme difficulty, another may perceive that he/she can accomplish without difficulty (Noreau & Fougeyrollas, 2000).

By far the most commonly identified predictors of participation have been environmental factors. Although Boschen et al. (2003) discussed a range of environmental factors such as mentoring from peers, familiarity with the environment, accessible housing and personal means of transport as all important for improving social participation levels, perhaps the most frequently identified predictor of participation has been high levels of social support from family and friends (Boschen et al., 2003; Larsson Lund et al., 2005).

Social Support: An Important Environmental Factor

For many years, social support has been identified extensively throughout the literature as an important contributor to a variety of outcomes including coping (Chan, Lee & Lieh-Mak, 2000a; deRidder & Schreurs, 1996; Derlega, Winstead, Oldfield & Barbee, 2003), occupational stress (van der Doef & Maes, 2000), positive outlook (Miller, 1997), social and community functioning (Boydell et al., 2002), loneliness (Beal & Stuifbergen, 2007), happiness (Taylor, Chatters, Hardison & Riley, 2001), quality of life (Frick, 2005), participation (Larsson Lund et al., 2005), psychological distress (Wade et al., 2004), protection of health and recovery from mental illness (Corrigan & Phelan, 2004) and other chronic health conditions (Helgeson & Cohen, 1996; Weinert, 2000). These effects of social support have also been found across a number of populations including caregivers (Chambers, Ryan & O'Connor, 2001; Wiles, 2003), people with HIV/AIDS (Zhou, 2007), people with acquired brain injury (McCluskey, 2000; Paterson & Stewart, 2002), the elderly and aging population (Litwin & Landau, 2000), people with chronic fatigue syndrome (Dickson, Knussen & Flowers, 2007), and the chronically ill (Miller, 1997).

Support from a variety of different sources has been identified as being important (Carbery & Buhrmester, 1998) including support from spouses (Frick, 2005; Schade, Semmer, Main, Hora & Boos, 1999), children (Pinquart, 2003) and friends (Carbery & Buhrmester, 1998; Manne & Miller, 1998; Manne et al., 2003). Similarly, a variety of types of support have been identified as being important including emotional support (Burleson, 2003; Miller 1997), informational support (Arora et al., 2007; Manns & May, 2007) and instrumental support (Dijkers et al., 2000). So widely recognised is the issue of social support that whole books have been

written on the topic (e.g., Cohen, Underwood & Gottlieb, 2000; Levy & Pescosolido, 2002).

Definitions of social support

For decades, the literature on social support has been characterised by multiple definitions (Caplan, 1974; House, 1981; Weiss, 1974) and there continues to be unresolved issues in the definition, measurement and understanding of how social support functions (Chronister et al., 2006). Dijkers et al. (2000) suggested that there are over 100 different measures of social support with a variety of underlying properties. Many people have described social support as a metaconstruct (Parks & Floyd, 1996; Vaux et al., 1986) that lacks specificity and definition (Barrera, 1986). What is clear is that social support consists of multiple domains, making it difficult to define and measure (Hutchison, 1999; Leiberman, 1986). O'Reilly (1988) found that 10 of 24 social support studies (41%) had either no or very unclear definitions of social support.

Parks and Floyd (1996) suggested that, in viewing social support as a metaconstruct, there are three distinct conceptual components, namely support network resources (structural), supportive behaviour (functional) and subjective appraisals of support (perceptual). They speculated that none of these components alone captures all that is meant by social support but taken together they describe the processes represented within most existing theories of social support. Laireiter and Baumann (1992) concluded that social support consisted of at least five components, namely those of social integration, network resources, supportive climate and environment, received and enacted support, and the perception of being supported.

Early conceptualisations of social support were mainly structural or functional in nature. Chronister et al. (2006) described the structural dimension of social support as capturing a 'person's connection with his or her personal network including the quantity (size, frequency of contacts) and characteristics (composition, density, homogeneity and multiplexity) of social ties in the network' (p. 76-77). They also suggested that a variety of different terms have been used to refer to the structural dimension including social embeddedness (Barrera, 1986; Wenger, Dykstra, Melkas & Knipscheer, 2007), support network resources (Vaux, 2000) and affiliation (Cohen & Wills, 1985; Field, Frank, Schiller, Riegle-Crumb & Muller, 2006). They defined the functional dimension of social support as involving the type and quality of supportive behaviour and social exchange (Chak, 1996; Cohen & Wills, 1985) such as emotional, instrumental and informational (Cutrona & Russell, 1990).

The perceptual dimension of social support was defined as reflecting an individual's subjective assessment of their social network (Sarason et al., 1991; Vaux, 2000). This includes their perceptions of their relationship with the network as a whole, as well as particular network relationships (e.g., spouse, co-worker, friend) or particular supports (e.g., emotional or instrumental). Indeed, it is argued that the actual support that people receive may only explain a small proportion of the support which the individual perceives (Lakey & Cassady, 1990).

Weiss (1974) described six functional provisions of social relationships including opportunity for nurturance, reassurance of worth, guidance, reliable alliance, social integration, and attachment. House's (1981) most commonly used definition of social support distinguished the functional aspects of social support, namely emotional support, instrumental support, informational support and appraisal

support. He conceptualised social support as the interactions or interpersonal exchanges between a provider and a recipient.

Chronister et al. (2006) also noted that there are many personal, contextual and interactional characteristics that can add to our understanding of social support.

Langford and colleagues (Langford, Bowsher, Maloney & Lillis, 1997) identified social network, social embeddedness and social climate as antecedents or precursors of social support. They suggested that the four functions of social support (emotional, instrumental, informational and appraisal support) can only occur in the presence of these antecedents. “Without a structure of people (network) with the quality of connectedness (embeddedness) required to generate an atmosphere of helpfulness and protection (social climate), social supportive behaviour can not occur” (Langford et al., 1997; p. 97). Social support consequences were considered to be positive health states such as personal competence, health maintenance behaviours, effective coping behaviours, perceived control, sense of stability, recognition of self-worth, positive affect, psychological well-being, and decreased anxiety and depression.

Structural definitions of social support have centred on the size and structure of social networks. Many researchers have conceptualised networks as consisting of various concentric circles where the innermost circles represent close relationships involving the exchange of intensive support. It is this network, consisting mostly of family members, that is typically considered to be the most stable throughout a person's life (Peek & Lin, 1999; van Tilburg, 1992). The outermost circles often include relationships that are task-related or function-related and involve fewer interactions. Networks, though typically measured as static, are usually dynamic, continually changing over time, depending on the life stage of the individual. For example, an adolescent will not have a spouse within their network and work

colleagues will not usually remain in the social network after retirement (van Tilburg, 1992). It is speculated that networks of personal relationships may change in response to life events although this is a relatively unexamined aspect of social support (Morgan, Carder & Neal, 1997).

Density of the network has been identified as an important factor to consider. A low density network or a network in which the majority of members do not know each other has been proposed to facilitate greater sharing of diverse experiences as well as minimising segregation of that network (Forrester-Jones, Jones, Heason & DiTerlizzi, 2004). Many Western cultures have a dense inner circle of close family who provide consistent and ongoing support and a sparse outer circle of friends who provide companionship (Vandell, 2000). These networks provide important support, but they also occupy the major part of a person's day. In 1988, Larson and Bradney estimated that working people were likely to spend 10 to 15 percent of their waking time with friends and relatives, 30-40 percent with co-workers and about 20-40 percent with household members. It is suggested that the outer dispersed circle of friends is what exposes one to diverse situations, experiences and resources (Wellman & Wortley, 1990). However, some researchers have suggested that it is this network that has decreased among the population more generally over the last 20 years (McPherson, Smith-Lovin & Brashears, 2006).

For people with disabilities and chronic illness in particular, networks appear to be significantly diminished (Beal & Stuijbergen, 2007; Isaksson et al., 2005; Ydreborg, Ekberg & Nordlund, 2006; Zencius & Wesolowski, 1999). Miller (1997) found that, for some people, their networks consisted primarily of their spouse and family whereas for others the network also included health care professionals. For many people who are hospitalised following injury, family and friend networks

remain consistent initially, sometimes providing more intense support (Kendall & Terry, 1996). However, prior to or following discharge from hospital, the support network weakens, leaving people and their family isolated (Finset, Dyrnes, Krogstad, & Berstad, 1995).

Effects of social support on physical and psychological health

Many conceptualizations of social support assume that they are, by definition, positive (Walen & Lachman, 2000). Although it is true that the majority of researchers have traditionally focused on the positive aspects of social support, social support does not always involve positive and beneficial effects (Hanna & Berndt, 1995; Okabayashi, Liang, Krause, Akiyama & Sugisawa, 2004). Conflict occurs in most relationships (Pierce, Sarason & Sarason, 1991). Chronister et al. (2006) proposed the need for researchers to recognise and measure separately the positive and negative aspects of social interactions. In fact, longitudinal studies that encompass both positive and negative aspects of relationships have shown that the negative aspects of social support appear to be as important, if not more important, than the positive ones in predicting psychological adjustment (Blankfeld & Holahan, 1999; Lincoln, 2000). For example, Karlovits and McColl (1999) found that difficulties in relationships with family, friends and acquaintances, feelings of loneliness and prejudicial attitudes were common stressors associated with poor community integration among people with acquired brain injury. Other researchers have described negative reactions such as insensitivity, negative emotional reactions, critical judgments, blame, rejection or avoidance, and discrimination (Dakof & Taylor, 1990; Dickson et al., 2007; Herbert & Dunkel-Schetter, 1992) as harmful. Ahrens and Campbell (2000) proposed that social support is only likely to be helpful

to the extent that these negative reactions and consequences can be avoided or minimised.

Various aspects of social support have been found to have positive effects on physical health, although the findings are somewhat equivocal. Social support has been variably related to illness management (Helgeson & Cohen, 1996; Weinert, 2000), functional status (Tsouna Hadjis, Vemmos, Zakopoulos & Stamatelopoulos, 2000), physical disability (O'Brien, 1993), lower mortality (Bryant & Rakowski, 1992), self care functioning (Evert, Harvey, Trauer & Herrman, 2003) and utilisation of health services (Kouzis & Eaton, 1998) across varied populations.

Even if it is accepted that social support plays an important role in physical health, it appears that its role in psychological health is equally important. Rintala and colleagues (Rintala, Young, Hart, Clearman & Fuhrer, 1992; Rintala, Young, Hart & Fuhrer, 1994) found lower social support was associated with the presence of psychiatric disorders. Indeed, social support has been associated with a range of other mental health issues. For example, Kishi, Robinson and Kosier (2001) found that low levels of social support among people with SCI were associated with increased suicidal ideation. However, Corrigan and Phelan (2004) found that network size and satisfaction was not significantly associated with psychiatric symptoms among people with mental illness.

Perhaps the area of psychological and mental health that has received the most attention in relation to social support is that of depression and mood. Historically, social support has a well-documented association with depressive symptoms (Cohen & Wills, 1985; George, Blazer, Hughes & Fowler, 1989; Kessler & McLeod, 1985). Social support has been found to mediate the effects of disability on depressive symptoms among older adults (Yang, 2006). Similarly, social support has been found

to be predictive of lower levels of depression in people with disabilities and chronic illness (Chronister et al., 2006; Zea, Belgrave, Townsend, Jarama & Banks, 1996).

People with cancer who have lower levels of social support available to them have also displayed higher levels of depression and hopelessness (Gil & Gilbar, 2001).

Some researchers have found that it is perceived social support that is associated with decreased depression (Toro, Tulloch & Ouellette, 2008). Others, such as Mullins and Mushel (1992), have found that it is the need for attachment and social integration that is related to a greater depressive mood. These findings highlight the need to consider the subjective nature of the relationship between social support and psychological health (Gencöz & Astan, 2006; Reinhardt, Boerner & Horowitz, 2006) as well as the differences between that support which is needed and that which is provided (Cutrona, Shaffer, Wesner & Gardner, 2007).

When considering structural dimensions of social support, network factors such as number of friends, presence of kin and frequency of contact with neighbours, have been significantly associated with subjective well-being (Taylor et al., 2001). However, Newsom and Schultz (1996) suggested that, in terms of consequences for psychological well-being, changes in the frequency of network contacts may not be of primary importance, particularly among older people. Rather they proposed that it is the subjective view of support relationships that is the key factor in determining psychological well-being. Further, they indicated that tangible support was far more predictive of depressive symptoms than informational support among older adults. Although Manne et al. (2003) agreed that it was the perceived availability of social support that was most influential for psychological well-being, emotional support provided by partners (Manne, Taylor, Dougherty, & Kemeny, 1997; Tower & Krasner, 2006) and by family members (Aymanns, Filipp, & Klauer, 1995; Serovich,

Kimberly, Mosack & Lewis, 2001) has been found to be particularly important for well-being.

Thus, it remains unclear exactly what aspects of social support are important for what aspects of psychological health and adjustment. More consistent findings appear when we consider the impact of social support on participation and quality of life. High levels of social support have been associated with adjustment to disability (Fronek, 2005; Parrott, Stuart & Cairns, 2000) and the well-being of individuals with physical disabilities (Krause et al., 2000) as well as the protection of self-esteem (Kinnunen, Feldt, Kinnunen & Pulkkinen, 2008; Tzonichaki & Kleftaras, 2002). Vocational outcomes, such as work participation among people with mental illness have been associated with belonging to, and actively participating in, social groups (i.e., family, friendships, gangs, voluntary association, or the workplace itself) (Alverson, Alverson, Drake & Becker, 1998). Numerous researchers have supported the beneficial role of social support in fostering improvements in quality of life or life satisfaction among various populations including older adults (Newsom & Schultz, 1996), people with intellectual disability (Forrester-Jones et al., 2004) and people with degenerative spinal disease (Laxton & Perrin, 2003). The association between emotional support and improved quality of life also appears more consistently in the disability literature (Arora et al., 2007; Chronister et al, 2006).

Social support and disability

Fifty years ago, Lawrence (1958) speculated that disability and chronic illness causes individuals to lose friends and family, compromising financial status and health. Indeed, Berkman, Oxman, and Seeman (1992) found that fewer sources of instrumental support and fewer face-to-face contacts with network members were

reported by those with greater disability. The reported number of emotional sources of support and non-face-to-face contacts, however, were not significantly related to disability. Those with greater impairment also reported that social support, in general, did not adequately meet their needs. In a large sample of older adults, Newsom and Schultz (1996) found that physical impairment was associated with fewer family contacts, fewer friendship contacts, a reduction in both belonging and tangible support, and a tendency to provide less material assistance to others. Capacity for reciprocity and feelings of being needed are identified as important aspects of social support (van Tilburg, 1992; Vaux, 2000) that may be disrupted by the impairment. Actual changes in the social network may occur because of limited or altered media for communication or limited community access, thereby displacing individuals from friends in the community (Jette, Keysor, Coster, Ni & Haley, 2005). Even if actual changes in support networks do not occur, those experiencing physical disability may still perceive waning support because they are less able to control when and where social interactions take place.

Social Support Following SCI

Increasingly, social support systems have been recognised in the literature as perhaps the most crucial resource for mediating or moderating the stresses that life events create for people. Naturally, SCI has an extremely traumatic effect upon individuals and their families. A person with a SCI and his or her family go through an array of emotions that accompany the physical and social issues. Learning to cope and adapt to such a traumatic, life-changing event takes time and support. A network of supportive family, friends, and professionals can facilitate this process (Gill, 1999). Indeed, Kinder (2005) conducted a secondary qualitative analysis of the transcripts of

eight women with paraplegia revealing three major themes related to SCI, namely: physiological aspects of SCI, associated with the traumatic event and its consequences; psychological aspects of SCI, associated with problem-solving, choices, and challenges; and social aspects of SCI, associated with personal and professional relationships. As rehabilitation professionals, there is a need for us to be able to identify these issues including the clients' evaluations of their social support networks and recognise the importance of expert peers (Hammell, 2007a).

Impact of social support on physical and psychological health following SCI

Social support has been linked to a variety of physical and psychosocial outcomes following SCI, including performance of activities of daily living (Boschen et al., 2003), physical activity (Kerstin, Gabriele & Richard, 2006), less health problems (Anson, Stanwyck & Krause, 1993), decreased risk for pressure ulcers (Lehman, 1995), improved perceived worth and purpose in life (Antle, 2004; Thompson, Coker, Krause & Henry, 2003), decreased hopelessness and depression (Beedie & Kennedy, 2002; Elliott et al., 1991), improved life satisfaction (Fuhrer, Rintala, Hart, Clearman & Young, 1992; Post, Ros & Schrijvers, 1999; Sherman, DeVinney & Sperling, 2004), less problems in participation (Boschen et al., 2003; Larsson Lund et al., 2005) and improved vocational outcomes (Crisp, 2005).

The impact of social support on the physical health of people with SCI can be considered in two domains, namely general health and physical function, and specific health issues related directly to the SCI itself. In general, although some studies have failed to show a relationship between social support and physical functioning (Fuhrer et al., 1992), others such as Boschen et al. (2003) have found that support from family and friends was a strong predictor of both performance of and satisfaction with

performance of daily life activities. Similarly, Anson et al., (1993) found that people who felt supported by the community experienced fewer health problems.

Furthermore, Kerstin et al. (2006) suggested that a lack of social support was a prohibitive factor for people with SCI in keeping physically active.

Research has also tended to focus on the impact of social support on the physical health issues that are unique to people with SCI. Perhaps the most dominant finding has been the relationship between adequate social support and the decreased risk of pressure ulcers (Lehman, 1995), although Anson et al. (1993) suggested that less perceived support has been related to a variety of health problems including fewer spinal cysts, lower blood pressure, shorter recovery time from decubitus ulcers, less pain below the level of injury and fewer hospital admissions.

In recent years, more attention has been paid to identifying the determinants of psychological health following SCI, with definitions of psychological health including factors such as hopelessness, depression, suicide, PTSD, purpose in life and adjustment to disability. Social support consistently appears as one of these determinants. It has been related to general well being (Elliott, Herrick, Witty, Godshall & Spruell, 1992) as well as psychological and emotional well being (Beedie & Kennedy, 2002). The quality of social support but not the quantity of support an individual receives from their support networks has been related to hopelessness and depression (Beedie & Kennedy, 2002), with better quality of social support being associated with lower levels of hopelessness and depression. Poor social support has been associated with an increased risk of suicide (Kishi et al., 2001) as well as increased risk of post-traumatic stress disorder (Danner & Radnitz, 2000). Indeed, Nielsen (2003) found that social support from friends was the largest identified predictor in PTSD symptomatology, accounting for 19% of the variance.

A multitude of studies have found that social support plays a very significant role in the perceived life satisfaction of people following SCI. Fuhrer et al. (1992) found that both the number of social supports as well as satisfaction with social support was related to greater life satisfaction. Wineman (1990) found that the supportiveness of one's social network was related to increased purpose in life. However, Rintala et al. (1992) found that perceived social support correlated positively with life satisfaction and psychological well-being, but correlated negatively with depression. Access to social support has similarly been related to participation (Larsson Lund et al., 2005) and health and non-health quality of life (Laxton & Perrin, 2003), whereas social isolation and loneliness have been associated with decreased life satisfaction (Tzonichaki & Kleftras, 2002). Indeed, Iso-Ahola and Park (1996) found that social support in the form of companionship and friendship acquired through participation in leisure activities is what buffers the adverse effects of stress on mental health.

Elliott et al. (1991) proposed that the type of support received was particularly important following SCI. Indeed, the importance of emotional support following SCI has been linked by various authors to outcomes of improved life satisfaction, adjustment to disability and decreased depression (McColl & Rosenthal, 1994; Post et al., 1999). Post et al. (1999) also provided evidence regarding the importance of the source of that support. Spouses and children were found to provide a high level of emotion-oriented support, and this was associated with greater life satisfaction. High levels of emotion-oriented support from friends was associated with poorer social functioning however, suggesting that emotional support can have both positive and negative effects depending on the source. Support sources provided problem-oriented support less frequently and this type of support failed to show a relationship with

either health or psychological well-being. These researchers proposed that the absence of a relationship between problem-oriented support and well-being may stem from the fact that this sample was 3-6 year post-injury, and such support may be more relevant in the early stages of SCI.

Indeed, the time-specific nature of social support has been highlighted by a number of researchers (Beedie and Kennedy, 2002; McColl, Lei & Skinner, 1995). Beedie and Kennedy (2002) suggested that the relative impact of social support on the psychological outcomes may increase as a function of time due to issues associated with the rehabilitation process and adjustment. They proposed that, at 6 weeks post-injury, individuals may not be mobilised, are faced with significant uncertainty regarding their diagnosis and may be more likely to minimise the potential difficulties that they may face in the future. Once individuals are in rehabilitation, they will develop some awareness of what their limitations are and what the future may hold in terms of required support from others.

Summary

SCI is a disability, typically acquired suddenly, that impacts on a multitude of life domains, including physical, psychological, social, vocational and financial. Although incidence figures for SCI are comparatively low when compared to many other acquired disabilities, the fact remains that the individual, familial and community costs of SCI are high, especially for the majority of people with SCI who are relatively young at the time of injury. Although an array of physical and psychological sequelae have been reported following SCI, it is the ability of the individual to reintegrate within the community that is perhaps most important for ongoing quality of life. The International Classification of Functioning Disability and

Health (ICF) highlighted the impact that environmental factors such as social support may have on outcomes following disability. For people with SCI, social support is a valued resource. Although defining and measuring social support remains a contentious and debated issue, it is recognised that social support has noted implications and benefits for both physical and psychological health following SCI and a continuing focus on research is needed to more clearly articulate the social support needs of people with SCI.

Chapter 2

The Special Case of Friendship

As highlighted in the previous chapter, Spinal Cord Injury (SCI) is a significant life event and outcomes are influenced by a variety of environmental factors, one of the most important of these being social support. This chapter will discuss the special case of friendship as one important source of social support and highlight the existing literature regarding friendships, both generally and within the SCI population. Specifically, the definitions of friendship as well as the importance and general scope of friendship will be discussed as will the functions that friendship holds. Friendships are vague and ambiguous, variable in form and cannot be measured in numbers (Uditsky, 1993). They cannot be compared to other relationships such as family relationships because the relationship rules are different. They are subjective in form and structure (La Gaipa, 1977) as well as definition (Wright, 1985). Sapadin (1988) suggested that friendship exists as both an ideal and a reality. It is typically the ideal rather than the reality that is examined in friendship research. Indeed, Knox and Hickson (2001) suggested that friendships are generally measured according to what the researcher considers to be important about the relationship rather than what the friends consider important. Through discussion of the friendship literature, the relatively aged nature of this literature will become apparent.

The literature examining friendship following SCI is sparse, usually only considered within a broader examination of social support more generally or within the context of peer support that develops between people with SCI during rehabilitation. This chapter will take a closer look at friendship following SCI, with a specific focus on descriptions of friendships following SCI, the known challenges and the impact of friendships on adjustment following injury.

The chapter will also outline the methodological issues inherent in the current SCI research literature as well as those issues that characterise existing research into friendships. Research following SCI is often focussed on recovery and cure, outcomes that are most frequently evaluated using traditional outcome assessment of physical functioning and neurological deficit. This focus has continued to ignore the more esoteric and potentially valued aspects of community participation, such as those offered within friendships. Focus needs to be more clearly directed to those outcomes that are most important to the individual. For the relatively young population of people with SCI, relationships such as friendship are likely to play a significant role in their lives prior to, during and following rehabilitation.

Through this discussion, the need for research that examines friendship following SCI with a focus on illustrating process will be uncovered as will the significance of the current study. There is clearly a need to examine the complexity of friendship as it is deemed to be important by the friends themselves, with a consideration of context, process and the need for theory development. Qualitative approaches to research, particularly those inherent within the grounded theory method are proposed as appropriate means by which to examine friendship and address some of the shortfalls of the existing literature.

Friendship: What is it?

The majority of research on social support has focussed on family members both more generally (e.g., Cutrona et al., 2007; Frain et al., 2007; McConkey, 2005) as well as within the SCI population (e.g., Chan, 2000b; Chan, Lee & Lieh-Mak, 2000b; Murphy, 1999; Pelletier, Alfano & Fink, 1994). Friendships however, are an essential component of social support and one component of social support that has

received comparatively little attention. Friendship relationships characterise some of the unique aspects of being human. What does one really mean when they say 'friend'? Fehr (1996) claimed that "there are as many definitions of friendship as there are social scientists studying the topic" (p. 5). Equally ambiguous are the range of dictionary definitions of friendship (O'Brien & O'Brien, 1993). Definitions of friendship range from formal definitions (Adams, Blieszner & de Vries, 2000; Hays, 1988; Wright, 1984) to lay definitions (Cole & Bradac, 1996; Sokolowski, 2001; Stainback & Stainback, 1990) and from superficial to intimate (Bishop, Jubala, Stainback & Stainback, 1996; Lydon, Jamieson & Holmes, 1997; Maeda & Ritchie, 2003). Because friendship does not involve formal legal obligations (Caroline, 1993; Wiseman, 1986), the term is often used haphazardly in both formal research and everyday conversation. It can include relationships involving short-term, superficial interactions or relationships involving long-standing connections with high levels of commitment (Matthews, 1986).

Despite the multiple and varied definitions of friend, the voluntary nature of the friendship bond appears to be common (Badhwar, 1989; Boydell et al., 2002; Caroline, 1993; Hays, 1988; Palisi & Ransford, 1987; Wiseman, 1986; Wright, 1984). Indeed, psychologists and sociologists have identified a number of qualities that characterise friendships and differentiate them from other types of social relationships. These include stability of interaction over time, reciprocity, exchange of positive affective behaviours, and well-developed negotiation and conflict resolution strategies (Abery & Fahnstock, 1994; Hartup, 1995). Friendships are differentiated from family and other formal relationships because friendship implies equality and voluntary association (Antonucci & Jackson, 1987). Close supportive friendships are more likely to cause individuals to feel valued as a person whereas support from

family members may be viewed as obligatory and taken for granted. Friendship, thus, is an informal and voluntary relationship (Chappell, 1994). Having a friend or friends, therefore, says something about the individual as a person because that person has been chosen from amongst others as special. As such, when information about friendships is considered only within the general context of social support, its true value is hidden.

A united definition of friendship, accepted by all researchers, does not yet exist. However, most researchers tend to perceive friendship as a close, intimate affective relationship between individuals that is based on reciprocity and stable social interactions (Buhrmester, 1990; Hartup, 1992). Friendship throughout the lifespan allows people to exchange mutual caring, emotional support, empathy, liking and intimacy, using skills such as compromise, understanding, empathy, emotional regulation and conflict resolution (Asher, Parker & Walker, 1996; Bauminger & Shulman, 2003; Buhrmester, 1996; Howes, 1996; Newcomb & Bagwell, 1996).

Lutfiyya (1989) concluded that the meaning of any friendship is tied to that meaning which its members give it. Common interests, equality of roles, mutuality, comprehension and conversation are best understood from the perspective of the friends themselves. Outsiders or non-members of the dyad cannot judge or measure the friendship as its participants do. Whether someone can or cannot be called a friend lies in the actual relationship itself (Matthews, 1983). Friends are people that we have feelings or emotional attachments to that only we can know or truly understand (Matthews, 1983). Therefore, when individuals identify themselves as friends, then that joint definition of friend is accepted as valid, regardless of whether they are perceived as friends by others.

The Importance of Friendships

"If I had to choose between betraying my country and betraying my friend, I hope I should have the guts to betray my country."

(Forster, 1962 cited in Long, 2003, p. 73).

The literature is replete with quotes that herald the importance placed on friendship throughout history. Indeed, the importance of friendship has been discussed in writing since at least the time of the Greeks (Gaventa, 1993). As previously identified, friends provide intimacy and affection, help people feel important and valued and provide companionship. Further, our sense of identity, or who we are as a person, is often gained through our experiences with other people, particularly those who have voluntarily associations with us such as friends. Personal accounts of surviving tragedy are often dominated by detailed descriptions of the value of friendships. For example, Mayes (2004) described how she had gradually found a new meaning to life and a new way of living, through her friendships, after 20 years of mental illness. Similarly, Neugeboren (2003) spoke of the healing effect provided by four lifelong friends after his heart attack.

Amado (1993) noted that the impact of friendships is poorly defined, particularly in terms of the more abstract or immeasurable aspects. As Long (2003) concluded, friendship is usually enjoyed in and of itself without needing to meet external standards. As such, friendships are difficult to maintain but perhaps more difficult to describe. Similarly, the personal loss that is experienced through the loss of friends is difficult to quantify. Indeed, Cooley, Glang and Voss (1997) described the loss of friends for children after acquired brain injury as perhaps the most devastating of all changes for the individual.

Although easily taken for granted, the importance of friendship is clearest to those who lack friendships in their lives (Bishop et al., 1996). Stable and rewarding interpersonal relationships are potentially the single most important factor influencing a person's quality of life (Kennedy & Itkonen 1996; McVilly et al., 2006) yet these significant relationships are rare or absent for many people with disability (Duvdevany & Arar, 2004; Fleming & Stenfert Kroese, 1990; Rapley & Beyer, 1996). As such, growing emphasis is being placed on the importance of relationships in the lives of people with disabilities (Knox & Hickson, 2001; Matheson et al., 2007).

Number and structure of friendships

How many friends is enough and what type of friends are best? These are difficult questions to answer as the need for friendship as well as access to friends is an individualised thing (Boydell et al., 2002). What clearly emerges from this literature is that the number of friends or the proportion of friends within networks must be considered in addition to network size for people with disabilities (Meeks & Hammond, 2001; Zencius & Wesolowski, 1999).

For most of us, friendships are clearly linked to our life phase where the number and structure of our networks follows a developmental trajectory. Unfortunately, in this area, the literature is characterised by a focus on two opposite ends of the life span, namely childhood and adolescence and the elderly. Unlike family ties, friendships are the result of free choice, primarily among individuals of like age and gender who have similar areas of interest.

Regardless of the level of closeness or intimacy, Litwin and Landau (2000) showed that friendship support is more limited in the elderly than that provided by family groupings, regardless of how close such friends may be. Although there is

some suggestion in the literature that older people can substitute for absent family relationships with close friends (fictive kin) (MacRae, 1992), problems associated with aging often make it difficult for friends to honour commitments in maintaining reciprocity and equality of roles. Subsequently, unlike family ties, which remain fairly consistent through old age, contact with friends can be subject to more variation (Mullins & Mushel, 1992). Because there are no socially defined norms or expectations about what the friendship role should entail, relations with friends often require greater initiative that is difficult for the older person to offer. Although some conditions such as health problems, transportation and retirement associated with aging may make interaction difficult (Allan & Adams 1989), some older adults do manage to maintain friendships for many decades (Shea, Thompson & Blieszner, 1988).

For the young person, developmental changes have been the focus of some research. Although parents continue to play a significant role in the support of young people, both theory and research have suggested that, by young adulthood, most individuals have begun to replace parents with peers (e.g., friends, dating partners) as primary supports (Carbery & Buhrmester, 1998; Vandell, 2000). Friendship has been linked with identity (Allan, 1998) and personal networks of friends will change as people's interests, commitments and identities change. Subsequently, these ties will not themselves be stable. Indeed, Rose and Serafica (1986) found that many of the young adults they studied had lost at least one close same-sex friend in the past five years. Despite the fact that particular friendships will likely disappear as people's circumstances and interests alter, the role of friendship itself remains important.

Researchers specifically interested in adult friendship have conducted a handful of studies examining differences in friendship patterns across different stages

of adulthood (Blieszner & Adams, 1992; Carbery & Buhrmester, 1998; Hess, 1979; Oswald & Clark, 2003; Rose, 1984). Most of these studies have focused on age-related differences in the more objective aspects of friendship such as the number of friends and the frequency of contact with friends. The focus of these studies has been on four particular life stages, namely high school, newlywed, middle-age, and pre-retirement. This research has found a slight increase in the number of friends, but a decrease in the frequency of contact with friends between high school and the newlywed stages. Similarly, it has been found that marriage can lead to an increase in the number of friends but friends gradually tend to decrease over the rest of the life course (Carbery & Buhrmester, 1998).

While there is a lack of stability in friendships over the course of an entire life, it is also likely that friendships show significant change over the short term, particularly following significant life change (e.g., illness, disability or divorce). Indeed, any significant life event may present potential challenges to the friendship because there is no filial or cultural obligation associated with the bonds in that relationship. However, some research has shown that individuals can maintain friendships in the face of these adverse events. For example, Vandehey (2003) compared the frequency of contact with friends and other relations throughout the illness trajectory following HIV/AIDS and found that frequency of contact was similar across the stages of illness and over time. In fact, 'very supportive' ratings increased from 76% to 81% over the two-year time period despite illness progression.

Forrester-Jones et al. (2004) suggested that, although for people with disabilities their friendship networks often remain low over time, positive life change such as gaining employment may facilitate expansion of those networks. Indeed, these authors found that network size increased significantly for people with intellectual

disability in situations where employment was gained. Unfortunately, increases were restricted to network members from those community or work contexts (i.e., expansion of friendships networks outside of these contexts did not occur). For other populations such as those who acquire disability as an adult, the changes in support networks can be substantial. For example, social isolation is a major problem following traumatic brain injury in both children and adults. Kozloff (1987) followed 14 adult patients, finding decreased social relationships and increased feelings of isolation over time. She suggested a decrease in the number of friends and the frequency of contact with those friends inevitably leads to social isolation. Cooley et al. (1997) discussed a similar situation for children with traumatic brain injury.

Functions of friendships

The functions of friendship are numerous and can be global or specific. Functions are the work of friendship or what it is that friends give us that ultimately impacts on our well-being. For the purposes of outlining the depth and breadth of friendship functions, a total of 17 different functions have been reported across the literature, namely 1) social support (emotional, practical, informational) (Carbery & Buhrmester, 1998; Dykstra, 1993; Sandstrom, 1996); 2) affection and intimacy (Monsour, 1992; Rose & Serafica, 1986; Shea et al., 1988); 3) self definition and identity (Amado, 1993; Hanna & Berndt, 1995; Neff & Harter, 2003); 4) acceptance and feeling valued (Amado, 1993; Argyle & Henderson, 1984; Gaventa, 1993); 5) validation of thoughts (Mendelson & Aboud, 1999; Vandell, 2000); 6) managing emotions and reassurance (Adams & Plaut, 2003; Oswald, Clark & Kelly, 2004); 7) testing and benchmarking (Aleman, 1997); 8) companionship (Jones, 1991; Mendelson & Aboud, 1999; Morgan et al., 1997); 9) dependability (Buss, 2000;

Maeda & Ritchie, 2003; Parks & Floyd, 1996); 10) source of mutual knowledge (Cole & Teboul, 2004; Planalp, 1993); 11) skill enhancement (Aleman, 1997, Buss, 2000); 12) shared activities (Cole & Teboul, 2004; Vaux, 1988); 13) complementary source of ideas (Lippit, 2007; Neff & Harter, 2003); 14) respite (Aleman, 1997); 15) advocacy (Amado, 1993); 16) protection (Mendelson & Aboud, 1999); and 17) conversation and communication (Burleson, Kunkel, Samter & Werking, 1996; Deutsch, Sullivan, Sage & Basile, 1991; Henderson & Gilding, 2004)

Friendship Following SCI: A Forgotten Relationship

When we consider the issue of friendship among people with SCI, we find that the literature is sparse yet heralds that friendships are an important issue for individuals with SCI. In a study examining quality of life for 547 community-dwelling adults with SCI, participants listed in decreasing order of importance 6 key factors that contributed significantly to quality of life, namely health, family, relationship with a significant other, friends, material comforts, and passive leisure (Boschen, 1997). Changes, both positive and negative, in friendships and relationships have been reported consequences of SCI (Boschen et al., 2003). As a result of sustaining a SCI, most individuals reported a substantial decrease in social interactions with friends (Taricco et al., 1992). As such, the comparative lack of research interest in friendships appears perplexing but may relate to assumptions made about friendships on the basis of quality of life research indicating high satisfaction with family relationships, living arrangements and social life (Dijkers, 1997).

Chan (2000a) however, reported that often persons with SCI experienced dissatisfaction with and declines in social role functioning and activities. There was a

change in the structure of their friendship network from people without disability to mostly people with disability. Chan proposed several potential explanations for these changes in friendship, namely a lack of motivation from the person with SCI, isolation from the general public, exclusion from social gatherings, and rejection from friends. They were 'isolated from the 'real' world or forced into the 'disabled' population' (p. 772). Indeed, in a controlled study, Kemp and Krause (1999) found that a non-disabled group rated many aspects of their lives considerably higher than the disabled group, namely health, health care, finances, friendships, work or time use and overall life.

Furthermore, involvement in activities where friendships are typically fostered has also been shown to significantly decrease following SCI. For instance, Tasiemski et al. (2005) found that the numbers of hours participating in sports decreased significantly after injury with a greater decrease in numbers participating in team sports in comparison to those participating in individual sports. These same researchers however, found that the highest level of satisfaction existed within social domains such as family life and contacts with friends whereas the lowest level of satisfaction related to the participant's sexual life and vocational status. Benony et al. (2002) found that individuals with SCI received more social support from people in general and from friends than controls.

In what appear to be contradictory findings, Parrott et al. (2000) found that friends afford opportunities for persons with SCI to reduce uncertainty about living with their injuries and how injury will impact personal relationships. However, they do suggest that pre-injury friends do not share the experience of being disabled, have little or no knowledge about SCI and evaluate the relationship through the bias of their previous experiences with the friend. As a result, they suggest that SCI often

leads to termination of the relationship. In summary, the impact of SCI on friendships remains unclear, compounded by contradictory findings. Further development of this evidence base is required, with specific attention needed on defining what it is about friendship that is being measured and how important that is to the person with SCI.

Impacts on adjustment to SCI

Lacking good friendships has been associated positively with loneliness (Parker and Asher, 1993; Hanna & Berndt, 1995) and negatively with life satisfaction (Kemp & Krause, 1999). Antle (2004) examined the correlates of global self-worth for 85 young people (ages 8-23) with spina bifida (a condition present at birth) or SCI (an acquired condition). Significant correlations were found between the perceptions of self-worth and age and the perceived social support of close friends. Danner and Radnitz (2000) found that the most consistent predictor of PTSD symptomatology was perceived social support from friends. However, perceived social support from friends did not predict PTSD diagnosis. Among the facilitators to adjustment and community integration identified by some people with SCI were support (emotional, financial and physical) provided by family and friends and mentoring offered by peers (Boschen et al., 2003).

Indeed, above and beyond the limited literature base on pre-existing friendships and their path following injury, peer support deserves special mention because it has been widely used in SCI rehabilitation and broader rehabilitation arenas throughout the world as a mechanism by which friendship can be encouraged. Manns and May (2007) discussed the mentoring offered by peers as an important information delivery strategy for people with SCI. Indeed, people with SCI sought both causal and formal mentoring relationships along the continuum of care. Basic survival skills can

be learnt in the supportive and encouraging atmosphere of most spinal units where role models and peers assist newly injured persons (Claesson, Sullivan & Siosteen, 1999). In a convenience sample of 7 mentees from a hospital-based SCI peer-mentoring project, Veith and colleagues (Veith, Sherman, Pellino & Yasui, 2006) found that mentees emphasized the importance of the mentor in providing practical, emotional, and identity-changing support. The mentor-mentee relationship was influenced by factors such as age and perceived friendliness but was formally defined in terms of five components of the relationship, namely credibility, equitability, mutuality, acceptance and normalization. This differentiated mentoring from other supportive relationships that exist both pre- and post-injury. These researchers concluded that because peer mentors provide unique supports not replicated by other relationships, the peer support relationship was quite distinct from that of existing friends. Subsequently, efforts to utilise peer support to substitute for existing friendships are likely to be ineffective. Indeed, Sherman et al. (2004) supported the contention that although peer support was related to improved occupational activity and life satisfaction following SCI, the support people received from different support sources held different meaning for the individual and impacted in different ways throughout the rehabilitation process. Similarly, in a study of peer support following traumatic brain injury, Hibbard et al. (2002) found that, although peer support was important to people, it did little to enhance supports provided through other sources, including support from friends. Wu and Williams (2001) however, did find that friends and peer supports were more influential as socialising agents than rehabilitation professionals.

With consistent support for peer mentoring and peer support programmes being provided, unmet needs for peer recreation and peer support groups remain

(McAweeney, Forchheimer & Tate, 1997). For some, peer supports will only be of benefit where offered informally within the rehabilitation environment, underscoring the fact that rehabilitation programmes and community services must offer both informal and formal peer support opportunities to facilitate the adjustment process (Boschen et al., 2003).

The focus on supporting existing interpersonal relationships such as friendships has received much less attention in the published literature than that of peer support. Anecdotally, Gill (1999) described how changes emerged between friends who had interests and activities they enjoyed together prior to the injury. After injury, they often struggled to identify anything in common. This phenomenon within interpersonal relationships can take on different forms: 1) the SCI person's acceptance or rejection of such relationships or 2) the friend's acceptance or rejection (Gill, 1999). A study by Brillhart and Johnson (1997) concurred by suggesting that people with disabilities often delayed socialising on return to their communities because of embarrassment but that family played an important role in facilitating socialisation at this time. Similarly, they identified that friends may feel uneducated about SCI, resulting in feelings of discomfort during interactions and subsequently avoidance of those interactions. It is in these instances that misperceptions about disability may emerge.

By far the most frequently cited research and clinical social support interventions have not addressed relationships such as friendship but have been related to family caregivers among populations such as people with cancer (Case, 2006; Ell, Nishimot, Mantell & Hamovitch, 1988) and people with mental illness (Cleary, Hunt, Walter & Freeman, 2006). Similarly among people with SCI, a parallel situation exists. Family is central in the networks of most people and therefore

inevitably family has a large impact on well-being in the context of hospitalisation. Individuals may be affected significantly when expectations of support from family are not forthcoming because they believe that family will always be there. In contrast, friendships are voluntary and it is unknown, especially in the context of hospitalisation, whether the expectations that are held of friends are lower. There is a paucity of research that informs this topic. Despite the important role of families in the rehabilitation process for individuals with disabilities (Frain et al., 2007), it is argued that friends play a different but equally important role, yet are rarely included in the rehabilitation process. Clearly, a greater understanding is needed of the challenges inherent within friendship research following SCI, particularly given that this research can act as a platform on which to build future efforts in this area.

Friendship research: needs and challenges

There is a paucity of relevant literature investigating friendship processes following spinal cord injury (SCI). Although significant research has been conducted in the area of assisting friendships for children with developmental disabilities (e.g., Amado, 1993; Cooley et al., 1997), adult friendship following disability is largely ignored within the rehabilitation literature.

The need for identification and measurement of social outcomes after SCI

Many of the challenges for people with SCI relate to the medical focus of rehabilitation. The dominance of physical research in the SCI literature 'reflects its palpable nature, coherent systems, relatively long tradition and preferential status within the medical, academic and funding establishments' (Asher, 2003, p. 16). The underlying assumption of the medical model is that an individual needs treatment for any difficulty that compromises normal functioning and/or causes discomfort. This

focus on the physical has resulted in a situation where the rehabilitation system continues to respond to psychological and social issues in a post-hoc manner. Interventions are reactive rather than preventative, occurring only at the time of crises. By this time, deterioration has already occurred (Jochims, 1995). Hammell (2007a) identified the three fundamental problems with traditional rehabilitation as the preoccupation with the physical dimension of SCI; the lack of attention to individuality; and the failure to prepare clients to meet the needs of the real world. Inherent within these fundamental problems is a lack of attention to relationships, particularly those that are not formally recognised within the rehabilitation system, such as friendships.

Research following SCI is often focussed on recovery and cure using outcome assessment of physical functioning and neurological deficit only. Research conducted since the World Health Organisation models of functioning (WHO, 1980; 2001) were developed, has addressed social concepts such as handicap and participation. However, this focus has continued to ignore the more abstract and potentially valued aspects of community participation, such as those offered within friendships.

Even where advances have been made in examining outcomes related to community integration and participation, the majority of these studies focus on limited aspects of community integration, such as marital status, leisure activity participation, or frequency and diversity of activities. Indeed, Dijkers (1998) highlighted that community integration is complex and multifaceted and this has not been reflected in the research to date.

Dijkers et al. (2000) argued that, although difficult to assess, social outcomes are critical once rehabilitation clients return to the community. The difficulty in assessing what is "normal" for relationships with others, lies in the tendency of the

research to make comparison of outcomes with able-bodied populations. Comparing pre- and post- injury status may be a better way to evaluate the success of rehabilitation but this does not account for changes in people or their priorities over time. This approach is also fraught with challenges because individuals may not recall the nature of their friendships prior to injury (Dijkers et al., 2000).

Rather than measuring relationships according to what a researcher or clinician believes is 'normal', exploration of relationships for people with SCI following injury needs to be focussed on what the individual subjectively sees as a normal level of functioning for them in their current life context (Dijkers et al., 2000). Our focus needs to be drawn to those outcomes that the individual judges as most important. For the relatively young population of people with SCI, relationships such as friendship are likely to play a significant role in their lives prior to, during and following rehabilitation.

Friendship research in clinical populations

Although little research within the SCI population has considered the topic of friendship, exploration of adult friendships has revealed some interesting findings in other populations. Ognibene and Collins (1998) found that secure individuals perceived more available support from friends and sought social support from friends more often than insecure individuals. However, friendship patterns have been found to be strongly influenced by a range of structural and contextual contexts (Dugan & Kivett, 1998). Perceived equity in friendship maintenance behaviours as well as factors such as positivity, supportiveness, openness and interaction have been identified as key considerations (Dugan & Kivett, 1998). Deterioration of the relationship between friends is likely to occur in situations where there are changes in

personality, distracting life events, conflicting expectations of friendship, variable life circumstances and betrayal (Oswald et al., 2004). Furthermore, Sias and colleagues (Sias, Heath, Perry, Silva & Fix, 2004) proposed that avoidance of discussion about important topics is characteristic of the friendship deterioration process. When considering this literature and extrapolating to the contexts of people with SCI, it becomes clear that these factors involved in friendship maintenance and deterioration may be particularly relevant to people with SCI throughout their life. Extended periods of separation from friends and dramatic personal changes for the injured person may mean that the injured individual has difficulty exhibiting reciprocal maintenance behaviours and is contextually exposed to factors that may heighten the risk of friendship deterioration.

Some literature has started to address the topic of friendship and recognise the contributions of some of these factors within clinical populations such as people with traumatic brain injury. Paterson and Stewart (2002) highlighted the importance of an individual's perception of their social being and their expectations related to this. Furthermore, they suggested that redefining the self following injury was particularly important in terms of social support and integration. A recent phenomenological study conducted by Jamieson et al. (2005) identified important implications for friendships in terms of acquiring an injury, living with an injury and actions that were considered helpful. This research has led to the development of a larger intervention study but this study is only in its infancy however.

The broader adult friendship literature

Where the literature on SCI rehabilitation is steeped in the medical tradition, the general literature on friendship has typically existed within the domain of psychological and sociological research. The friendship literature has rarely focussed

on clinical populations. Indeed, a large proportion of the adult friendship literature has been conducted with university populations (e.g., Cole & Bradac, 1996; Parker & deVries, 1993; Shackelford & Buss, 1996) or the elderly (e.g., Dykstra, 1993; Matthews, 1983; Reinhardt, Boerner & Benn, 2003). Although the friendships of children with disability, particularly those with developmental or intellectual disabilities have received some attention (e.g., Longoria & Marini, 2006; Weiserbs & Gottlieb, 2000), this has not been applied to adults with disabilities. As such, not only is there a paucity of research that links these bodies of knowledge, this task will not be easy given the vastly different paradigms within which they have emerged.

The preponderance of friendship research has been conducted on child and adolescent samples leading to a great deal of evidence about supporting relationships in school settings. However, adult friendship has different characteristics to young people's friendships. Adolescents' friendships are generally centred on school or neighbourhood whereas adults are often characterised by geographical dispersion (Sapadin, 1988). The psychological and sociological literature on adult friendships is often limited in focus and rarely considered from a developmental perspective (Neff & Harter, 2003; Weinstock & Bond, 2000), something which has been achieved much more effectively within the childhood literature on friendship. Adult friendship was traditionally treated as merely an attribute of individuals in earlier studies (Blieszner & Adams, 1992) but has recently been recognised as a relationship of significance. Further, when friendship has been studied, attention has usually been paid to only one dimension of friendship. For instance, several studies have examined intimacy (e.g., Monsour, 1992; Parks & Floyd, 1996). Others have examined the frequency and quality of contact with friends (e.g., Ennet & Bauman, 1996; Way, Cowal, Gingold, Pahl & Bissessar, 2001). Rarely are friendship processes in their entirety examined.

The failure of studies to consider friendship in its entirety may relate to the fact that studies have often utilised different definitions of friendship, or not defined friendship at all. Some authors focus on only one aspect of the experience of being a friend and having a friend (Lea, 1989), failing to recognise the multi-dimensional nature of the experience. For instance, Savin-Williams and Berndt (1990) noted that researchers have seldom distinguished between the number and quality of friendships in their studies. In addition, there has been little differentiation between the different levels of friendship. Researchers' attention has focused on the structure and phases of same-sex friendships (Neff & Harter, 2003). In other instances, the focus has been on the relationship between objective characteristics of friends such as the number or availability of friends or social integration. Other foci have included the degree of similarity between respondents and identified friends (Matthews, 1983). As noted by Carbery and Buhrmester (1998), research has, by and large, been conceptually limited to asking participants to identify who provides instrumental, informational and emotional support, in times of stress.

In contrast to this view, friendship is a complex construct that occurs dynamically across multiple contexts. This lack of clarity and narrow focus within friendship research is caused by and contributes to conceptual and theoretical confusion (Weinstock & Bond, 2000) and leaves many questions unanswered about the friendship process. Why do friendships dissolve? What are the strategies used by individuals to maintain friendships in the context of significant life events. Existing studies tend to identify only one or two potential predictors of friendship. Hobfoll (1990) suggested that the range of factors that are often considered confounding variables may be important in and of themselves and useful for representing the process by which social support is sought and received. He suggested that differences

in outcome are potentially confounded because of the complexity of the contexts within which friendship occurs. The challenges for friendship research therefore clearly surround three distinct but related needs, namely the need for recognising the importance of context, the need for understanding dynamic friendship process, and the need for a parsimonious complex theory. The final challenge for friendship research lies in its potential to capture personal meaning, articulating friendship in ways that are meaningful to those involved.

The big picture: the importance of contexts and their influence on friendship

According to ecological systems models, specific contexts have an impact on people's behaviours, which, in turn, are affected by their experiences in other contexts (Noonan, Tennstedt, & Rebelsky, 1996). Chappell (1994) argued that any examination of social relationships must include an analysis of the constraints these relationships face. Scant attention has been paid to the constraints imposed by context on social support (Parks & Floyd, 1996) or the specific situational factors that are predictive of social support (Hobfoll & Stokes, 1988). Indeed, much of the research on personal relationships has tended to ignore the social context in which a given friendship is embedded (Duck, 1993; Parks & Eggert, 1991). When influenced by the contexts within which they are constructed and maintained, friendships cannot be based solely on individual choice and ongoing commitment (Allan, 1998). Evident in the literature is a clear gap in describing friendships within the contexts that they occur.

Therefore, in order to understand friendships and outcomes following SCI, a study of the contexts within which they occur is imperative. There is a tendency in the social and behavioural sciences to focus on personality and individual traits (gender,

race, education level) as predictors of outcomes. However, these cannot explain the complexity of rehabilitation and the journey that individuals and their friends follow after injury. Indeed, to the contrary, Dijkers (1998) suggested that these predictors divert attention from an exploration of environmental issues such as social support, personal assistance services, architectural barriers, economic disincentives, attitudes and discriminatory practices that have potentially greater explanatory power. In other words, community integration and participation in friendships is facilitated by factors other than impairment or disability per se.

A body of evidence is emerging that outlines the range of different contexts that could, or should be considered in the study of friendship. Indeed, the impact of context operates at different levels over time, influencing both patterns and forms of friendship. 'Context' is a complex concept that is not easily defined. It incorporates everything around a relationship that contributes to its development, maintenance and dissolution (Adams & Allan, 1998). According to Allan (1998), an exploration of context within research on personal relationships will facilitate the integration of the existing fragmented literature across a variety of disciplinary areas.

Badley (1995) categorized contextual factors into three broad groups namely the physical environment, the social situation, and the resources available to individuals. Verbrugge and Jette (1994) identified extra-individual, intra-individual and risk factors whereas Wang, Badley and Gignac (2006) identified four types of factors based on how they affected the process, namely moderating, mediating, independent and confounding factors. Adams and Blieszner (1994), on the other hand, identified structural, cultural and historical contexts as being important for consideration. For the purposes of the ensuing discussion, contexts have been categorised as they relate to the environments of people with SCI, namely relationship

contexts, socio-political contexts and geographic contexts as well as the rehabilitation or service system context.

Relationship context

The study of friendship requires attention to multiple levels of analysis, as well as the specific relationship context (Hanna & Berndt, 1995). House (1981) discusses three categories to consider in any examination of social support, namely the characteristics of specific individuals that facilitate or impede their ability to give or receive support, the properties of the relationships themselves that may facilitate or inhibit the giving or receiving of support and the social or cultural conditions that foster or impede the giving or receiving of social support. Similarly, Dunkel-Schetter and Skokan (1990) suggested that stress factors, recipient factors, relationship history and provider factors are equally important. The context of the relationship itself is an underlying similarity across these typologies. In choosing a friend or friendship group, we also inherit the context in which we will learn skills, influence others, and are influenced by others (Urberg, Degirmencioglu & Tolson, 1998).

In examining what is meant by the relationship context, researchers have referred to the notion that there is more than one party involved and therefore more than one perspective to consider. Assessing both individuals in a relationship provides a deeper understanding of friendship processes (Oswald et al., 2004). Although traditionally support has been considered from the recipient's perspective, it is equally important to include the perspective of the provider as well as the interaction between the two (Schwarzer & Leppin, 1991; Schwarzer & Weiner, 1991). It is important to understand the relationship between the thoughts, feelings and behaviours of both friends (Oswald et al., 2004). Indeed, friends may differ in their agreement about the existence of friendship (Adams & Blieszner, 1994), the level of intimacy involved

(Williams & Solano, 1983) and the patterns of give and take over time within the friendship. Although friendship researchers have recognised the importance of examining the dyad rather than the individual alone, the reality exists that very few have looked beyond the individual response to friendship. The most effective way to access the relationship exists in the exploration of the perspectives of both participants about the friendship as well as the everyday talk that occurs within the friendship (Hanna & Berndt, 1995).

Related to this is the distinction between having a friend and being a friend (Davis & Todd, 1985). Although support has been studied more from the perspective of the recipient rather than that of the provider (House, 1981; Dunkel-Schetter & Skokan, 1990), each individual has similarities and differences in how they define the nature, meaning and functions of that friendship. The essence of friendship lies in the perceptions of self and friend in the context of their specific real-life relationships (Lea, 1989). Different people get different things out of friendship and equally what one gives to a friendship is different for different people. Although reciprocity appears essential to some degree, the extent to which each person gives to and takes from what is offered in the friendship will be perceived differently by different members of the friendship (Lea, 1989).

There are a number of levels at which relationship contexts may vary including closeness, expectations, comfort, disclosure, activities, work and commitment, insight and recognition, relationship style, values, skills and perceptions of quality. Each have been examined and included in studies but typically in isolation. Not everyone is a close friend and the closeness of that friend will have a significant impact on the nature of that friendship. Similarly, friendships experience different

demands created by the expectations in the relationship (Duck, 1983), often based on culture and experience (Brock, Sarason, Sangvui & Gurung, 1998).

The degree to which people feel comfortable within a friendship and the freedom this comfort gives them to be their true self is an important dimension of the relationship context. Among individuals with disabilities in particular or other minority groups, one or both friends may feel discomfort caused by stigma or societal expectations (Thompson, 2000). The degree to which each member of the friendship will utilise disclosure within the friendship and about the friendship to other parties may also vary (Duck, 1983).

The nature of friendship is expressed not only through different levels of closeness, comfort and disclosure but also through the range of activities and situations that are considered typical for those friends (Duck, 1983). Although our feelings about a friendship may influence the activities that we perform together as friends, equally the activities that we perform may dictate the feelings that we have about the friendship, thereby determining the patterns of behaviour that are used by friends in seeking and participating in these activities.

Some people struggle in relationships because they lack awareness of the demands and limits or boundaries of the friendship. An important aspect of the relationship context is the recognition of and insight friends have into their social interactions (Duck, 1983). An important skill to acquire and develop, then, relies on being able to recognise situations that are appropriate to that particular relationship, remembering that these may differ across relationships. Some people may adopt standard relationship styles within the context of all of their friendships whereas others may have relationship styles that vary significantly depending on the

friendship. Neff and Harter (2003) found that the costs and benefits of each relationship style change across different relationship contexts.

The level of familiarity between friendship dyads and the level of social skills that each brings to the relationship are also important aspects of the relationship context. Past research has shown that newly formed friendships may experience a honeymoon period because they lack familiarity with each other. Conflict rarely occurs during this phase but escalates as people become more familiar and comfortable expressing themselves within the friendship (Furman, 1984; Hanna & Berndt, 1995). The skills that are most important for forming supportive friendships may differ from those needed for maintaining friendships (Buhrmester and Furman, 1986; Duck, 1983). Therefore the skills that each partner brings to the friendship form an important dimension of that relationship context.

Aspects of the relationship context are not merely limited to the dyad itself however. A person's broader social network may equally influence perceptions and receipt of support (Laireiter & Baumann 1992; Veiel & Baumann, 1992). Carbery and Buhrmester (1998) suggested that friendship has rarely been studied in the contexts of these other relationships. It is likely that friendships change with the addition of other roles such as those of the family. Adult friendships, marriages and other relationships cannot be separated from the highly interdependent context of the broader social network within which these relationships occur. Therefore, we cannot consider one relationship in isolation from those that surround it (Carbery & Buhrmester, 1998). As such, we need to extend our research beyond the dyad alone, considering how it is embedded in larger networks of social relationships with family, neighbours and organisations (Baxter & Montgomery, 1996, Braithwaite & Baxter, 1995; Duck, 1983).

Social and political contexts

Vandell (2000) supported the contention that dyadic experiences are not limited to the dyads in which they occur. Multiple relationships are important because they meet different needs. As such, friendship is also related to the larger social and political context as well as at the individual interpersonal level. Multiple aspects of the social and political contexts appear relevant to consider. Firstly, at a broad level, there are contextual considerations attached to culture and social movements. Friendship may be reflective of broader societal structures (e.g., collectivism or individualism) (Burda, Vaux & Schill, 1984; Gonzalez, Moreno & Schneider, 2004; Vaux, 1988; 1990). Patterns of friendship result from the interaction between stable (e.g., social structure) and dynamic (e.g. social movements) cultural worlds (Adams & Plaut, 2003; Allan, 1998).

At a more 'local' level, contextual factors such as discrimination and stigma, policy and social status may be particularly influential when examining friendships following disability. For instance, due to the stigma and fear surrounding the condition, people with HIV/AIDS have felt significant impacts on their friendships and their subsequent levels of loneliness (Rokach, 2000).

For people with disabilities, current policy directions may impact directly on friendships, with their increasing emphasis on the inclusion of people with disabilities through informal care and social relationships. Although the existing range of policies and programs seldom offer people with disability the flexible personal assistance needed to pursue activities with friends (O'Brien & O'Brien, 1993), emerging policy directions may have a beneficial flow-on effect for the social relationships of people

with disability. The possible effects of policy change remain to emerge within the literature.

For many people with disabilities, their socioeconomic situations and subsequent social status is often challenged, with significant implications for their informal relationships. Poverty, for example, limits not only the extent to which people can do things with friends but also the feelings of shame they may experience when associating with people who were once perceived to be equal peers. The loss of vocational roles often signifies the loss of one of the primary avenues for meeting people and establishing new connections. Both unemployment and poverty may compromise individual feelings of confidence and self-esteem required to form new relationships or maintain existing relationships (O'Brien & O'Brien, 1993).

Social settings such as those offered by work, leisure, parenting or retirement are important contextual factors to consider in the examination of friendships. For instance, whilst work will not guarantee social relationships, it provides the opportunity to meet other people and thereby maintain network size (Forrester-Jones et al., 2004; Riches & Green, 2003). Stewart (1985) argues that the significant amount of time in work offers opportunities for individuals to develop familiarity through the sharing of common experiences, concerns, language and culture. New friendships develop with the appearance of new needs and with the entrance of the individual into new social settings such as the rehabilitation setting. Friendships are organized and constructed by the people present in any particular social setting (Sapadin, 1988). Other researchers have highlighted that the removal of individuals from social settings can have particularly deleterious effects on friendships, such as when women experienced social dying while living at home with a terminal illness (Young, Bury & Elston, 1999).

Geographic contexts

Accessibility to different environments may affect how people with disabilities perceive themselves and how others regard them, highlighting the potential difficulties and limitations that may be placed on the friendships of people with disabilities when separated by geographic location. Indeed, Skär (2003) found that adolescents with disabilities saw themselves as any other teenager in physical surroundings where accessibility was good (e.g., in the home). However, inaccessible social environments were created by inaccessible locations and facilities. For example, inclusive schools have been found to foster friendships (Stainback & Stainback, 1990). Similarly, McVilly et al. (2006) found that the settings within which individuals lived were more significant predictors of friendship activities than any individual characteristics. Tzonichaki and Kleftaras (2002) suggested that architectural modifications can facilitate social interactions by improving physical access and community mobility for people with SCI. Similarly, opportunities for social interaction and the development of friendships have also been found to be influenced by other aspects of the habitat, such as patterns of community housing (Hays & Oxley, 1986).

The rehabilitation and service system context

Any investigation of friendship following injury, chronic illness or disability would not be complete without a consideration of the ways in which the rehabilitation and service system context influences friendship patterns. Indeed, when examining

contexts within which friendship occurs following SCI, this may perhaps be the most important context as it is usually unfamiliar to both individuals and has not previously been encountered within their friendship. Friendships and relationships are affected by the ways in which the health, rehabilitation and human services systems interact with their day-to-day functioning (Perske, 1988). Friendship may be one of the most challenging frontiers remaining in rehabilitation confronting healthcare professionals (O'Brien & O'Brien, 1993). Healthcare and rehabilitation professionals are mandated to achieve person-centredness in service provision, addressing the person's specific and holistic situations including their friendships (Leplege et al., 2007). Subsequently, the entire context of the rehabilitation process and the person's unique environment must be taken into account. Although the impact of the service system has often been discussed and researched at a macro level (e.g., policy implications for empowerment, philosophical underpinnings on outcomes), closer examination of the various day to day routines of these contexts have been less forthcoming but will be integral to any examination of friendship following disability.

The need for understanding dynamic friendship process

Parallel to the need for researchers to consider the context within which friendship occurs is an impetus for researchers to become more process-focussed. Outcomes alone provide little understanding of the rehabilitation process, especially the ways in which rehabilitation interacts with the background, life contexts, goals and coping skills of individuals. If we are to truly understand outcomes, we must also understand the process or pathways by which they are achieved.

Indeed, the study of friendship by developmental psychologists has been limited to examining outcomes within structural domains such as the presence, nature

and quality of friendships (Hartup, 1996). Duck (1983) even suggested that researchers have been reluctant to look at what people actually do in friendship (functional/process aspects) for fear that the research will interfere with the relationship. Close friendships involve the complex exchange of many intangible, emotional resources, which have rarely been studied explicitly.

Social psychological approaches to the exploration of friendship focus more specifically on functional and process perspectives of social support, offering access to a variety of existing relationship theories including social exchange theory, social learning theory and social comparison theory that aim to explain what happens within personal relationships (Leiberman, 1986; Stewart, 1993). However, it remains that this research frequently reflects examination of prediction rather than process (Hobfoll, 1990).

Wiseman (1986) proposed that the friendship dyad itself has its own developmental process where the norms and values of each individual friendship take shape during its formative period. This developmental process within the friendship will be paralleled by the developmental life stage of the individuals involved within the friendship. However, much of the literature fails to recognise this because it is focussed on people within similar life phases or fails to take into account the socio-cultural factors that distinguish these different life phases. For example, a person whose injury occurs during adolescence will experience much different impacts on their friendships than a person who sustains their injury when they are married with three children. It is therefore important to consider the life stages of the individuals and the impact of these factors on the friendship itself as well as develop theories that account for and explain developmental context.

Perhaps the most important factor in examining friendship process is that of time. Hanna and Berndt (1995) suggested that people approach their relationships in ways that reflect temporal change. Life events such as widowhood or retirement affect availability and meaning of different types and aspects of relationships (Morgan et al., 1997) and, therefore, represent a factor that will be reflected in friendships. For example, the need for friendship has been found to decline sharply after the age of approximately thirty, except for those people who experience serious disruptions in their life (e.g., divorce or death of a spouse). Given that all personal relationships exist within the confines of time and space, it is not surprising that temporal contexts are important. Indeed, it makes sense that friendship patterns will not remain constant over time (Allan, 1998). Personal networks constantly undergo change. Certain individuals leave a network; others enter it over the passage of time (van Tilburg, 1992). As stated by Matthews (1983), the fact that friendships have a past, present and future is often lost in research that focuses only on those relationships that are currently 'active'.

The literature is characterised by an abundance of cross-sectional views of friendship that do little to explain the processes of commencing, maintaining and dissolving friendships. Most longitudinal studies are relatively short-term and narrowly focused in terms of predictors (Hartup, 1995). As such, they only give us glimpses of what friendship really is. As proposed by Braithwaite and Harter (2000), 'stability is but a momentary transition in a stream of continuous change' (p. 208). There is a paucity of information about the dynamics of friendships (Dugan & Kivett, 1998) and, as such, our understanding of friendship remains tentative.

In 1994, Adams and Blieszner suggested that the friendship literature generally included measures of how often and for how long friendship interactions

occurred, the nature of the interaction and level of reciprocity. This research has revealed that interaction takes place but not the nature of the processes involved. As such, this literature is characterised by detailed description but provides little understanding of process in any theoretical sense.

The most detailed descriptions of the process of friendships have emerged from the literature examining friendships among adults with intellectual disabilities within residential or service systems, although these descriptions of process appear to have emerged from anecdotal observations rather than empirical research. Lutfiyya (1993) described how two individuals undergo a process by which they jointly come to define their relationship as a friendship. She stated that

Over time, the specific events may be lost or forgotten, but something more than the sum of the discrete interactions was created. As the people spend time together, they establish a history of activities and memories. This becomes the friendship, an abstract construction that carries meaning for each person involved... Certain events take place that help the individuals examine and refine their relationship with one another... Friends do not progress through this process of becoming friends and defining the nature of their friendship in the same ways. The process of creating and maintaining a friendship does not always follow a linear progression; that is, the friendship may not move in a straight path from two people getting to know each other to becoming closer as time passes. Some friendships can cool off and/or end, whereas others continue to grow (p.104-105).

The process by which friendship occurs following significant life events such as acquired injury remains unknown and, therefore, deserving of further investigation.

The need for a parsimonious yet complex theory

There is a need for theory, sufficiently complex to explain the context and process of friendship following injury. Indeed, Adams and Blieszner (1994) suggested that one of the more serious problems with much of the friendship literature relates to the fact that researchers often fail to attach theoretical argument to their analyses,

either inductively or deductively. Theoretical statements about personal relationships can be blurred by the lack of clarity in the concepts they contain (Parks & Floyd, 1996). As such, the absence of theoretical reasoning is common because concept definitions remain vague (Stewart 1989; Hutchison, 1999). The benefits of theory lie in its ability to capture the dynamic rather than static nature of friendship, thereby explaining process.

Capturing personal meaning

A complex theory of friendship that explains both process and context will not be sufficient if the true subjective nature of friendships is not captured. Thus, understanding of friendships must come from the personal stories of people, rather than from professional discussions of possible theories devoid of personal meaning. In reviewing literature on friendship, Thompson (2000) noted that most of the research ignored the perceptions of the individual, utilising the perspectives and opinions of able-bodied individuals instead to identify where the difficulties exist. Little research has focused on the meaning and process of friendship from the perspective of individuals involved in the friendship (Matthews, 1983). Although these authors proposed this situation 25 years ago, little has changed when looking at the literature today.

Research is needed to examine the nature of friendship, loneliness and the impact of these on the lives of people with disabilities from the perspectives of the people involved (Hopps, Pepin, Arseneau, Frechette & Begin, 2001; Knox & Hickson, 2001). Therefore, a primary concern of research on friendship must be to gain an understanding of friendship through participatory approaches to research (Barnes, Mercer & Shakespeare, 1999; Oliver, 1996). Indeed, Hanna and Berndt

(1995) agreed that future studies on friendship would benefit from a greater focus on the meanings people place on their relationships and social interactions and how these change over time across different life stages.

Another important consideration for theory development lies in the examination of multiple sources of information reflecting the fact that there are multiple personal meanings of relevance for different stakeholders. Hartup (1995), in describing children's friendships, suggested that multiple sources of information should be used in research, including the 'insiders' views of children themselves and those of outside observers. As such, the consideration of a range of sources of information will give a variety of subjective personal meanings to how friendships are perceived, from positions of varying closeness and various backgrounds.

Qualitative Research: Research for Context, Process, Theory and Meaning

To address the challenges facing friendship research, qualitative research clearly emerges as the research of choice. Qualitative research is ideally suited to explaining where (context), how (process) and for whom (personal meaning) friendships are enacted following injury. Further, inductive approaches are necessary for the development of theory to explain a complex and socially constructed phenomenon such as friendship.

Qualitative research offers the ability to capture real life contextual relevance. Research conducted in laboratory settings or beyond the real life settings of people will not capture the interactive nature of relationships in the same depth (Ahrens & Campbell, 2000). Indeed, Hopps et al. (2001) found that participants in their research wanted to discuss their own experiences and perceived quantitative items irrelevant to their experiences across different contexts. Similarly, Matthews (1983) suggested that

the literature is lacking because it fails to examine friendships in the context of people's unfolding lives. It is imperative that research focuses on the functional and more intangible aspects of friendship, rather than merely the numbers of people within one's social network (Hutchison, 1999).

Further, longitudinal research is one of the most pressing needs in this area. Leiberman (1986) questioned the value of cross-sectional studies in social science research because they lack the ability to capture the complex changing and fluid environment that characterises important social relationships. Longitudinal designs in social support research are important in order to capture the process of social support across time (Hutchison, 1999; Langford et al., 1997).

Longitudinal qualitative research has the capacity to track changes over time in ways that are personally meaningful to the people concerned and within the contexts in which they occur. Carbery and Buhrmester (1998) suggested that the existing literature provides a fairly limited description of how changes in the relational features of friendship are linked to broader contextual issues. Relationships are dynamic, developing and evolving over time and existing research does little to capture this change, often merely studying the outcomes of friendship in isolation from the interactive processes that connect them (Adams & Blieszner, 1994; Elkins & Peterson, 1993). Wiseman (1986) proposed that there are many aspects of friendship that lend themselves to longitudinal qualitative investigation, namely the spontaneity of its development, the idiosyncratic nature of friendship behaviours and the fragility of the friendship bond.

Many friendship researchers have reported findings about the effect of individual characteristics on various aspects of friendship patterns but very few have described the processes underpinning these effects. Duck (1990) likened this situation

to trying to explain the connection between ingredients (inputs) and dinner (outputs) without discussing cooking (process). Similarly, Adams and Blieszner (1994) stated that:

Analyses of friendship must take into account the interacting effects of social structure and psychological disposition as manifested in and expressed through the effects of being a particular gender, age, race and class, in a particular structural and cultural context. One friendship must not be treated as equivalent to another (Adams & Blieszner, 1994, p.180).

For decades, symbolic interactionists, such as Blumer (1969), have emphasized the importance of examining the processes by which personal meanings develop. The underlying assumption of this approach is that human beings act towards others on the basis of the meanings others have for them arising out of social interaction. These meanings are developed and modified through an interpretative process used by the person in dealing with people they encounter (Bell, Pavis, Cunningham-Burley, & Amos, 1998). What clearly emerges is that a study of friendship processes following SCI would be ideally aligned with a symbolic interactionist approach.

Griffin and Sparks (1990b) warned that, in order to adequately capture what is really happening when examining process, pre-empting theoretical rationales must be avoided as they are unlikely to relate to these processes from the outset. Polit and Hungler (1993) also stressed that qualitative approaches to theory development are more appropriate when investigating topics such as social support and friendship. Indeed, many of the shortcomings associated with the social support and friendship literature have been related to its atheoretical nature (Noonan et al., 1996). As such, theories are needed to inform future research and intervention. However, the nature of a good theory and the process of arriving at such a theory is less clear.

A theory is a ‘description of an unobserved aspect of the world and may consist of a collection of interrelated laws or a systematic set of ideas... used to both explain and predict phenomena’ (Siegert et al., 2007, p. 1605). Siegert et al. (2007) identified the necessary components of a good rehabilitation theory that could be equally applied to a good friendship theory, namely explanation of assumptions about human nature and orientations held by rehabilitation systems, factors that have causative impacts and the ability to set clear intervention targets. The current study was initiated with the intention of developing a parsimonious and complex substantive theory to assist in understanding the complex and changing process of friendship following SCI. The ultimate goal of the research was to inform practice through the development of a sound theory.

Given the exploratory nature of the topic, a Grounded Theory design was chosen to investigate friendship processes. Grounded Theory aims to develop an integrated theory that explains behavioural processes (Glaser & Strauss, 1967) and informs clinical intervention. Because the topic of friendship remains largely unexplored, qualitative approaches are appropriate to offer insight into the ‘how’ and ‘why’ of the process of friendship occurs following SCI (Rich & Ginsburg, 1999). Glaser (1992) described Grounded Theory as the ‘systematic generation of theory from data’ (p.12). Theories go beyond mere description of themes, and focus on conceptualisation and exploration of the relationships between emergent themes, thereby identifying the causal assumptions identified by Siegert et al (2007) as being necessary for a good theory.

Summary

Friendship is a significant relationship within which social support is exchanged. Despite the degree of interest in social support as a construct, existing literature has failed to investigate the complexity of friendship. Friendships cannot be measured numerically nor compared to other relationships, such as family relationships, because the societal rules that govern these relationships are different. Friendships are ambiguous and subjective in form and structure.

Knox and Hickson (2001) suggested that friendships are generally measured in terms of what the researcher considers to be important relationship attributes or skills rather than what the person considers important. Although much of the general friendship literature is dated, the paucity of literature examining friendships following SCI is particularly apparent. Much of the research conducted following SCI has focussed on neurological outcome and physical functioning, with comparatively little attention being paid to social outcomes. Furthermore, the existing friendship literature is limited by its lack of focus on personal meaning within friendships, the processes that occur within friendships and the importance of the context within which friendships are enacted. When considering friendship following SCI, there is clearly a need to examine the complexity of friendship as it is deemed to be important by the friends themselves, with a consideration of context, process and the need for theory development. The current study will address this need using a longitudinal qualitative Grounded Theory design.

Chapter 3

Method

There is a growing enthusiasm for qualitative research in the health sciences. This reflects the recognition that traditional quantitative research approaches have rendered client and consumer voices invisible and that they are unable to illuminate the experience of (and thus the appropriate response to) illness, injury or disability (Hammell, Carpenter & Dyck, 2000, preface).

In light of this growing enthusiasm, the client or consumer is informing policy and practice by being empowered as the expert. Hammell and Carpenter (2004) highlighted the role of qualitative methods as a means of exploring the complex issues arising from living with a disability. The current study embraces the client as expert in the research process, not only to illuminate the challenges and processes involved in friendship following injury, but also to provide a sound and relevant foundation for changes in clinical practice and policy.

When seeking to understand the perspective of the insider, qualitative methods are particularly appropriate. Qualitative methods are equally appropriate when context is central to the research question or where the research relates to poorly understood phenomena (Bogdan & Biklen, 1998). Each of these requirements is relevant for investigating the friendship process following traumatic injury. Clients, their families and friends experience multiple unfamiliar contexts that are likely to influence human behaviour, actions and ideas. Indeed, it would not be possible to separate an investigation of friendship from the physical, economic and sociocultural environments within which they function.

Little is known about the issue of friendship following injury. Research has been dominated by a medical model that is centred on assessment of physical functioning and adjustment. There is a growing recognition that disability is merely one aspect or event along the continuum of a person's life. Life both includes and values other roles, including those that are inherent in friendships (Carpenter, 1994). However, little is known about the 'insider' perspective of friendships. Even at an anecdotal level, clinicians rarely incorporate an assessment of friendships into the rehabilitation process. This chapter will describe the grounded theory design that was selected to guide the current study. The chapter will outline the ways in which the sample was drawn to inform theory development and the variety of data collection strategies that were used to ensure the theory was grounded.

Grounded Theory

The tenets that characterise symbolic interactionism are inherently appropriate for the investigation of friendships following traumatic injury. Symbolic interactionism is a theory about human behaviour and an approach to the study of human conduct and group life. It is a dynamic approach, concerned with the meanings of events, the symbols people use to convey those meanings and the way in which beliefs and the meanings they attach to events influences how they act. These meanings are developed through a continual process of interpretation and definition as the individual moves within and across contexts.

The research design most commonly linked with symbolic interactionism is Grounded Theory. Grounded Theory is a qualitative approach to research developed for the purpose of studying social phenomena from the perspective of symbolic interactionism (Bowers, 1988; Glaser & Strauss, 1967). The major assumptions

underlying Grounded Theory are that research involves:

- a) Discovery of social and psychological processes;
- b) Simultaneous data collection and analysis;
- c) Avoidance of preconceived theoretical frameworks, ensuring that both the processes and outcomes of research are grounded in the data;
- d) A focus on theory discovery and development;
- e) Development, refinement and elaboration of conceptual categories through theoretical sampling;
- f) Increasing levels of analytic abstraction (Charmaz, 1995; Glaser & Strauss, 1967)

Stern (1987) claimed that Grounded Theory is best suited to investigations of new areas or topics where little research exists or to gain a fresh perspective in a familiar situation. Furthermore, Strauss and Corbin (1990) emphasised that the method is useful in situations where phenomena are not static but dynamic in response to evolving settings and contexts, requiring responsiveness to change to be built into the research design.

The purpose of this Grounded Theory study was to systematically generate a parsimonious theory that could explain behavioural processes related to friendship following SCI. Specifically, the study aimed to determine the conditions under which friendships existed and changed following SCI, and the actions associated with the maintenance or dissolution of friendship bonds.

The Grounded Theory approach consists of systematic inductive guidelines for collecting and analysing data to build theoretical frameworks that explain the data (Glaser, 1978). Unlike the traditional linear approach taken in quantitative studies, the Grounded Theory processes of sampling, data collection and analysis are dynamic and

cyclical, continuing until the data become saturated and theory emerges. The major assumption of the Grounded Theory approach is that the researcher has as few preconceived ideas as possible (Glaser & Strauss, 1967). A Grounded Theory must be inductively derived from the collected data, theoretically elaborated and judged according to specific evaluative criteria that are most relevant to the Grounded Theory method (Haig, 1995). The goal of good Grounded Theory is the construction of a “parsimonious theory with concepts linked together in explanatory relationships that, in accounting for the variation in the data, explain how participants resolve their basic psychosocial problem” (Schreiber & Stern, 2001, p.78).

In addition to the defining feature of simultaneous data collection and analysis, the Grounded Theory approach includes the use of the constant comparative method, memo writing aimed at constructing conceptual analyses, theoretical sampling to refine the researchers emerging theoretical notions and integration of the final theoretical framework (Charmaz, 1995).

Pluralism and the Grounded Theory Divide

The Grounded Theory approach to research has been plagued by speculation, debate and disagreement surrounding its methods and philosophies. Indeed, a growing literature base describes the pitfalls of the Grounded Theory approach. For example, Becker (1993) identified five major problems or challenges associated with Grounded Theory research;

- a) Using selective rather than theoretical sampling;
- b) Failure to allow the theory to emerge from the data;
- c) Using the wrong theoretical paradigms;
- d) Inappropriate or incorrect use of constant comparison;

- e) Over-reliance on computer programs to identify the core categories based on frequency of occurrence.

Similarly, Wilson and Hutchinson (1996) detailed several common methodological mistakes inherent in using the Grounded Theory approach, namely,

- a) Slurring of qualitative methods;
- b) Generational erosion and methodological transgression (undermining of original tenets of method);
- c) Premature closure (descriptive rather than analytic frameworks);
- d) Overly generic labels that lack substantive application;
- e) Preconceived concepts that fail to recognise context.

Pluralism or method slurring is one of the most confusing methodological traps for the novice researcher (Johnson, Long & White, 2000), Strong criticism has been leveled at researchers who fail to adopt methods in their purest form (Baker, Norton, Young and Ward, 1998). Grounded Theory approaches have frequently been integrated with other methods, leading to complexity and confusion across the various interpretations. However, Johnson et al. (2000) concluded that qualitative methods are more flexible than is often admitted. Pluralism recognises this reality as long as standards are simultaneously implemented to maintain rigour through integrity, clear accounts, reflexivity and critical reflection. Indeed, Layder (1991) suggested that pluralism can enhance both the theoretical and practice relevance of Grounded Theory.

Johnson et al. (2000) highlighted the fact that there is no such thing as the 'right way' to do Grounded Theory, as best evidenced by Glaser and Strauss who later diverged in their opinions about the approach and its application after initially proposing the Grounded Theory approach in partnership. Melia (1996) outlined four

major differences that have emerged between the original founders, namely:

- a) The nature of research question;
- b) The way in which initial coding begins;
- c) The variety in positions on emergence of theory from data;
- d) The notion of saturation of categories.

Melia (1996) suggested that Strauss and Corbin (1990) moved into a post-positivist paradigm and towards more constructivist approaches where objective reality exists, but is viewed differently by different parties. In this sense, Strauss and Corbin (1990) promoted the inclusion of respondent perspectives in analysis whereas Glaser (1978) remained firmly entrenched in the more positivist notion that there is one objective external reality that applies to all situations.

Constructivist Approach

In terms of the degree of constructivist thought that is embedded in Grounded Theory, several researchers have contributed to the expansion and differentiation of the approach. Indeed, there are now a multitude of different perspectives on the tenets and applications of the Grounded Theory approach. The variety of positions that grounded theorists adopt are located at various points along 'a methodological spiral' and are reflective of their underlying ontologies (Mills, Bonner & Francis, 2006, p. 1). In confronting these differences in understanding and applying the approach within the current study, I was most influenced by Charmaz (1995) who proposed an extreme constructivist approach on the constructivist/positivist dimension. Charmaz (2006) described Grounded Theory as being characterised by first hand knowledge of empirical worlds. Her approach recognised multiple social realities that are the products of interaction and mutual development by the researcher and participant.

This approach focuses on a more interpretive understanding of participant meanings (Guba & Lincoln, 1994; Schwandt, 1994). Charmaz proposed that a more constructivist approach to Grounded Theory would use similar tools to more positivist approaches, but in a different way. Specifically, the constructivist approach reaffirms the importance of studying people in their natural settings, inclusive of participant meaning. Common language and socialization inherent in the research process allows for the sharing of meaning (Chenitz & Swanson, 1986).

In exploring my own thoughts on the various interpretations of the Grounded Theory approach, I was drawn most strongly to the constructivist notion that human beings do not find or discover knowledge but rather construct it through their interactions, using new experiences to continually test and modify this knowledge (Schwandt, 2000). In examining my own philosophies of life in general and in relation to undertaking a thesis exploring friendship following SCI, the Constructivist approach, with its appreciation of multiple truths and realities resonated most strongly. Furthermore, my own personal philosophy on needing to share power with participants was acceptable within constructivist enquiry, allowing for mutuality between the researcher and participants in the research process. I did not just want to be an objective observer. Further, I respected and valued the constructivist perspective that we are all influenced by our history and cultural context, which in turn shape our view of the world and our meanings of truth.

In applying a research methodology, I could not completely remove the views of reality that had developed for me through my own historical personal, cultural and clinical context. This context has been described in detail in Appendix A and is intended to be read as a prologue to the research. Equally, my participants could not remove their realities from the environmental contexts of the hospital and

rehabilitation. The key issues for me to consider in applying this constructivist approach to Grounded Theory was how I would ensure mutual construction of meaning during interviews and a meaningful reconstruction of their stories into a theory (Mills et al., 2006), while still maintaining some objectivity. I will outline and justify the methodological decisions I have made throughout the next two chapters, and how I have managed to adhere to constructivist principles while applying more traditional aspects of the Grounded Theory approach. I recognised that the data I collected would not provide a single view of reality but multiple realities that would emerge from the interactive process as well as the temporal, cultural and structural contexts within which that interaction took place (Charmaz, 2000). This approach would also be the only way I could find theoretical sensitivity, heightening my own level of insight into friendships, my awareness of the complexity underlying the words and actions of participants and my ability to reconstruct meaning from the data generated in that interaction with the participants (Strauss & Corbin, 1998).

The use of a constructivist Grounded Theory approach resulted in the development of an integrated substantive theory that recognised the multiple voices and realities for people with SCI and their friends, as well as providing a clear direction for intervention and improvement of clinical practice. In order to more clearly inform clinical practice in this area, the level of theory remained substantive, and therefore relatively limited in the range and scope of concepts it addressed that were situated in the particular context of SCI rehabilitation.

Sampling in Grounded Theory

A total of 60 interviews were conducted across several groups of participants, including 19 people with SCI, 8 of their friends, 3 family members and 10 hospital

and community rehabilitation staff. Of the 19 individuals with SCI, 4 completed one interview only, 11 completed two interviews only and 4 completed all three interviews. Of the friends, 7 completed one interview and 1 completed two interviews. Family and rehabilitation staff completed one interview only. Additional data was collected through published literature, SCI network publications, personal biographies and websites discussing friendship and/or disability. Collectively, this data informed the resultant theory through a process of constant comparison where hypotheses emerging from existing data were checked against each new piece of data (Glaser, 1998). The processes of sampling, data collection and data analysis were cyclical and continued, where feasible, until data saturation occurred or when additional data failed to uncover any new information.

The sampling process for this study was multifaceted, prefaced at the outset by maximum variation sampling that facilitated the widest inclusion of a diverse range of data sources within the substantive area of SCI rehabilitation. Maximum variation sampling was used in the initial sample selection to identify primary data sources. This initial sample selection included as much variability within the substantive area as possible in order to avoid theoretical foreclosure (Glaser, 1978). Through the Grounded Theory processes of constant comparison, maximum variation sampling was replaced with more theoretical sampling. Glaser (1978) suggested that, in the initial stages of theoretical sampling, decisions about the collection of data are based only on a general sociological perspective and the general subject area (Glaser, 1978; Lincoln & Guba, 1985). Sampling was not limited by the number of participants or data sources (Cutcliffe, 2000) and was determined as a function of theoretical completeness (Baker, Wuest & Stern, 1992).

In the current study, because theory was aimed at the substantive level, it was

important to first sample within the substantive area only. These first samples then acted as gatekeepers for continued sampling based on their relevance to the emerging theory, through the process of theoretical sampling (Lincoln & Guba, 1985). Indeed, Glaser (1978) stated that an important rule when the analyst is still new at generating theory is to sample exclusively within the substantive area until a core category has been discovered and integrated into an emerging framework. Groups were chosen as the need emerged through the research rather than before the research began (Glaser & Strauss, 1967).

Maximum variation sampling

Sampling in Grounded Theory does not aim for the sample to be representative of the population but rather aims to be representative of the data itself (Glaser, 1978). Glaser (1998) suggested the demographic variables that underpin most sampling strategies must earn their way into the theory. Grounded Theory typically begins with a selective sampling strategy to achieve phenomenological variation and then proceeds to theoretical sampling (Glaser & Strauss, 1967). Strauss and Corbin (1998) recommended that initial sample selection should ensure as much variability as possible to avoid foreclosing prematurely on the discovery of concepts and categories (Miles & Huberman, 1984) and ensuring saturation of categories (Glaser, 1978). As Patton (1987) stated, “any common patterns that emerge from great variation are of particular interest and value in capturing the core experiences and central shared aspects” (p.53).

To ensure maximum variability, participants were only excluded from participation if they had severe communication difficulties that prevented their participation in interviews. On a few occasions, participants were excluded due to

advice from treating professionals regarding their current mental ill health.

Participants were recruited from discharge lists of the Spinal Injuries Unit (SIU) and the Transitional Rehabilitation Program (TRP) within the Queensland Spinal Cord Injuries Service (QSCIS), which is the only inpatient rehabilitation facility for people with SCI in the state of Queensland. It was considered unethical and irrelevant to sample people at the acute stage of a traumatic injury, both due to the stressful nature of the event and the fact that there may not have been any post-injury interaction with their friends. Thus, people with SCI were recruited in person at the time of discharge from hospital (either immediately prior to or immediately following discharge depending on the best time for each participant).

People with SCI were provided with a verbal explanation of the research. A family member or friend could be present while the study was explained. An information sheet and consent form (Appendix B and C) were given to participants. Individuals with limited hand functioning were assisted by a family member or their treating therapist to complete consent forms

During the consent process, individuals with SCI were asked to identify and contact at least one friend who might verbally agree to participate. Friends who had provided verbal agreement to the participant were contacted and invited to participate. Flyers were also placed within the SIU advertising the study and encouraging friends to participate. If the friend declined participation, the subject was not broached again, unless initiated by the participant. Information sheets and consent forms for the friends are attached in Appendix D and E respectively.

Theoretical sampling

Although initial sampling occurred within the substantive area of people with

SCI and their nominated friends, theoretical sampling was used as the theory began to emerge from the initial iterative data collection and analysis process (Glaser, 1978; Lincoln & Guba, 1985). As categories emerged from the initial data, these categories determined the selection of subsequent participants and interview questions based on their ability to provide important information to guide theory development (Strauss & Corbin, 1990). Thus, the ongoing analysis influenced future questions and sampling strategies.

For instance, people who were not directly in the substantive area of study, but were “neighbours” to the topic, were deliberately selected to expand the emerging theory (Miles & Huberman, 1984). Some of the emerging theoretical categories required access to other participant groups including family members of people with SCI and hospital and community rehabilitation staff. For example, inpatient and community rehabilitation staff were included to expand the emerging theory. Thus, although participants commented retrospectively on their period in hospital, hospital staff were able to comment on their observations made during this period across many people with SCI. Family members were included to explore emerging categories that related to the facilitation of friendship and the role of family in information dissemination to friends. Common themes that emerged across these diverse groups were of particular relevance as they presented opportunities to expand and define categories and the applicability of the theory.

Family members were recruited via letter, information sheet and consent form mailed to the injured person (see Appendix F, G and H). If participants agreed, they then sought verbal approval from family members to be contacted. In recruiting hospital and community rehabilitation staff, only verbal consent was obtained as they were discussing broad clinical observations rather than personal circumstances. Staff

members were provided with an information sheet as attached in Appendix I.

Sample size and theoretical saturation

In Grounded Theory, sample size is not pre-determined by the researcher but is determined by the emerging theory and saturation of categories (Glaser, 1998). Evidence of saturation occurred when all new data appeared to fit into established concepts and categories and major variation in these categories was accounted for (Hutchinson, 1986). In reality, practical and contextual constraints associated with ethical procedures, time, resources and access also influenced sample size. Miles and Huberman (1994) suggested that the continued immersion of the researcher in an environment, may lead to the discovery of additional layers and complexity, thereby complicating decisions about when to finish sampling. However, Strauss and Corbin (1990) suggested that saturation is not an absolute indicator, but should be measured in degrees, hinting that complete saturation may not be achievable. Although several relatively saturated categories (including the core categories) emerged from the data, saturation was elusive in some areas of this research. For instance, in relation to the collection and analysis of data from friends, the extent of variation in this data and the difficulty accessing friends meant that saturation in this area was not evident. However, the data collected from friends contributed to the saturation of other categories.

Sample Characteristics

Participants included 19 people with SCI, 8 friends of people with SCI, 3 family members and 10 hospital and community rehabilitation staff. Figure 3.1 shows the relationships that existed amongst the participants.

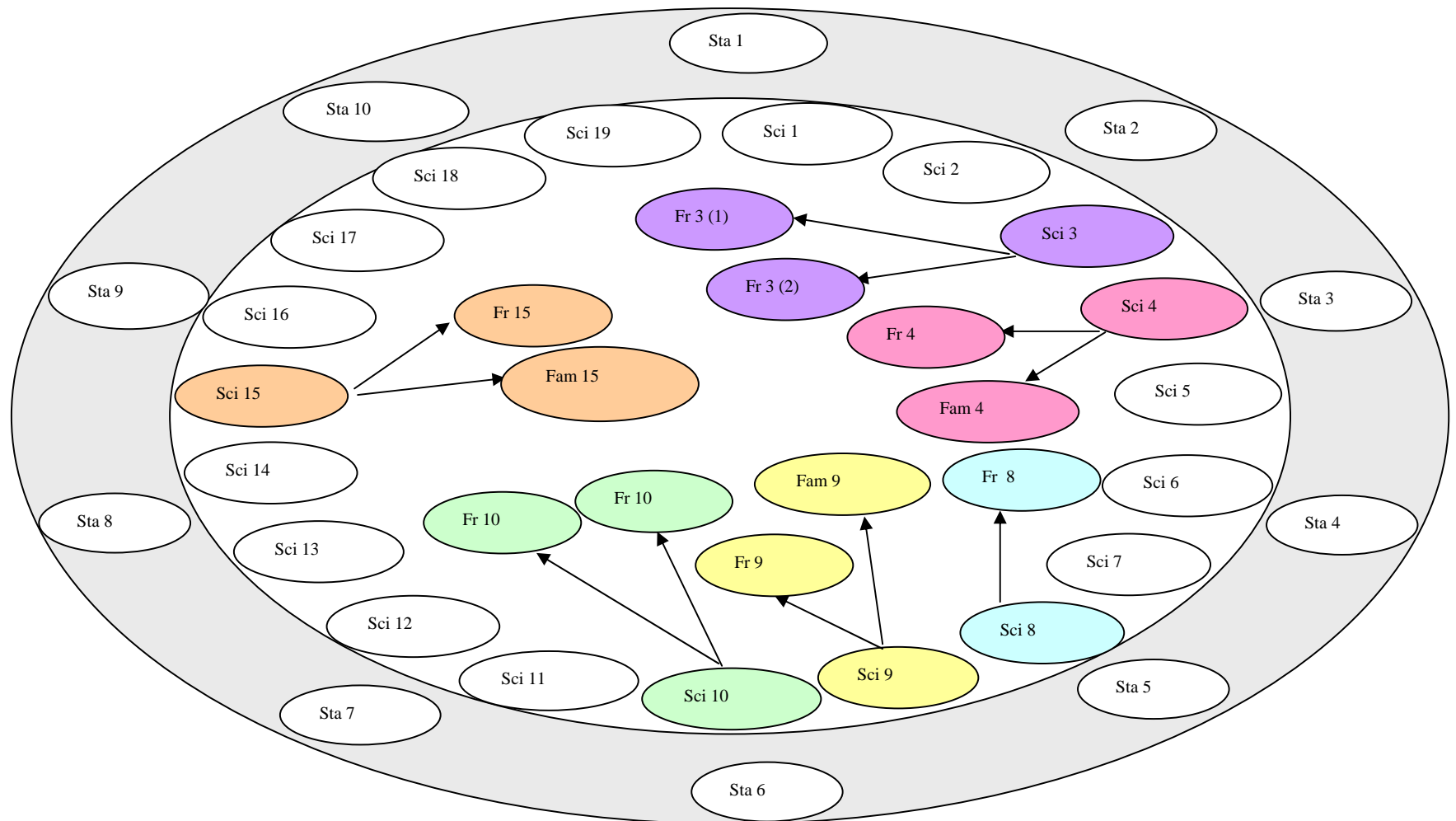


Figure 3.1: Relationships between participants with SCI (Sci), friends (Fr), family members (Fam) and rehabilitation staff (Sta).
 NB: Numbers indicate the ID number allocated to each participant

Table 3.1 shows demographic details for the study participants with SCI. Consistent with national and international trends in SCI, the sample was predominantly male (84%) and younger than 50 years of age at the time of injury (68%). Over half (58%) of the sample lived in a metropolitan location at the time of their injury. Approximately half of the participants had sustained their injury as a result of a motor vehicle accident (48%), while over 40% sustained their injury through a fall and the remaining individuals were injured in diving or surfing accidents. Over 30% of participants lived alone on discharge, 48% lived with partners and 20% lived with their parents or siblings. At the time of the initial interview, 53% of the sample was single, 37% married and 10% divorced.

The sample consisted predominantly of individuals with injuries below C7 (74%) and only 26% with high-level tetraplegia between C4 and C6. Over half of the participants had neurologically complete injuries (52%). Almost 80% of participants could not walk functionally at the time of the initial interview. On average, participants had a total length of stay in hospital of 217.5 days (SD=125.8). Total length of stay in hospital ranged from 78 days to 511 days and participants received an average of 12.3 (SD=20.2) hours of personal care per week at the time of the initial interview. Demographic details are not provided for family members and friends, as this information was not collected from these participants. The only demographic information collected from family members related to their relationship to the person with SCI (i.e., one mother, one sister and one wife).

Table 3.1. Demographic Details of SCI Participants

	Spinal cord injury (n=19)
	n (%)
Gender	
Male	16 (84%)
Female	3 (16%)
Age	
<21	1 (5%)
21-30	6 (32%)
31-40	4 (21%)
41-50	2 (10%)
>50	6 (32%)
Location	
Metropolitan	11 (58%)
Regional	3 (16%)
Rural	4 (21%)
Interstate	1 (5%)
Level of injury	
C4 and above	3 (16%)
C5-C6	2 (10%)
C7-T8	7 (37%)
T9 and below	7 (37%)
Completeness of injury	
Complete	10 (52%)
Incomplete	9 (48%)
Cause of injury	
Motor vehicle	9 (48%)
Fall	8 (42%)
Dive/surf	2 (10%)
Walking status at interview	
Walking	4 (21%)
Not walking	15 (79%)
Marital status at interview	
Single	10 (53%)
Married/defacto	7 (37%)
Divorced	2 (10%)
Living status at discharge	
Alone	6 (32%)
Partner and/or children	9 (48%)
Parents and/or siblings	4 (20%)

Data collection

Glaser (1978) argued that, in Grounded Theory, everything is data. In the current study, the data determined (a) what was explored in the research (b) the

literature searched (c) the research questions developed and (d) the number of participants in the study (Stern & Pyles, 1985; Cutcliffe, 2000). Traditionally, data collection within the Grounded Theory approach has utilised multiple methods (Flick, 2002). Data collection procedures may involve interviews, and observations as well as other sources such as government documents, videotapes, newspapers, letters, and books. Indeed, data collection may involve any information source that may shed light on questions under study. In the current study, all of these different data collection techniques provided data that was coded in the same way (Glaser & Strauss, 1967).

Although the current study included some quantitative data from primary and secondary data sources, most data was qualitative in nature. Table 3.2 outlines the methods of data collection, the data sources, who collected the data and when it was collected. Interviews were conducted at up to three points in time, namely at discharge, 1 month post-discharge and 4-6 months post-discharge. Given that participants had been hospitalised for different periods of time, these interviews occurred at variable times since the injury.

Seed (1995) suggested that longitudinal research is vital because reality is evolving and dynamic, incorporating temporal processes. Data collection over a period of time has the advantage of decreasing the likelihood of socially preferred responses or differences in behaviour attributable to the presence of the researcher (Carpenter & Hammell, 2000). Longitudinal data collection within the current study also allowed exploration of previous interviews, expansion, clarification and member checking. By always reading previous interviews beforehand, it helped to show interest in the participant. It also helped to explore previous expectations about friendship and whether they had been fulfilled.

Table 3.2: Data collection methods, sources, timing and administration

Data collection	Data sources	Collected by	When
Semi-structured interviews and observations	Primary data sources people with SCI and their nominated friends	Researcher and Research Assistant	At discharge (interview 1) 1 month post discharge (interview 2) 4-6 months post discharge (interview 3)
Semi-structured interviews and observation	Inpatient and community rehabilitation staff	Researcher	At various points as defined by the emerging theory
Semi-structured interviews and observation	Family members	Researcher and Research Assistant	At various points as defined by the emerging theory
Written documentation	Published literature, internet websites and state association newsletters	Researcher	At various points as defined by the emerging theory

Interviews

Interview protocols for the initial interviews with people with SCI (Appendix J), their friends (Appendix K), their family members (Appendix L) and rehabilitation staff (Appendix M) are attached. Guides for the second and third interview protocols are also attached (Appendix N and O respectively), although these varied across participants.

The interview was the principal data collection method used, especially during the early stages of the data collection process. Interviews allowed access to participant perspectives with their underlying beliefs and values, feelings, thoughts and motivations. The meaning that participants attached to events would not have been directly observable or accessible within written questionnaire formats (Rich & Ginsburg, 1999). Active interactions that occurred between the research and participants within the constructivist approach were contextually based and not neutral in valence (Mills et al., 2006). There is, however, no typical Grounded Theory

interview and the interview needs to be adapted to suit the circumstances of the study, the substantive area in question and the nature of the population (Wimpenny & Gass, 2000). There are differences and similarities in respect to the interview method used in Grounded Theory as compared to other qualitative methodologies (e.g., phenomenology, ethnography) and it is important to ensure that the interview as a method of data collection is consistent with the underlying principles of the methodology being used.

A combination of both formal and informal interviews was used in the current study (Chenitz & Swanson, 1986; Wimpenny & Gass, 2000). The initial interviews were semi-structured as Morse (1994) suggests that this type of interview is suited to research that aims to understand, describe and develop theory. Broad questions were required because it was difficult to spontaneously generate in-depth discussions about friendships, particularly for people who had not been cued to consider friendships in any depth since their injury. The questions provided direction and focus on the topic of investigation, but also allowed flexibility in questioning (Lincoln & Guba, 1985).

During the early stages of data collection, as new categories continued to emerge, the interviews remained more open-ended conversation. Subsequent interviews were then directed at elaborating categories guided by analytical questions and the relationships between them (Strauss, 1987). Thus, the latter interviews became more structured and less open than they may be in other qualitative approaches (e.g. Phenomenology).

King's (1994) criteria were used for developing the initial interview protocols on the basis of personal experience of the area, basic understanding of the research literature and informal discussions with other professionals. In the current study, interview protocols were proof read and altered according to feedback provided by the

research assistant and/or two clinical rehabilitation staff. Although my personal experience played some role in the initial development of the interview protocols, external auditing of each interview protocol helped to ensure that my personal views did not dominate the process (Lincoln & Guba, 1985). Theoretical expansion on the interview process was also facilitated through the memoing process, with additional or more directed interview questions often being developed directly from written memos.

A critical incident technique was intentionally incorporated into the interview protocol to allow concrete examples to emerge and to contextualise experiences. Asking participants to describe specific events or incidents during the interviews (e.g., the happiest time that friends had experienced since injury) assisted me to capture greater description of process and context. Charmaz' (2001) techniques of framing, shaping and managing interview questions were used to ensure data was both accurate and contained in-depth descriptions of process. Research credibility was enhanced within the interviewing process, by using strategies such as reframing and expanding questions (Krefting, 1991). However, flexibility was maintained to ensure that interesting directions and rich data were not lost in the process of theoretical sampling. There was also a need to be aware of what and how things were asked and the ways in which this directed and shaped the data obtained. For instance, asking more personal questions towards the middle and latter stages of the interview allowed participants to develop trust and safety before disclosing private information.

Similarly, sensitivity to the interviewee was critical given the vulnerability of the population and the quite personal nature of the questions being asked. In order to facilitate sensitivity, the interviews followed a process of 1) setting the scene and establishing rapport, 2) seeking information in depth, 3) feeling and reflection, 4)

searching for the narrative and critical incidents and 5) ending on a positive note. I was always cautious not to begin with questions that restricted the potential for opening the field of the substantive area up for investigation. Glaser (1992) noted that when asking questions, the Grounded Theory researcher never asks the question directly during the interview, as this would preconceive the emergence of data. As such, interview protocols began with broad questions about injury then focused on friendships and, in particular, processes related to how and why friendships changed.

All interviews were conducted in person initially. In general, interviews took between 30 minutes and 2.5 hours each, with the family interviews tending to be the longest in length. An experienced interviewer was employed as a research assistant to conduct interviews in this study for reasons of confidentiality and credibility (i.e., the participants knew me as being part of the service they attended rather than as an independent researcher). Where appropriate, I conducted a sub-sample of interviews to ensure my connection with the participants. However, I worked closely with the research assistant throughout the process, listening to audio-recordings of the interviews immediately following completion.

Second or third interviews were conducted by telephone if people were discharged to rural or remote locations or if requested by the participant. The recognised disadvantages associated with telephone interviewing (Neuman, 1994) were minimized by initially establishing rapport as well as using the same interviewer each time for any individual participant. Data collection became easier as trust was gained. Participants were sometimes initially reluctant to nominate friends to participate, but by the second or third interview they trusted the researcher to maintain their confidentiality.

Observation

Observations were incorporated into individual interviews to identify any contextual and non-verbal cues that could enhance and inform the theory. These observations were recorded in two ways; through additional notes recorded on the interview transcripts to highlight the contextual relevance of non-verbal and verbal descriptions and through specific field note observation sheets that were adapted from the work of Morse and Field (1995) and Carpenter and Hammell (2000). A copy of these sheets is included in Appendix P.

Observations also occurred in the rehabilitation setting to identify the way in which current clinical practices addressed friendships of people with SCI within that context. Although difficult to observe directly within the rehabilitation environment, I tried to remain constantly vigilant to the treatment of friendships and the factors within the rehabilitation environment that may impact on friendships.

These observations were subjectively described within the context of my personal and clinical positioning and therefore represented anecdotal comparisons rather than structured observation data. Glaser and Strauss (1967) suggested that this kind of data can be trusted if the experience of observation was lived by the person making the observation as was the case in this study because this was the clinical arena within which I worked. To counteract the tendency of particular stakeholders to present only certain aspects of their behaviour in my presence, these observations were paralleled by observations in other contexts (e.g., in interviews within home, community and rehabilitation environments). This strategy minimized the bias in the findings by facilitating the discovery of the underlying causes of variation (e.g. hospital environment, researcher, social environment) (Glaser and Strauss, 1967).

The published literature and written documentation

Written documentation, including published literature, internet data, interest articles, books written by consumers telling their personal stories and disability organization newsletters were included as a secondary data source and integrated with the existing data, but only after a theory had begun to emerge. There is some confusion about where a literature review is integrated within the Grounded Theory approach and this is dependent on the Grounded Theory approach taken. Strauss and Corbin (1998) suggested that a preliminary literature review could be conducted early to place the study within a context, providing another voice and for stimulation of thought; whereas Glaser (1978) suggested that no literature should be introduced until later once the theory has emerged clearly from the collected data to prevent contamination. The more accepted and well-documented approach is that the literature review should not be conducted prior to commencing data collection and analysis (Stern, 1994). Schreiber and Stern (2001) suggested that there is a need to sensitise oneself through literature first. To that effect, Smith and Biley (1997) suggested that general reading of the literature may be carried out to obtain a feel for the issues at work in the substantive area and identify any gaps to be filled in using Grounded Theory but it is important however that the reading is not too extensive.

What appears most relevant is that literature must earn its way into the theory and should not be utilised as explanation, justification or proof of the emerging theory but analysed, compared and contrasted to aid in refinement of the theory (Glaser, 1998). For the novice researcher, it is easier to achieve this if literature is introduced only once categories are well developed from the interview data (Glaser, 1978). Personally, it was almost impossible for me to be completely divorced from the literature, no matter what the substantive topic under investigation, given my long-

term role in rehabilitation. Thus, I began collecting and analyzing data in the field, at the same time as reading broadly on SCI and community integration. Literature on friendship and other theoretical readings were only introduced when theory was sufficiently grounded. To this effect, I did not introduce or use literature as a data source until such time as I had derived a core category from data-directed questions.

Prior to commencement, a brief literature review was conducted to confirm that this topic had not been explored substantively in the past. Following completion of the analysis, a full literature review was conducted and placed at the beginning of this thesis (see Chapters 1 and 2). It was only during the conduct of this full literature review that literature was used as data to confirm, expand and explain the categories identified from participant data.

Other written documentation was sampled on the basis of emerging categories and helped to facilitate saturation of those categories while providing another voice, across a variety of contexts. For example, Internet data was often consumer-produced for consumers, thereby representing information relayed between people with SCI and their networks. These data provided a different perspective to that provided within interviews with a researcher as they represented people in their natural context, expressing issues of value and relevance to them individually and as a group.

Preparation for analysis

Field notes were recorded immediately after completion of each interview and this data was included in the analysis. Interviews were transcribed verbatim with notes made to highlight aspects of the interaction, not obvious through the verbatim transcription (e.g. laughing, long pauses, crying). Transcription of data occurred within one week of data collection, particularly during the latter stages of data

collection to ensure timely analysis. Administrative support for transcription was provided by one person who, to ensure quality control and accuracy, listened to the interviews again after transcription, correcting any obvious errors. I also reviewed the interviews soon after transcription, meaning that the interviews were heard or read, simultaneously with the audio recording, on five occasions, at interview, prior to transcription and three times after transcription. Further reading of the transcripts was conducted in the absence of the audio recording.

Human Research Ethics

Two Human Research Ethics Committees (HREC), namely the Griffith University HREC and the Princess Alexandra Hospital HREC approved the study. The current study, as in most Grounded Theory studies presented specific challenges for ethical approval because the nature of the study, sampling strategies and sample size, as well as data collection could not be predicted prior to the commencement of the study. Thus, amendments to the approved protocol were made on five occasions, as theoretical sampling guided the selection of different comparison groups and additional data collection methods. Each variation to protocol necessitated waiting time (15 months in total).

Summary

Qualitative methods are appropriate when context is integral to the research question, where the research question relates to understanding a phenomenon about which little is known or when seeking to understand the 'inside' point of view of study participants (Bogdan & Biklen, 1998). Given the exploratory nature of research on post-injury friendships, the inherent focus on social process and the need to

develop frameworks to guide clinical practice within injury rehabilitation, this study employed a Grounded Theory approach from a Constructivist perspective. The purpose of the study was to systematically generate a parsimonious theory to explain behavioural processes related to friendship following SCI. Specifically, the study purpose was to determine, in context, the conditions under which friendships exist and change following SCI, and the actions associated with the maintenance or dissolution of friendship bonds.

Participants for the study were selected using maximum variation sampling initially followed by theoretical sampling as the theory began to emerge from the data. A total of 60 interviews were conducted across several groups of participants, including 19 people with SCI, 8 of their friends, 3 family members and 10 hospital and community rehabilitation staff. The selection and range of data sources were guided by the emerging theory and this data informed the resultant theory through a process of constant comparison where hypotheses emerging from existing data were checked against each new piece of data. The following chapter describes how the data analysis process utilised within the current study guided the development of the resultant theory from the range of data sources included.

Chapter 4

Data Analysis

Data analysis is an interaction between the actual data, the developing theory, the written memos and the researcher. Raw data that emerges from the data collection process gives rise to codes which, through constant comparison, are combined to form categories and hypotheses. Categories and hypotheses are checked against the data and the researcher's conclusions (Glaser & Strauss, 1967) using a process involving data collecting, open coding, writing memos, identifying a core category, selective coding in terms of the core category, sorting memos and writing up the theory. In this chapter, I will describe the data analysis process I used in the current study. Seed (1995) suggested that research, inclusive of its negatives, challenges and limitations should be described to facilitate learning among others and to enhance transferability. Thus, I have been as thorough as possible in describing my processes and my thoughts about the research. In the rest of this chapter I will describe the coding process, the methods used for constant comparison and the procedures adopted to ensure methodological rigour.

Data analysis

The data analysis process I used involved data collecting, open coding, writing memos, identifying a core category, selective coding in terms of the core category, sorting memos and writing up the theory. In total, there were over 4000 pages of interview transcripts, memos, personal journal and written documents (excluding the published literature) that contributed to the current theory development.

According to Strauss and Corbin (1990), even though the specific rules of analysis differ depending on the Grounded Theory approach taken, there are several underlying philosophies and procedures that always apply. These are

- a) Data collection and analysis are interrelated and simultaneous processes;
- b) Concepts are provisional and tentative at first, earning their way into the theory by repeated presentation in accumulating data;
- c) Concepts, not the actual data, are the basic unit of analysis and the basic work of the researcher;
- d) Abstractions of concepts leads to the development of categories and relationships between categories;
- e) Abstract concepts are developed in terms of their properties, conditions, actions, interactions and consequences;
- f) Sampling proceeds on theoretical grounds, on the basis of concepts, not participants;
- g) Concepts are challenged with all new data through constant comparison to guard against bias;
- h) Patterns and variations must be accounted for by incorporating process into the theory;
- i) Writing theoretical memos is the basic work of theory development, becoming more complex as does the theory;
- j) Broader structural conditions or contextual factors must be analysed and integrated into the theory.

Strauss and Corbin (1990) described three types of coding, namely, open (interpretive analysis and conceptual labelling), axial (identification of relationships between categories and subcategories using coding paradigms of conditions, contexts,

strategies, and consequences to identify the core category) and selective (unification and description of categories and subcategories around a core category). Glaser and Strauss (1967) used the notions of open, theoretical and selective coding, with similar connotations. These coding phases are often aided by diagramming (visualisation of data) and the use of conditional and consequential matrices (relationship mapping) (Strauss & Corbin, 1990).

Charmaz (1995), a constructivist, suggested that axial coding and conditional matrices are constraints to theory construction and should be excluded from the coding process. Other constructivist theorists, such as Mills et al. (2006), suggested that these techniques are merely tools for constructing dense theory and, therefore, have a valued role in theory development. For the current study, no tool or coding phase was excluded merely on the basis of theorist or version. As a new Grounded Theorist, I felt that it was useful to have more rather than less tools at my disposal to assist in the data analysis process. Thus, a variety of tools were used where needed.

The data analysis process

Complexity in data analysis is influenced by many factors including the number of interviews for comparison, the diversity of interviews and the varying levels of analysis and comparison. The data analysis process begins early in Grounded Theory and this is quite unfamiliar to someone 'raised' within a positivist research culture. In the current study, the process began with interviews being transcribed verbatim immediately following completion to ensure that analysis could commence as early as possible. The next steps involved listening to the tapes and memoing any apparent cues onto the transcripts that had been missed by the transcriber (e.g., long pauses or client non-verbal behaviour recalled from interviews) so as to ensure

inclusion of behaviours and processes that were not explicitly stated in the text of the interview. These 'context' memos occurred as supplements to data and the reflective process and were later incorporated within more analytic memos (Hammersley & Atkinson, 1995).

The data analysis process was cyclical and iterative, consistent with the Grounded Theory method (Glaser, 1992). The analysis process was primarily guided by Eaves (2001), with additions and clarifications taken from other Grounded Theorists when necessary. The analysis protocol outlined by Eaves (2001) provided step-by-step guidance, which helped me as a novice Grounded Theory researcher, to more practically apply the analysis method. The Eaves technique combines approaches from different Grounded Theorists but holds values consistent with the constructivist approach selected for this study. As such, analysis was applied in ways that were meaningful to the co-construction of meaning between the participants and the researcher.

Eaves (2001) developed her synthesis from works of Charmaz, Chesler, Corbin and Strauss to address the lack of clarity and the inconsistencies surrounding Grounded Theory analysis. Table 4.1 outlines the way in which the synthesis technique offered by Eaves aligned to the traditional notions of open, theoretical and selective coding and the ensuing discussion illustrates how these were applied during the analysis process.

It is important to emphasise, that although I have presented the analysis as a linear process, in reality, multiple steps occurred simultaneously (e.g., often open coding of new transcripts was occurring while categories were being identified through theoretical coding). Further, the processes were recursive rather than linear.

Nevertheless, the early steps did tend to occur more at the beginning stages of analysis.

Table 4.1: A comparison of Eaves (2001) synthesis techniques with traditional notions of open, theoretical and selective coding.

Traditional	Eaves (2001) synthesis techniques
Open Coding	Line by line invivo coding Listing all invivo codes Developing shorter code phrases Reduction through grouping of similar code phrases Creating clusters Reducing clusters to meta clusters with labels Forming concepts from labels
Theoretical Coding	Grouping of similar concepts through constant comparison to develop categories Identifying subcategories as characteristics and properties of categories along a continuum or dimensional range Making linkages among categories to facilitate conceptual order Identifying core categories Identifying basic psychosocial problem (BSP) and basic psychosocial process (BPSP) from core categories
Selective coding	Generating mini-theories from core categories and BSP and BPSP using existing and new data Developing explanatory frameworks leading to derivation of substantive theory

Open coding

The open coding process of breaking down, examining, comparing, conceptualising and categorising data has been described by numerous authors including Strauss and Corbin (1998) and Miles and Huberman (1994). The purpose of this early coding phase was to identify and name phenomena, which was a necessary first step in concept development. During open coding, coding of the data occurred in every way possible and for as many concepts as possible. New concepts emerged and new incidences were integrated into existing concepts as I coded the range of data available using constant comparisons. Even information that was not obviously stated was coded (Glaser, 1978), which was considered important given that participants

were unlikely to have considered the implications of injury on their friendships at the time of first data collection.

As described by Eaves (2001), the process was commenced using *line-by-line invivo coding* where key words were underlined and transferred to the right margin. This coding was conducted manually to begin with but was later translated to coding within qualitative analysis software. As invivo codes were developed they were added to a *separate listing of all invivo codes and shorter code phrases* that captured the main idea. I also wrote a line-by-line index to each transcript, summarising its content words or phrases thereby creating a visual tally of the degree to which codes and concepts were repeated throughout conversations.

Two types of codes were developed, namely substantive (empirical foundation of the substantive area) and theoretical (relationships between substantive codes). These codes were often produced simultaneously and thus, were recorded in memos. However the focus of analysis was more on the development of substantive codes during open coding and more on theoretical codes as theoretical integration and sorting of memos occurred (Glaser, 1978). Substantive codes or invivo coding represented the substance of the data and often used the words of the participants directly (Cutcliffe, 2000). The outcome of the open coding process was a list of substantive or invivo codes.

Coding for situations where data was not stated explicitly occurred by writing memos. For instance, at one point in the analysis, I recorded, 'I have heard from staff about people who have no friends visit, but there is no respondent data where that is apparent'. These memos helped to direct theoretical sampling, but also highlighted areas where my previous assumptions or prevailing assumptions in the environment needed to be questioned.

The *descriptive code phrases were reduced by grouping together similar code phrases, resulted in labelled meta-clusters (i.e., concepts)*. Each transcript was open coded four times. Multiple codes were often assigned to one piece of data to ensure complete coverage, unlike content analysis where only one code is applied to one piece of data (Rennie, Phillips & Quartaro, 1988). Certain codes did not materialise in early coding, but emerged in later interviews. In these instances, I chose not to return to the beginning and recode all transcripts immediately but rather proceeded, searching for saturation throughout the remaining interviews. Where opportunities presented to repeat open coding on a transcript, any earlier instances of these codes were then identified.

The constant comparative method (Glaser & Strauss, 1967) was an integral part of the open coding process. The rules for constant comparison suggested by Glaser (1978) were applied, despite using a hybrid synthesis technique. Specifically, a set of questions regarding the data were kept in mind from the start. These included questions such as ‘What is this data about?’, ‘What concept does this incident indicate?’ and ‘What is actually happening in the data?’. Broader questions such as ‘What is the basic psychosocial problem faced by the participants?’ and ‘What is the basic psychosocial process that addresses the problem?’ were asked early in the open coding process to ensure sensitivity to the need to account for the majority of the variation in the data.

Care was taken to avoid foreclosing too early. I applied deliberate delaying techniques, coding some interviews, leaving the data open for a period of time, and then returning to the interviews after reflection. I continued to ask myself questions such as ‘what am I getting?’ and ‘what am I not getting?’ in order to prevent foreclosure. My personal journal helped to facilitate this process by allowing me to

record any sense of a core category without foreclosure. When I later reviewed my journal recordings, my initial impressions were clearly premature and indeed, the concepts which appeared to be core at that point did not remain so throughout the analysis. As suggested by Glaser (1978), I conducted all coding myself, with the second coder and third coder only coding to facilitate inter-rater reliability calculations.

Theoretical coding

Theoretical coding was the second major step in the coding process and involved the grouping of concepts into categories and the identification of relationships between categories, which ultimately informed the development of hypotheses to be integrated into the theory (Lincoln & Guba, 1985). A key aim of this coding phase was to identify a core category that reflected the majority of variation in the data. For the current study, this aim was to identify a core friendship problem that accounted for the majority of the data as well as a core friendship process related to how people managed their friendships following injury.

According to Eaves (2001), the development of categories represents a move from 'invivo' open coding to more conceptual coding as the first step of theoretical coding. Glaser (1978) argued that there is a need to move beyond mere substantive coding to theoretical coding to produce a Grounded Theory. Theoretical coding was progressed by asking 'what is happening here?' and 'how do these substantive codes relate to each other?', thereby resulting in categories that tended to be more abstract and relational. These categories were the outcome of the theoretical coding process and significantly more abstract than the evidence from which they were derived (Glaser & Strauss, 1967).

Following on from category development, *subcategories were identified to describe the characteristics and properties of categories along a continuum or dimensional range*. This process was informed by strategies offered by a variety of Grounded Theorists. For instance, Glaser and Strauss (1967) recommended identifying features of the data that are indicative of a particular category. They distinguished these indicators from properties, which are the elements within categories. Thus, both indicators and properties were identified for each of the categories identified in the current study.

Axial or theoretical coding helps to analyse connections between categories, and make connections between a category and its subcategories (Strauss & Corbin, 1990). Axial coding was characterised by four steps that focused on linking categories, namely

- a) Hypothetical relationships between categories;
- b) Checking of hypothesised relationships against existing data;
- c) Ongoing exploration of the properties of categories;
- d) Exploration of variation.

Tentative theoretical statements were made following attempts to link the causes and consequences of the categories identified in the substantive area of friendships. Although checking of hypothesised relationships occurred against the data, I did not aim to achieve verification in the traditional sense but merely make the link between categories. Memos helped to ground these suggestions in data, ask questions, guide theoretical sampling and identify where there was a need to return to open coding of new information. At this stage, I recorded in my personal journal my struggles with the 'positivist' need to establish 'proof'. In these instances, I debriefed with others to keep me immersed in the Grounded Theory method.

In making connections between categories, Glaser (1978) described 6 properties to be considered (i.e., contexts, consequences, causes, conditions, covariances, and contingents) as demonstrated in Figure 4.1. In delineating this variety of possible relationships that may exist among categories and concepts as a methodological decision prior to analysis, it sensitised me to these relationships during the coding process.

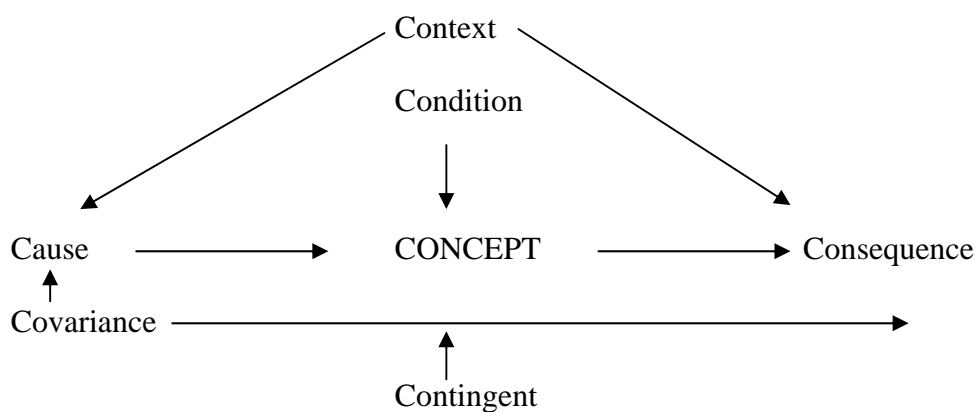


Figure 4.1 The Six C coding paradigm offered by Glaser (1978)

The Core Category

The key aim of Grounded Theory is the development of at least one core category. The core category must be central, frequent and related to as many other categories and their properties as possible. The core category should have implications for formal theory without necessarily representing formal theory directly (Glaser & Strauss, 1967). Processes described within the core category should be the most clearly articulated due to their overarching relevance and explanatory power.

A core category can be any kind of theoretical code, a process, a condition, dimensions, a consequence or indeed, several of the above. For the current study, two

core categories were identified as central themes that accounted for the greatest variation in the data, leading to the discovery of a basic psychosocial problem and basic psychosocial process characterised by temporal stages and aimed at improving or addressing the basic psychosocial problem. The core categories were identified by asking questions such as ‘What is the main analytic idea presented?’, ‘If my findings are to be summarised in a few sentences, what do I say?’, ‘What does all the action/interaction seem to be about?’ and ‘How can I explain the variation that I see between and among the categories?’

When using the constructivist approach, it is necessary to ensure identification of the core category by raising the conceptual level (Glaser, 1978) while ensuring that the co-constructions of meaning were still evident within the participant narrative (Charmaz, 2006). Strauss and Corbin (1990) utilised the notion of the storyline to capture the centrality of the core category, which meant constantly asking myself if the core categories represented the storyline for each transcript. Thus, I was able to obtain sufficient conceptual density while remaining 'connected' to the voices of the participants, thereby feeling that I remained true to the constructivist approach.

The ultimate goal of identifying the Basic Psychosocial Problem and Process also guided the development of core categories (Glaser & Strauss, 1967). Hutchinson (1986) proposed that the Basic Psychosocial Process explains and accounts for change that occurs over time, accounting for or explaining contextual variation. The Basic Psychosocial Problem is a problem shared by participants, but not necessarily articulated directly by them (Hutchinson, 1986). Although all Basic Psychosocial Processes are core categories, not all core categories are Basic Psychosocial Processes. In the current study, the Basic Psychosocial Problem and the Basic Psychosocial Process represented the two core categories identified.

According to Glaser (1978), Basic Psychosocial Processes change over time and occur at the individual or group level. One major aim of Grounded Theory is to determine how contextual features of the environment influence the direction and form of identified social processes (Benoliel, 1996). In the current study, processes were initially considered only at the psychological level, but social structural processes emerged as being critical (i.e., the contextual impact of the rehabilitation environment). Indeed, participants engaged with several social systems (e.g., hospital, family and community), each of which interacted with friendships.

No suggestion is made that the Basic Psychosocial Problem and Process are the only issues of theoretical importance to friendship. However, these core categories explained much of the variation found in the actions, interactions, and perceptions expressed in data (Glaser, 1978) and are, therefore, meaningful conclusions.

Selective coding

The selective coding process was the third major step in the coding process and involved a return to the raw data and inclusion of new information gathered through theoretical sampling to consider the support for the core friendship problem and process. In this phase, the aim was to identify, define and extend the description of the core problem and process (Glaser, 1978) by analysing and coding data in terms of how it was associated with the Basic Psychosocial Problem and Process. Selective coding began when I was sure that the variation within the data was explained within the confines of the core categories (Glaser, 1978).

Glaser (1978) suggested that a couple of core psychological constructs are all that is necessary with at most 10-15 categories. Additional categories run the risk of diluting the impact of the analysis while adding only minor variations to the core

processes. These core categories should represent the integrated and parsimonious theory that is the aim of the Grounded Theory method, accounting for broad variation across a variety of situations (Strauss & Corbin, 1990). Categories should be presented at their simplest level because over-elaboration (e.g., too many properties and relationships) cloud the theory and its importance (Glaser, 1978).

The generation of mini-theories from the core categories was an important analysis step during selective coding, aided by diagramming (Strauss & Corbin, 1990) or visual representations of relationships between dimensions, conditions, actions and consequences identified in the data analysis process. As I generated mini-theories from the core categories, I identified poorly developed categories and acquired new sources of data where necessary. Theoretical saturation is the point at which additional data collection and analysis fails to add significantly to the developing theory, its categories, properties, causes and consequences (Strauss & Corbin, 1990). This is a critical task in the selective coding process. On numerous occasions, I believed my categories were saturated, only to discover that I needed to return to the field or search for other data. Glaser and Strauss (1967) recognised that, although efforts should be made to saturate all categories, core categories are the most important. As categories, their properties and interactions became integrated around the core categories, theoretical saturation began to emerge, leading to the *development of an explanatory framework and a substantive theory* of friendship following injury.

Constant comparative method

The common thread that connected all phases of the analysis process was the use of the constant comparative method. Comparative analysis is the identification of patterns and relationships. Each item of data is compared with every other item of

data, to produce a theoretically and conceptually dense theory. Glaser (1978) suggested that there are two questions that facilitate this process, namely 'what is happening in the data?' and 'what action does each particular happening, incident or event or idea represent?'. This resulted in the identification of categories, relationships between categories and a core category around which all other categories revolved (Chiovitti & Piran, 2003).

Glaser and Strauss (1967) proposed four stages in the constant comparative method, namely generating, integrating categories and their properties, delimiting and then writing the emerging theory. Bursnall (2003) utilised the constant comparative method initially to compare incidents in the data to each other incident with an emphasis on the meaning not simply grouping. In doing this, her aim was conceptual specification, not conceptual definition (Glaser, 1978). Concepts were then later compared to each other and grouped into categories (grouped concepts or codes) then categories to categories and memos to new incidents and memos to memos. Similarly in the current study, the constant comparative method was used at multiple levels of analysis and ensured that all kinds of aids such as memo writing, rereading, coding, displays, data matrices and diagrams were used to stay true to the principles of comparison. Issues such as the level of comparison, the phase of the research in which it took place and the reasons and results of the comparison were considered throughout to ensure that the constant comparative method was used in conjunction with theoretical sampling.

For the current study, the approach outlined by Boeije (2002) for ensuring multilevel constant comparison was adopted. Boeije (2002) suggested that comparisons occur at five major levels for data generated from multiple players. Table 4.2 highlights how these levels were incorporated into the current analysis.

Table 4.2 Multiple levels of constant comparison

Level	When	Tasks	Outcome	Guiding questions
Comparison with a single interview	Open coding	<ul style="list-style-type: none"> Summarising the core of interview Finding consensus on the interpretation of fragments Developing concepts and understanding 	<ul style="list-style-type: none"> A summary of the interview List of provisional in vivo codes Descriptive code phrases Extended memos 	<ul style="list-style-type: none"> What is the core message of the interview? How are different fragments related? Is the interview consistent? Are there contradictions? What do fragments with the same code have in common?
Comparisons between interviews within the same group of participants (e.g. friend to friend)	Open and Theoretical coding	<ul style="list-style-type: none"> Developing conceptualisation of the subject Developing criteria for comparing interviews Hypothesising about patterns and types and 	<ul style="list-style-type: none"> Expansion of code words until all relevant themes are uncovered A detailed description of concepts Criteria for comparing interviews Feel for the clusters of interviews 	<ul style="list-style-type: none"> Is A talking about the same as B? What do both interviews reveal about the category? What combinations of concepts occur? What interpretations exist for this? What are the similarities and differences between interviews? What criteria underlie this comparison?
Comparison of interviews from different groups (e.g. friends to people with SCI)	Theoretical coding	<ul style="list-style-type: none"> Triangulating data sources 	<ul style="list-style-type: none"> Development of a comprehensive picture 	<ul style="list-style-type: none"> What does group 1 say about certain themes? What does group 2 have to say about the same themes? What themes appear in group 1 but not group 2? Why do they see things similarly or differently? What nuances, details or new information does group 2 supply about group 1?
Comparison in pairs at the level of the couple (e.g. friend to person with SCI)	Theoretical coding	<ul style="list-style-type: none"> Selecting themes from open coding that concern the relationship itself Summarising the relationship Finding consensus on interpretation 	<ul style="list-style-type: none"> Conceptualisation of relationship issues Understanding of the interaction between parties 	<ul style="list-style-type: none"> What is the relationship like from both perspectives? Are there contradictions/agreements between them? What are the central issues and how are they resolved?
Comparison between couples (friend/person with SCI with friend/person with SCI)	Theoretical coding	<ul style="list-style-type: none"> Finding criteria to compare couples Hypothesising about patterns and types of relationships 	<ul style="list-style-type: none"> Development of criteria for mutual comparison 	<ul style="list-style-type: none"> What are the typical differences between couple A and B? What are the possible reasons for this? On which criteria can couples be compared? What patterns exist in the relationships of couples that experience the phenomenon.

An additional layer of comparison across time was incorporated into the data analysis process in this study as a result of the longitudinal nature of the research. All data was viewed within a temporal context, to ensure that an understanding of past

events and expectations of the future were captured (Suto, 2000) but also to ensure that the analysis did not become overly descriptive. This temporal level of analysis was incorporated for all levels listed in Table 4.2, where possible. For example, second and third interviews with the person with SCI were compared with earlier interviews with the person with SCI. Similarly, second interviews with a dyad were compared with first interviews of a dyad.

Data from families and rehabilitation staff were initiated as a result of theoretical sampling and as such, were not included in the major comparisons. They were, however, included in the constant comparative process at the selective coding level and were coded in direct relation to the core categories that emerged from participant and friend data.

Memoing as a tool

Theoretical memos were a key factor in the process of generating theory. Memos were integral to ensure that the theory achieved abstraction and reflected the journey of the researcher's thinking (Glaser, 1978). In its traditional form, memoing involves informal recording of ideas and theorising about codes and their relationships (Miles & Huberman, 1994; Glaser, 1978) and may include sentences, paragraphs, diagrams, models or short stories. They help to move analysis from the empirical to the conceptual level (Glaser, 1978). As Glaser (1992) suggested, memoing is the creative part while coding is more systematic.

Although memoing commenced at the outset of the study, I found, as did Bursnall (2003), that early memoing was very descriptive and with continued immersion and open coding, memos became more conceptual over time. As outlined above, and advocated by Glaser and Strauss (1967), theoretical notes and analytical

memos were kept open as long as feasible to facilitate expansion and, in some instances, complete revision to reflect emerging conceptual thought. Glaser and Strauss (1967) highlighted the need to always stop coding to record a memo. Given the level of conceptual thought and memoing that occurred in relation to the coding process, one page of transcript took anywhere from 5 minutes to 3 hours to code, depending on the relevance of the material, the ease with which saturation of categories occurred, the number of new categories emerging, the stage of theory development and my own mood and concentration (Glaser & Strauss, 1967). The source of memos was typically the constant comparative method in the initial stages of the study, but later, memos were developed about memos, becoming more abstract (Glaser, 1978). This process, known as memo-sparking, was extremely important towards the end of data analysis and prior to memo sorting (although some memo sparking continued into the sorting and writing phases). Memos were inclusive of theoretically developed ideas at any point in time. They were written as they occurred within a train of thought, frequently agrammatical and sometimes illegible (something I learned to avoid over time). The written memos developed throughout the study represented the basis of all writing and were easily sortable, achieved by labelling each with a title related to the category or property that the memo was about.

I also found it useful to date the memos so I had a temporal record of my thoughts on the data. This practice paralleled the reflexive process recorded in my journal.

In summary, throughout the entire process of data analysis, memos were written to a) interpret raw data b) articulate categories c) examine relationships among categories d) explain major categories e) explore methodological issues and f) generate theory. Memos were essentially any written exploration of my ideas about

the data, codes, categories or themes. These memos also helped to keep track of problems and highlight how, when and why methodological decisions were made.

Using N-vivo

The decision to use computer software to aid analysis is a personal one, influenced by a multitude of factors such as the nature of the data and the researchers' preferred approach to data analysis. Initially, I commenced data analysis for this project using a manual coding approach, but half way through my analysis, the amount of data became unmanageable and I decided to use the N-vivo software for data management purposes.

Traditional Grounded Theory as outlined by Glaser and Strauss (1967) was developed prior to the introduction of qualitative software and, therefore, was based on manual analysis of data. Even Strauss and Corbin (1998) only briefly refer to the use of software for data storage, handling and analysis. Thus, the use of qualitative software programs in Grounded Theory analysis remains controversial.

For some researchers, such as Becker (1993), the use of qualitative software results in overly flat and simplified descriptive results. However, those who criticise the use of software often overlook the fact that the program does not analyse the data itself. It is merely a tool to assist the researcher. The advantage of software lies in its ability to facilitate and speed up administrative tasks such as data handling, allowing the researcher to focus on discovery of theory, the central task of the Grounded Theory method. Furthermore, where the researcher ensures, as I have, that reflexivity is maintained, the distancing that can result from software is avoided. Reading and rereading data, listening to audio recordings of interviews, memo writing, attention to non-verbal behaviour and exploration of context all help to prevent distancing from

the data. Thus, the perceived difficulties associated with software use become negligible. Many aspects of data analysis were assisted by the use of N-Vivo, such as correcting and revising conversation transcripts, data storage and retrieval, open and selective coding, reflective memo writing and the preparation of a story line (Strauss & Corbin, 1990). Further, N-Vivo supported the diagramming of concepts and the use of coding paradigms (within theoretical coding) to facilitate concept organisation and to clarify relationships between concepts over time. The most useful aspect of analysis software was in the final stage of theory building, because the software enabled me to clearly identify the relationships within the data (Strauss & Corbin, 1990).

Methodological rigour

General principles

It is recognised that two individuals working independently with the same data are unlikely to achieve the same outcomes, or the same theory (Glaser & Strauss, 1967). This variability is even more anticipated within the constructivist approaches to Grounded Theory (Charmaz, 1983; 2001; Mills et al., 2006).

Nevertheless, there are a range of criteria for evaluating qualitative research, and Grounded Theory research that differ greatly from those used within the positivist research paradigm (Glaser & Strauss, 1967). Researchers such as Lincoln and Guba (1985) proposed the concepts of credibility, auditability or dependability and fittingness or transferability against which to judge the quality of qualitative research. Credibility refers to the degree to which the findings are believable and relies on the use of methods, such as member checking, multiple respondents and data collection sources, multiple qualified research personnel and attention to reflexivity. Auditability refers to whether the research process can be clearly followed and is enhanced by the

transparency of the process and the use of multiple coders. Transferability refers to whether the findings can be applied to other settings which depends greatly on an adequate description of context, sufficient levels of theoretical abstraction and the integration of the theory is integrated into the existing body of knowledge.

Credibility

Credibility is reflected through the use of multiple interview respondents and longitudinal interviews, multiple methods, multiple coders and peer debriefing, member checks and negative case analysis (Lincoln & Guba, 1985).

Member checking

Member checking is a process whereby the conceptualisations of the data are returned to participants and according to Glaser (1978), participants should be able to relate to the findings as well as offer feedback regarding the model. Member checking can be achieved in two ways; either participants may be given the opportunity to review and edit interview transcripts at an early stage, or they can be asked to comment on a draft of the categories and themes derived as part of the data analysis process (Carpenter & Hammell, 2000). It is always key to remember, particularly within the constructivist approach, that no single reality exists so with member checking it is 'not so much confirmation... as a commentary from them on the plausibility of the interpretations offered' (Baxter and Eyles, 1997, p.512).

Within the longitudinal design of the current study, second or subsequent interviews had two aims, namely member checking as well as prospective data collection on the ongoing process of friendship (new and old data). Member checks including findings and early emergent theoretical propositions were integrated into the

interview process. This occurred for each participant on at least one occasion where multiple interviews were conducted (Lincoln & Guba, 1985).

Multiple Participants and Interviews

Multiple interviews were included across a range of primary and secondary data sources to triangulate data collection, ensuring that the conceptualisations of the data were not specific to the data collection methods used. Credibility was further enhanced within the present study by having multiple data collection points spread longitudinally over a period of up to 6 months for each participant. Although not all participants were involved in multiple interviews, this did occur for 15 participants with SCI, with 11 having two interviews and 4 having three interviews. One friend participated in two interviews. The use of a longitudinal design allowed exploration of previous interviews, expansion, clarification and member checking to proceed without unnecessary and unconsented contact. When preparing for additional interviews, the researcher always read the previous interview beforehand and deliberately explored previous expectations of the participant regarding their friendships.

Multiple Coders

Similarly, multiple interviewers and coders were used to enhance credibility. By exploring early theoretical reasoning through further data collection and using a second interviewer, the analysis process helped to identify conceptualisations that were peculiar to the researcher or time (Cutcliffe, 2000). In the current study, both interviewers were trained psychologists with experience in the relevant field.

To ensure that the process was consistent across both interviewers, a third person was asked to rate interviews of both interviewers. To identify the degree to

which bias may possibly be impacting, multiple coders were used. The intent was to establish consensus on the themes and concepts emerging from the data within a subsample of interviews that were multiply coded. This was possible despite the different perspectives and theoretical interests of the different researchers (Lincoln & Guba, 1985). Inter-rater reliability was calculated across the two interviewers and the independent coder. Interviews were selected randomly but included a sample of interviews conducted by each interviewer. Inter-rater reliability was calculated at the broadest level of coding. Calculating inter-rater reliability at the level of open coding or in-vivo coding was deemed necessary as it was recognised that further along the path in analysis, coding would vary, consistent with the constructivist approach. Furthermore by calculating inter-rater reliability at this point, discrepancies were highlighted earlier in the process before theory development proceeded too far (Glaser, 1978).

In total, ten interviews were multiply coded, 4 with friends, 4 with participants, 2 staff and 2 family members. Calculations proceeded using percent agreement as it was not possible to use kappa coefficients because of the fact that there was no finite number of items. Disagreements included excerpts of text coded by one person and not the other as well as excerpts of text that were coded differently by the coders based on perceived meaning. Inter-rater reliability was calculated at 87% agreement prior to discussion, but disagreements were then discussed to reach agreement. The agreed definitions became a reference and memo for further coding.

Chiovitti and Piran (2003) described several processes for enhancing rigour including:

- a) Participant guided inquiry;
- b) Member checking;

- c) The use of participants actual words;
- d) Articulation of the researchers personal views and insights about the phenomenon explored;
- e) Use of post-comment interview sheets as a tool;
- f) Writing and integration of a personal journal;
- g) Monitoring of how the literature is used.

Each of these methods were applied or integrated at various stages of the project to demonstrate to the reader that credibility had been achieved, but also to reinforce personal feelings of being able to adequately capture friendship in a way that actively incorporated the participant voice. To demonstrate the credibility of my processes, I have included excerpts from my personal journal in Appendix Q.

Auditability

Auditability relates to the transparency of the methodological process and how well the findings, interpretations and recommendations are supported by the data (Lincoln & Guba, 1985). Sandelowski (1986) emphasised that rigour can only be achieved if researchers clearly describe and justify what was done at each step in the study, a process referred to as an audit trail. Although detailed descriptions of methodology are often sacrificed to enhance the flow of writing, I have chosen to keep these descriptions as detailed as possible. I did this in order to enhance auditability, not only for the reader to judge, but also for myself as a constant check of each methodological decision I made. These methodological decisions comprised a large proportion of the memos written, especially at the commencement of data collection. Ultimately however, the aim was to establish transparency of process through the description of a clear audit trail.

Transferability

Strauss and Corbin (1998) suggested that the transferability of a Grounded Theory is achieved through a process of abstraction that evolves throughout course of data collection and analysis. The more abstract the concepts and the more variation uncovered in the original study, the more likely it is to capture the processes as they apply to a broad range of situations. Abstraction of the substantive theory allows comparison to other substantive areas (Glaser, 1978). Furthermore, transferability is reflected in the thick description of findings and contextual factors to allow readers to compare to their own experiences or settings (Lincoln & Guba, 1985). Indeed, Glaser and Strauss (1967) suggested that the researcher should aim to describe the research context in sufficient detail so as to enable the reader to envision themselves within that context. In the current study, observations made during interviews were recorded on observation sheets adapted from Carpenter and Hammell (2000) in order to capture these contextual descriptions.

Grounded Theory Criteria

When considering Grounded Theory specifically, Glaser (1978) proposed that the main criteria were those of fit, functionality, relevance and modifiability. Fit refers to the ability of the theory or categories to fit to the collected data. Constant comparison is a process by which quickly emerging categories can be examined in the light of both existing and new data ensuring that relevance is maintained and they still 'work' in the emerging theory. Functionality refers to the utility of the conceptual framework developed, how well it works, explains and predicts what will happen, and interprets process. Relevance is reflected in the degree to which the theory relates

processes that are relevant and workable for academics, participants, and significant laymen alike (Glaser & Strauss, 1967). Finally, modifiability is reflected in the durability of the theory as it accounts for variation (e.g., accounts for real world change) and the flexibility of the theory to change as conditions change (e.g., incorporates new raw data).

Strauss and Corbin (1990) suggested that there are a range of questions a qualitative researcher needs to ask throughout the analysis that will guide decisions about rigour, as shown in Table 4.3. I used these questions to reflect on my analysis as I progressed. Table 4.3 also shows how these criteria and questions correspond to those recommended by Lincoln and Guba (1985).

Table 4.3: Evaluative criteria for qualitative research and Grounded Theory used in the study

Credibility	Fit	Have some informants/respondents reviewed the material with me and interpreted, dissented, challenged my interpretations? And then, how do I report these departures/agreements in perspective?
	Fit	How far do I want to go with respect to theorising the words informants?
	Fit	Where have I backed into the passive voice and backed away from responsibility for my interpretations behind the words of participants?
	Fit	Who am I afraid will see these analyses?
	Functionality	What dreams do I have about the material presented?
	Functionality	Empirical grounding of concepts assessed by asking...Are concepts generated?
	Functionality	Are the concepts systematically related?
	Functionality	Are there many conceptual linkages and are the categories well developed?
	Functionality	Do the categories have conceptual density?
	Auditability	Modifiability
Transferability	Relevance	Do the theoretical findings seem significant and to what extent?
	Modifiability	Has 'process' been taken into account?
Transferability	Relevance	Have I deployed multiple methods so that very different kinds of analyses can be constructed?
	Fit	Have I described the mundane?
	Relevance	Have I connected the 'voices' and 'stories' of individuals back to the set of historic, structural, and economic relations in which they are situated?
	Functionality	Have I considered how these data could be used for social and rehabilitation policies?
	Relevance	To what extent has my analysis offered an alternative to the commonsense or dominant discourse?

Relevance	What challenges might very different audiences pose to the analysis presented?
Relevance	Are the broader conditions that affect the phenomenon under study built into its explanation?

In summary, several techniques were used to ensure credibility, auditability and transferability. Sufficient foresight within the study planning allowed these techniques to be implemented at appropriate times within the research process, rather than occurring retrospectively, although even up until the last day of thesis completion, new ideas for improving rigour emerged. As Hammell and Carpenter (2004) and Baxter and Eyles (1997) proposed, there is a need to explore and adapt several aspects of rigour where appropriate to the study, which I was able to achieve through:

- a) The provision of information on the appropriateness of the methodology (chapter 3);
- b) The use of multiple methods and a description of the reasons for each choice (chapter 3);
- c) Adequate information on participant selection (chapter 3);
- d) Adequate description and details of how interviews were conducted (chapter 3);
- e) A critical exploration of the researchers role (chapter 4 and Appendix A);
- f) The presentation of verbatim quotations linked back to specific participants (chapters 5 and 6);
- g) Thick descriptions of how data were converted into theoretical constructs (chapter 4 , 5 and 6);
- h) A clear statement about the length of time spent in fieldwork (chapter 3 and 4);

- i) A detailed discussion relating the current findings to existing research (chapter 7);
- j) Member checking with respondents to clarify meanings and interpretations (chapter 4);
- k) Attention to and description of power relations involved in data collection processes and any steps taken to avert or minimise these (chapter 3);
- l) Consideration of the ethical implications of representation and publication (chapter 3).

The quality of the theory is evidenced in its ability to satisfy the criteria of *fit*, *relevance*, *functionality* and *modifiability* (Glaser, 1978). The developed theory satisfied the grounded theory principle of *fit* as the categories and concepts emerged from the data itself and were representative of that data. The incorporation of member checking within the longitudinal interviewing process allowed participants to respond to the developing theory and challenge my interpretations. Further, it allowed participants to contribute to the abstraction process, but at a level that remained relevant to the participant.

The theory satisfied the grounded theory principle of *relevance* because it was developed using multiple methods of data collection, multiple methods of comparison and analysis and multiple perspectives. The theory connected and explained the historical, psychological and social contexts and backgrounds of participants, but was also described within the context of my own historical, psychological and social background. As such, audiences from very different backgrounds, even without an understanding of rehabilitation or SCI, will easily understand the theory and the ways in which it accounts for differences in background. Further, the study has relevance for all individuals with SCI and their friends as well as the broad rehabilitation and

geographic communities within which they aim to reintegrate. Finally, the theory has relevance for policy makers who have the capacity to alter these contexts.

The ultimate *functionality* of the theory developed lies in its translation to the clinical setting and governmental decision-making. The aim of this study was to alter the rehabilitation and community contexts within which individuals with SCI and their friends live in such a way as to facilitate the maintenance of friendships following injury. The *functionality* of the theory is reflected in the degree to which these categories of the theory were explicated from and explained in sufficient detail so as to allow future operationalisation of these concepts within more positivist research frameworks or clinical practice contexts should the need arise. The theory allows for the development of hypotheses that can form the basis of future verificational research. Linking the causes, consequences, contexts, contingencies, covariances and conditions (Glaser, 1978) for these relationships allows other researchers to verify these predictive relationships.

Finally, the *modifiability* of the theory is reflected in its ability to explicate process, those changes over time that are determinants of friendship outcomes. It explains how friendships are challenged and how individuals and the interactions between individuals and groups work to manage those challenges. It accounts for significant amounts of variation, inherent in the fact that the theory is relative rather than absolute and is explanatory of demographic or contextual differences.

The final theory

The ultimate product of the analysis process is the final written theory. In order to write the theory, a process of memo sorting and moving back and forth between memos and text occurred. A description of this process is included in

Appendix R. Although this theory is presented as a static final product, it is only a representation of a point in time when generating theory (Glaser & Strauss, 1967). The theory presented is only one possible explanation for the data and thus should be considered emergent and tentative. Theoretical processes should be imagined on a continuum with some people experiencing them more than others (Glaser, 1992). The presented theory is composed of categories and their mutual connections, that describe and explain substantive phenomena (Walker & Avant, 1988). Specifically for this study, the resulting theory was substantive theory, relevant mostly to the people concerned but readily modifiable (Glaser, 1978). Although gaps in the theory may be possibilities for future research, they cannot be criticisms of the theory. The process for the theory development represent the detailed journey from data collection to a finished product of writing.

In summary, Hammell (2000) suggested that the writeup should be descriptive of research purpose and objective, the intended audience, the inclusion of participants within in the research process, the ultimate value and significance of the research and the intended dissemination of findings to all stakeholders. I have endeavoured to achieve this standard to ensure that this research makes a valuable contribution to the field.

Summary

This chapter has described the iterative data analysis process that occurred simultaneously with data collection in this study. The process involved data collecting, open coding, writing memos, identifying a core category, refining the core category, sorting memos and writing up the theory. For the current study, over 4000

pages of interview transcripts, memos, personal journal and written documents were analysed and contributed to the current theory development.

Using the analysis protocol outlined by Eaves (2001), which combines approaches from different Grounded Theorists but is consistent with the constructivist approach, analysis proceeded through the processes of open, theoretical and selective coding. Constant comparison was undertaken at multiple levels as proposed by Boeije (2002). Memoing and the keeping of a personal journal assisted the analysis process by facilitating the abstraction of concepts, focussing on core category development and managing the need for reflexive thought throughout the data analysis process. Qualitative software was utilised as a data management tool to facilitate the analysis of such extensive data.

Principles of rigour were incorporated into the design that were consistent with both general qualitative research criteria (credibility, auditability and transferability) and Grounded Theory specific criteria (fit, relevance, functionality and modifiability). Member checking, multiple participants and interviews over time, multiple coders, an exploration of reflexivity, a clear audit trail and the consideration of ethical principles of research conduct were all incorporated to strengthen rigour.

Chapter 5: Results

Diverging life paths: The intersection of injury and friendship

*Two roads diverged in a wood, and I, I took the one less travelled by,
and that has made all the difference*

Robert Frost (1874-1963)

Sustaining a SCI is a significant event for the individual and those around them. Whether consciously recognised as an issue of importance or not, the people with SCI, their friends, families and rehabilitation staff who participated in this study witnessed a transformation in the friendships of people following injury. SCI represented a divergence of the life paths of friends. Siegert et al. (2007) contended that it is our life plans that define who we are, and provide a relatively stable compass by which we navigate our way through life. Given that continuity over time is considered to be a hallmark of life (Agahi, Ahacic & Parker, 2006), the sudden onset of disability represents a major disruption to the continuity of a person's life path (Cott, Wiles & Devitt, 2007). Bury (1982) coined the phrase "biographical disruption" to describe this experience. As one friend in the current study stated, "I mean you can't like have an accident and not expect it to change you, change your lifestyle" (4Fr1). (NB: Quotation identification is participant ID [1-19], followed by participant group [Sci, Fr, Fam, Sta], followed by the interview number [1-3])

This chapter describes participant experiences of diverging life paths and the process by which participants were exposed to a series of contextual factors that impacted on their friendships in a variety of ways. *Diverging life paths* emerged as the basic psychosocial problem faced by friendships following injury and was defined by

the concepts of *enforced separation* and *priority drift* as outlined below. The next chapter describes the basic psychosocial process of *reconnecting life paths* that friends employed to negotiate the challenges inherent in these diverging life paths. Although presented separately for conceptual clarity, these processes occurred simultaneously and in a circular fashion, with each existing as both cause and effect. The basic tenets of these processes lie in the fact that they are constantly changing over time in an interactive and cyclical way. Diverging life paths prompted reconnecting which, in turn, reduced divergence. Over time, the general tendency was for divergence of life paths to decrease in frequency with reconnecting of life paths becoming the more dominant process.

Diverging life paths

Diverging life paths was a *temporal process* that evolved over time and could occur at a number of levels including *physical, cognitive, emotional* and *behavioural*. The degree to which people with SCI and their friends experienced diverging life paths was dependent on a number of *personal* (e.g. marital status) and *contextual* (e.g. living situation post-discharge) factors, although the developed theory is sufficiently abstract as to account for the variability of these factors, without needing to include them as specific categories.

Some friends did not perceive that their life paths had diverged at all, or at least no more than might have occurred in the absence of the injury. Thus, they believed that SCI had *little impact* on their friendships. “Nothing has really changed between us, we’re always pretty close without seeing each other too regularly, and we’ve just stayed the same, yeah, we still get on like a house on fire” (8Sci1). Indeed, diverging life paths were recognised as frequently occurring in the *absence of injury*

but many recognised that this divergence tended to be exacerbated or emphasised with the *presence of injury*.

I think one of the big things for people who are sort of at their late teens, early twenties, even mid twenties, is the friends getting married, you know forming relationships and pairing off and feeling excluded from that process sometimes. So that someone who may have been a close friend or that has a close friend that have gone through school together, and they have surfed together and they have done whatever together now his friend has got a girlfriend and the relationship is pretty serious and his friend is probably devoting more time and that probably happens in that life stage anyway, friendships change and friends devoting more time to marriage but I think it is more difficult for people who have an acquired disability that is quite severe because it, they are somewhat excluded from that process and the risk is that they get left on the sidelines, they get left behind and they feel like that sometimes (4Sta1).

Indeed, many participants perceived that their life paths had become so different following injury that perhaps the friendship would not *survive*.

Friends kind of drifted away a little bit, which is good, because you've found out who your mates are instead of having... 15-20 friends, I've got probably 10 really good close friends now instead, so I know them a lot better (6Sci2).

In some instances, diverging life paths were recognised by staff or families but not by the individuals within the friendship itself. Similarly, when a divergent life path was recognised, people with SCI and their friends were likely to *attribute* the loss of their friendship to the injury. In contrast, family and rehabilitation staff were more likely to believe that this divergence would have been inevitable developmentally.

They were going to go different ways anyway but he had so much hope and everything invested in this friendship and when you threw in the spinal injury, it might have been a natural drifting apart as she got boyfriends or he got girlfriends or when they came out of that school environment and one moved out of the area, but he wouldn't relate it to that...he related it to his spinal injury... you know some people go to uni and others don't so there is that drift (2Sta1).

For some of the diverging friendships, there was the perception that the life path of only one individual (typically the person with SCI) had changed.

I can think of someone who is just sort of finishing uni and all his friends have gone overseas on a big European trip and you know he was to be there too. So they have just gone and done all these you know things in life, big important things in life that he hasn't been able to do. So I think that is you know, he is an intelligent young man and it is quite devastating for him that he couldn't actually, couldn't really go and do the same things that you would, you know, that you had plans to do, you know big life plans. So I think perhaps you know the friends continue to do things and they just can't get involved (9Sta1).

In other instances, there was a perception held by both parties, that they had each experienced diverging life paths. "No relationship is ever the same, every relationship with every single different person will be different" (17Sci1).

Regardless of the antecedents to divergent life paths (e.g., whether due to *developmental* processes or related to the injury), SCI was often perceived by people with injury, their friends or family as a life event that had significant ramifications for their personal future, but also for the *future of their friendships*. When participants discussed a diverging life path, it was typically described as a *sudden* event that occurred on the day the injury occurred. However, when participants spoke of their life and friendships in the early days after injury, these diverging life paths were rarely apparent, indicating a slower progression towards *recognition of divergence*. The recognition that there had been a divergence of life paths only became apparent as participants had time to *reflect on their experiences* over the ensuing months.

Sustaining an SCI imposed an *enforced separation* on individuals and their friends, in that individuals were removed from their friendships at the physical, cognitive, emotional and/or behavioural levels. The concept of *enforced separation* was characterised by *environmental separation, role separation, identity separation* and *interactional separation*. Over time, through the processes of *enforced separation*, the future of friendships was challenged by a *priority drift*, characterised by the concepts of *immediate need, vulnerability to a new world, facing the unknown*, and *reality shifting over time*. Table 5.1 outlines the categories that represent

diverging life paths and the associated codes from which these categories emerged. These codes were principally the product of the open coding process and formed part of defining the boundaries and relationships of the categories that emerged during open and theoretical coding. The 6 C coding paradigm was useful in identifying these codes. For example, *temporal* was a context within which diverging life paths occurred while *anxiety* was a consequence of enforced separation.

	Contexts, conditions and causes	Covariances and contingents	Consequences
Diverging life paths	Temporal Emotional Physical Behavioural Cognitive Personal Contextual Presence of injury Absence of injury Sudden	Attribution Recognition of divergence Developmental Reflection	Impact Future of friendships Friendship survival
Enforced separation	Hospitalisation Sudden No control	Domain Valence Time	Anxiety Denial Resignation
Priority Drift	Contextual Life events Cognitive	Changing priorities Developmental Time	

Table 5.1: Codes (context, condition, cause, consequence, covariance and contingent) underlying the categories for diverging life paths

Enforced separation

All people who sustain an injury to their spinal cord are hospitalised for medical management of that injury and rehabilitation. In the current study, *hospitalisation* removed individuals from their life contexts including their homes, their jobs, their families, their communities and their friends. By necessity this separation was *sudden* – people were often airlifted to hospital from the scene of their

injury and had no contact with friends until some time later. The individual with SCI, their family members and friends had *no control* over this separation; it was enforced. Although enforced separation occurred initially at an environmental level, there were a variety of cognitive, emotional and behavioural consequences that generated other forms of separation (i.e., *role separation, identity separation and interactional separation*). The degree to which people perceived the separation to impact on their friendship appeared to depend on the degree to which these other *domains* were influenced. For instance, individuals who lived in rural communities tended to experience this separation more acutely than individuals who lived in the city. “People who come from the country who are in [capital city] for long periods of time, well life goes on for the people who are at home and when you get back it is just not the same” (4Sta1). Different people felt the effects of this separation to different degrees, often depending on the *valence* they attached to being removed from their life contexts.

Oh, yeah, I'd like eventually to go home...but yeah, I'm not real confident that it might happen, but we're trying yeah, got some people out there that are working towards it, I'd like to go home eventually, yeah...Oh I could be here forever. Going home is a goal and the council are trying to get me a unit, they haven't got me a unit out there, but carers are the big problem, at the moment there are no carers (8Sci1).

For some, the enforced separation intensified over *time*, as they became more and more alienated from their life, even after being discharged from hospital. For others, this separation dissipated over time, as they completed their hospitalisation and returned home. For most people with SCI this separation, at least initially, was characterised by some feelings of *anxiety, denial or resignation*.

This is the difficulty with regional clients [those who live outside the capital city] in that they don't have that involvement from friends from the word go and they are often very anxious about going home and trying to re-establish those friendships because those people haven't really known what they have gone through and what is involved in having a SCI (3Sta1).

The concepts of *environmental separation, role separation, identity separation and*

interactional separation are explored in more detail below. The codes that represent these concepts are attached in Appendix S.

Environmental separation

An individual who is hospitalised is geographically separated from their friends. This *geographic isolation* created *proximity* issues for friendships. “Yeah, leaving, yeah leaving it all behind, leaving her behind, you just want to pack her up in your suitcase and take her home every time you come down” (4Fr1). Physical separation and loss of proximity has been found to be associated with friendship dissolution among college students (Rose, 1984), so it is not surprising to find that traumatic separation created many emotional reactions for friends. For many participants, this separation was protracted, where length of hospital stay exceeded one year (e.g., 3Sci). During this time, the person with SCI is absent from their community and friends, thereby experiencing *displacement* from those friends.

It was a lot closer than it is now, yeah it’s a strain on [us] being apart. It’s harder to keep contact, because...[she] has got kids and work and everything, so she finds it harder to keep contact and that sort of thing... long distance relationships are hard to work, um... (4Sci1).

There was often a significant *change of pace* and *lack of spontaneity* associated with the enforced nature of the environmental separation that inherently influenced the ways in which the separation was experienced by both parties. “The fact that I don’t have the freedom to go out with them when I want to, I’m stuck here, you know, and the fact that I can’t walk, you know, it does, it gets um... frustrating at times” (11Sci1). Indeed, “there’s no such thing as a spontaneous trip to town and back, it’s a planned trip to town and back” (15Fa1).

Characteristics of the *hospital environment* and the *hospital experience* frequently exacerbated this environmental separation.

Because you're in a set routine of, you know, showering, OT, gym, tea time, back to bed, type of thing, yeah. Plus you're in a room with three other patients, and they have their family and friends and visitors coming and going all the time, so you do find it quite hard (8Sci1).

Opportunities for reducing the environmental separation, such as visits from friends, were pitted against the need to participate in therapy sessions or other hospital routine. "Because the day was pretty well filled in with OT's and physio-terrorists [colloquial and sarcastic term used to refer to physiotherapists] and gym people...nurses...bowel therapy, it's all such fun [said with sarcasm]" (3Sci1). The inability to leave the hospital on outings with friends was an important aspect of the hospital experience that exacerbated environmental separation between friends. "To start with it was just hanging around the room because I couldn't go anywhere" (18Sci1).

For established friendships, the geographical separation of friends may be sufficient to end the friendship, although in other cases, it has been found to help two individuals confirm and strengthen their ties to each other (Lutfiyya, 1989). There were a few examples in the current study of how the traumatic event and its associated separation had strengthened some friendships. "Yeah we were sort of work colleagues before, but you know, like I'd never been around his house and he'd never been around my house, just sort of work mates, but it has got closer since my accident, yeah" (10Sci3).

Although the enforced separation at an environmental level appears obvious (i.e., related to being hospitalised), environmental separation affected individuals with SCI and their friends within both hospital and community contexts. One family member described the inherent difficulties experienced by friends when trying to negotiate an outing in the community setting:

Because they could see that, oh, you know, this is hard, [he] isn't transferring into the car like in a sec [second], you know? And oh, we do have to take the wheelchair, and oh, we do have to work out where is flat and where you can

get over the gutter and, you know, all of those things you have to think about. There was sort of a big switch then I think, and yeah, that sort of reality of, you know, oh he actually is in a wheelchair, because I guess if you're in bed or, and you know, the spinal unit is... is one of those hospital settings, and it's all, it's sort of... I guess when you see somebody in a wheelchair in the spinal unit it looks normal (15Fa1).

The mere presence of the person with SCI in the community did not ensure their re-inclusion in that community. Although *residential placement* (i.e., transfer to supported accommodation rather than the normal home environment) in some instances ensured the continuance of environmental separation between friends, other factors appeared to engender separation. The *living status* of the person with SCI was relevant as noted by rehabilitation staff: "The usual thing that happens for a lot of our clients is that they end up having to go back to live with mum and dad [after having been independent] or whoever and so they are out of their social group" (2Sta1). Some individuals were able to live independently in their own homes, but were restricted in terms of *physical access* to the community. This lack of access impacted on their ability to participate in friendships and exacerbated the environmental separation.

Wheelchair access makes things difficult, being able to go somewhere where you can get a wheelchair in, there's quite a lot of places that you just don't, until you end up in a chair and you go there regularly, you never actually really think that they haven't got wheelchair access. Until you go there and you think 'whoops, can't go there anymore, they haven't got any wheelchair access' (8Sci1).

One staff member related the following story:

I can think of one older man who was a primary producer and I think they had moved off of their property so they had probably had sort of retired already and sort of moved to the edge of town in a house, but he became extremely isolated and very bitter about it. He talked about the experience of just sitting on his verandah and when the show was in town and watching his mates go past with the cattle trucks to take the cattle into the show and nobody stopping and just feeling like he was really on the sidelines and he became very bitter and very isolated (4Sta1).

Thus, *limited public awareness, inadequate transport or inappropriate community*

access services contributed to continuing environmental separation in the community. “I wouldn’t go very far because I didn’t have a vehicle, and there’s no transport... so I’d have to rely on other people, so it was mainly their decision, I suppose, to go out” (19Sci1).

Individuals with SCI experienced environmental separation from their friends, not merely as a result of the physical environment, but also due to the social environment. In some instances, people with SCI exacerbated their environmental separation by *withdrawing* from community activities and social participation. Although some people withdrew during their hospitalisation, others reported withdrawing from their networks more over time. In some instances, withdrawal was a reaction to the perceived potential for rejection from friends, but ultimately caused the environmental separation from those friends. In other instances, environmental separation itself created such significant barriers that individuals chose to withdraw from friendships, often resulting in significant social isolation.

You know they might not have done a lot socially but I just don’t think....I think if anything, if they come home and they have not got those friends and they have withdrawn into just family and do you know what I mean and they have let those age appropriate activities go, I think it is difficult to pull that back and I think they can become very socially isolated (2Sta1).

In other instances, the social environment that was created inadvertently by rehabilitation and community services staff inhibited friendships. Limited *staff recognition of the friendship role*, the *high pressure/low time clinical context* and the *perceived hassles for staff* in facilitating friendship were factors that increased the social separation of people with SCI and their friends. The following statement made by one person with SCI highlighted a negative situation where staff interference occurred.

Occasionally you will get a problem if some bitch of a nurse feels like acting out if they have had a crap day and they are like “I am feeling tired, I am

feeling shitty, oh I can take it out, transfer it onto a visitor of someone”, and so then they go off at the person just because there’s these visiting hours which are never ever enforced unless, they are only enforced if the person [nurse] feels like going off really (9Sci1).

The following account relayed by a staff member also revealed significant staff interference that created social separation for friendships.

I don’t think we recognise the importance of those relationships and how tenuous they can be and you hear stories about people who have travelled hours from the country to come down and visit and being ordered out of the bed area because some procedure needs to take place, often it is a minor procedure that is routine that is being conducted within the ward and really could be conducted an hour later with no real consequences but and then the family and friends who are only having a short time to visit are missing out on some of that time because of the convenience of the hospital staff (4Sta1).

People live their lives within cultural contexts that hold meaning for them. As such, separation from that cultural context has implications for the environmental separation experienced by individuals with SCI and their friends. *Cultural displacement* may be equally as important as physical displacement, with its associated separation from the behaviours and values considered to be “normal” for the individual and their friends. Friends from small country towns had to translate their friendship into a new cultural context when they were visiting a hospitalised friend: “...in a big city like this and being used to being in a small little place, yeah a big wide open space [expression of being overwhelmed by the city]” (4Fr1).

Ultimately, environmental separation between friends was experienced by one or both parties as feelings of *loneliness* and *social isolation* that, in turn, had negative implications for friendships. “You get pretty lonely for a while; it takes a bit of getting used to. But then after a while you start to think “well, I’ve got to get my life back, you know” (8Sci1). “[I] can’t wait for her to come home; miss her, like yeah, you miss her all the time, and yeah. It’s got to be hard on everybody else as well, it has to be” (4Fr1).

Tzonichaki and Kleftras (2002) suggested that loneliness may not only be related to limited social contact but also to the behaviours that individuals with SCI exhibit toward their support system as they come to terms with their very personal and traumatic circumstances. These behaviours may prompt interpersonal negativity and rejection, thereby widening the enforced separation between friends. There was some recognition of this interactive aspect of separation: “I think if you are a negative person, you’re not going to hold your friends” (6Sci1). Participants with SCI sometimes spoke of withdrawing behaviours (e.g., denying visitation from friends) that they utilised when having bad days. Friends were typically unaware of these behaviours or attributed them to the circumstances rather than taking it as an affront to the friendship. Participants with SCI also attempted to cover up these behaviours in an attempt to protect the friend (e.g., using therapy as a reason for denying visitation).

Role separation

In everyday life, individuals hold a number of roles that are extremely important for their well-being, providing meaning and substance to their existence. These roles may be related to the family, such as husband or wife, the workplace (i.e., employee, supervisor, part of a team) or the social context, such as friend or neighbour. Following SCI, most participants reported that a *change of roles* occurred as they were separated from the contexts within which their roles occurred. “For a lot of the friendships [she] was the giver in the friendship, she was always a happy, warm, giving person, and when she was no longer available to do that, the friendship just waned” (4Fa1). One person with SCI described the altered roles in their friendship in the following way.

I’m a little bit more reliant on [friend] to come around and do things, which I don’t like doing...I just don’t like relying on people to do things, I’d rather do

them myself, and there's just some things that I can't do physically and it really pisses me off, I'm used to being in control and I've lost some of that control (11Sci2).

A parallel concept in the literature is that of "turnings" or transitions in a person's life where they take on a new set of roles, enter into relations with a new set of people, and acquire a new perception of themselves as friends (Matthews, 1983). In this sense, the occurrence of an SCI in the context of friendship represented a potential "turning" in the lives of both people with SCI and their friends.

Although sometimes precipitated by environmental separation, the nature of the injury itself often prevented participation in valued roles that had been held prior to the SCI. In many instances however, the impact on role separation depended on the orientation of the friendship prior to the injury (i.e., based on *emotional connections* or *activity orientations*).

And talking about that is something that is probably when they had their injury and they were in the unit, people probably stopped coming and it was difficult to maintain those friendships when they got home, they weren't able to engage in the sorts of things that they used to do and um particularly for young blokes who you know surfing was their life or some other activity and they have just not re-established those roles with those groups (6Sta1).

These changes impacted on friendships because friendships were often intricately linked to the roles people held. For instance, where friends had *common interests*, their roles were often tied to that activity such that without the role, there was no place for the person in the friendship.

Because [his] relationship with his friends is actually one of a participation sort of friendships, it's like he, his friends are made through the sports that he does, so he's got a surfing group of friends, and a bike riding group of friends, and you know, those sort of things. So I guess they instantly, you know, all they could see was [him] on his motorbike, or [him] on his pushbike, or [him] on his surfboard, and it was, like, there's no way that guy is gonna [going to] be in a wheelchair, you know? They just couldn't come to terms with that at all (15Fa1).

You don't do half the things you used to do once upon a time. She can't do them, and yeah, you find it really hard because you'll be walking through a

shopping centre and you half expect her to get up and start walking, like get up out of the chair and walk around the shopping centre with you, and you've actually got to stop and realise, you think "oh, no she can't." So yeah, I would imagine that it is quite difficult on her as well (4Fr1).

Making a *meaningful contribution* to society through valued social and vocational roles was extremely important to people following injury and many of their friendships were tied to their participation in these roles.

Most of my friendships, well, they came mainly from work; because of the hours we used to put in. There were a few people we knew from outside, but there were some that we invariably met through work, so it was a fairly close unit...If I had to do something else, I don't know what I'd do (3Sci1).

Participants often described being *on the sidelines* when they discussed the reduction or loss of role *participation*, and the resultant role separation from their friends. For some people, this related to separation from *leisure* roles – "[I] just don't football train with them, and I don't play football with them, that's it, I just sit on the sideline and watch now" (6Sci1). For others, separation involved the loss of *vocational* roles and for others, it represented a separation from everyday activity. "I'm limited in that [participation in activities]; so I'll still go down to the pub and have a beer and that, watch them ride the bikes, you know, I don't really know, just limited things, going shopping" (5Sci1). Regardless of the role, friendships that were linked to roles experienced difficulties that often had flow-on effects for interactional separation. "I haven't... haven't seen them much lately because they've all been working" (18Sci1).

Independence was perceived as being an important or even essential prerequisite for role participation and impacted on friendships because friends were separated from their traditionally equal friend role and were thrown into an unequal *personal care* role. In the context of bladder and bowel management, one participant described the following incident where the nature of her friendships altered as a result

of her loss of independence.

One of them, I went over and I'd woken up and I'd had an accident; and she was good, she just gave me some stuff and left the room for a while, while I cleaned up as well as I could, got dressed and got up to the hospital. She had to go back and clean the sheets and stuff, but yeah, it didn't faze her. My other friend, the one with the children, she's actually a carer up home, for indigenous [people]; and so yeah, I mean nothing will phase her. So yeah, it was...it was fine for her, she accepted the accident. It was harder for me, so I had a few tears then, just you feel like humiliation and that sort of thing (4Sci1).

The *carer versus friend* role separation often caused significant strain and fear among either people with SCI or their friends and in some instances placed strain on the friend's ability to fulfil other roles.

One of her friends, the older friends, asked if she could become one of her carers, and so she started doing the evening shift, but she's just resigned because she just found it too hard, it's, you know eight to nine or nine to ten at night and she's got three children, and her partner was getting upset by the fact that she was out every night during the week, um, with [person with SCI]. So she's just had to pull the plug (4Fa1).

The *functions and roles of friends* varied across different friendships, depending on the background of the friendships (e.g., *school friendships* or *work friendships*), the types of support that were typically exchanged within the friendships (e.g., *emotional support* or *informational support* or *practical support*), the *friend's rights* within the friendship or the *expectations of friends* held by each party. The extent to which factors impacted on the friendship depended on the ways in which each party *defined the friendship role*. For some, the role of friends was defined as someone to "muck around; go to the pub; get drunk, that's a friend, they just hang out with you" or having a "mate that you can hang around with, and can talk to, and I don't know, just someone you get along with really" (18Sci1). Within these definitions of friendships, the post-SCI roles were less affected.

Some haven't [contacted me], but given the situation, you know, that's... that's understandable, it's not like I've been close to them, I've just gone for a ride with them, so some different people react different ways and it doesn't

mean they won't talk to me again...if you're going for a ride, but you don't have a big social connection outside of that it's not like you've got to pretend that you're great friends or anything like that (15Sci1).

Other people defined friendships as being more integral to survival and the ability to thrive. Friends played a more general supportive role for the individual and, as described below, they *buffered low periods* or played the role of *Good Samaritan* by providing high levels of practical support.

- Interviewer: Alright, in terms of your friends that you had before your injury; what role are they playing in your life now?
- Interviewee: Oh they're just there for support mainly, yeah.
- Interviewer: Okay, what does support mean?
- Interviewee: Oh just somebody to talk to when you're a bit down, a bit lonely, or bloody you've got the shits with the world or whatever, yeah (8Sci2).
- Interviewer: So when you say they're always supporting you, what do you mean?
- Interviewee: Oh if I fall out of me chair they help me up (5Sci1).

Depending on the function of the friendship, expectations of friends following the injury tended to differ, leading to different conclusions about the post-injury friendship. Some friendships were fairly incidental prior to injury, meaning that each party did not play an active role in maintaining the friendship. These friendships typically remained fairly incidental following injury but experienced difficulties if the roles changed and one party (typically the friend) became much more directed in maintaining contact or providing practical support. Indeed, staff suggested those superficial friendships were extremely difficult to maintain, especially in the face of significant disability.

I do see, I do see that a lot of the friends will, like, they don't maintain those, you know, superficial friendships, especially the higher the level of injury [i.e., more severe paralysis] is, the more inclined, you know, the more probability is that they won't maintain those friendships or the socialisation that they used to have with those friendships. So instead of going to the pub they might say come around and have a drink but it is not the same (5Sta1).

In other instances, where friends played active roles in maintaining the

friendship prior to injury, there were expectations placed on friends (e.g., making the effort to visit or ring) following injury to fulfil these roles and subsequent disappointment in instances where friends did not meet expectations.

A lot of people I know, who I would consider friends, we haven't heard from. It's easy enough to pick up the phone. There would be no more than four or five people that we've maintained contact with (3Sci1).

One staff member described this issue in the context of the expectations that individuals may have of their friends versus their family and the functions or roles that they expect friends and family to fulfil.

I think it is about, particularly the young guys; it is about being accepted by your peers means that you are the same person. Like they will wipe their families as quick as, you know, because the friends....., it doesn't matter if they have a disability or whatever, the friends, the peer group is the important thing and if the friends don't visit, it is very, very hurtful. They know mum and dad or family will visit (2Sta1).

Many factors contributed to the functions and roles of friendships, including, *family expectations of friends*, the *impact on and costs to friends*, the *closeness* of the relationship, the *harmony between friends*, and the *peer group acceptance* of that friendship. "It just really depends on... you know, the relationship that you had prior to the injury..." (15Fa1).

There was considerable evidence that the *functions and roles of family* prior to and following the injury impacted on the way in which the family engaged with the individual's friends following the injury. Where the *impact on and costs to the family* following SCI were high, and *respite for the family* was required, friends were often called upon to adopt roles that were inconsistent with those they had held prior to the injury. Indeed, there is some suggestion in the literature on elderly populations that older people lacking in kin often tend to substitute for missing relatives by converting close friends into fictive or quasi-kin (Dykstra, 1993). This finding has also been replicated in younger populations (Tierney & Venegas, 2006). An illustrative example

of this process was supplied by one family member.

Oh I'll be really selfish here initially, I enjoyed [her] friends coming down because it gave her a whole new group, um, of people to talk with and um... and relate to, it gave me time out, and it gave her time out from me, because I didn't feel guilty for not being there if her friends were there with her. So that was valuable for all, particularly I suppose for [her] and I, that um, we could take time out from one another, and that refreshed us then for being back together again (4Fa1).

In other cases, the family adopted a *protective role*, sometimes actively removing friends from typical roles or discouraging them from being involved. As one family member stated, "we are less supportive of that friendship, you know I would not cry buckets if she disappeared into the wilderness, because I know that friendship is a 'taking' friendship" (4Fa1). This response impacted on friends who became acutely aware of the position of the family.

I see the family being very protective all of the time, and they want to be there, they want to force preference over everything. But yeah, I mean I've come down here once with mum, mum and I come down here and her mum was down here, and it was a sin for me to touch her wheelchair, and in the end I said 'stuff it, this is crap' and started pushing her around. But she's [mother] always on your case 'are you sure you should be doing this, this and this? [friend] isn't pushing you around is she?' (4Fr1).

Families were tied to roles by *filial obligation*. *Family involvement* in the rehabilitation process was often significant, but this opportunity for involvement was not replicated for friends. Thus, the likelihood of role separation was significant during this period of time.

Role separation for either member of a dyad had considerable impact on the friendship. There was some evidence of positive adjustments in response to the changing roles (e.g., friends who played a more active role in the friendship itself prompted greater involvement and interaction that acted to bring those friendships closer, thereby reducing the loneliness experienced by the person with SCI).

It's actually a good feeling knowing that you've got, your friends are there to, take the time out to come and see you... it's just a good feeling knowing that

there's people actually that care, which a lot of people don't these days, a lot of people don't give a hang about the guy next to you or whatever, it's good to know that people actually went out of their way to do that (16Sci1).

However, for the majority of people with SCI, the *impact on adjustment* caused by role separation was substantial. Role separation often occurred in conjunction with pity. Friends altered the roles that they played in the friendship because of feelings of pity for the person with SCI. This often placated their own need to feel like they were making an active contribution to the friendship.

You ring him up, well there's always, as I suppose there would be, you're always thinking, you know, poor bugger's [Australian colloquial term] there in a wheelchair, he doesn't particularly want you to feel sorry for him, he just wants you to ring him up or go and see him every now and then, and probably by doing that you get a bit of satisfaction in knowing that you're sort of helping him through it a bit, aren't ya [you]? (8Fr1).

However, this pity fostered an inequality in roles that, although often not explicitly stated by friends to the injured person, was frequently sensed by the person with SCI.

The worst thing is the people that come out of the woodworks after you haven't seen them in months or twelve months or two years, and they come in and see you. I didn't like that the most, I found that hard, and I got angry with those people that came in because I didn't want them in there...Well I think they don't have enough time to talk to you in the last month, six months, or twelve months; why all of a sudden because I'm sick, come in and see me, see me now because they feel sorry for me? (6Sci1).

The perception of *obligated friendship* was common and was often apparent to the participants with SCI. Rather than engendering positive feelings as thought by friends, it only served to enhance feelings of social isolation.

Everyone usually has their group of people to chat to and whatnot, and there is the trickiness of when people come over and talk you don't, there's the... it's interesting considering whether it's talking out of an interest to talk or whether it's a um, through the sort of sense of obligation of "oh I better talk for a couple minutes to the sort of guy in the chair, and then I'll have my sense of civic duty sort of stated, and then I'll go on doing to what I wanted to do," or whatnot. It's tricky puzzling out that sort of thing sometimes, but that's the nature of all sorts of social interaction, it just sort of adds an extra factor to them (9Sci2).

Identity separation

Identity relates to our perceptions of who we are as a person. Thompson et al. (2003) proposed that people who sustain a SCI, need to find a new sense of “I am”. When we experience significant life events, these tend to change some aspect of our self, making us a different person. In the current study, *identity separation* occurred when one or both friends experienced a change in their sense of self, which was often related to the degree of role separation that was experienced. For instance, an inability to fulfil typical life roles changed how individuals defined themselves. Alternatively, a change in how individuals defined themselves following their injury influenced the degree to which they maintained typical life roles.

We all have, you know, tickets that fly off us that sort of tell us who we are. You know, like I am a nurse and I am a mother and I am a volunteer at dancing and, you know, all those things that, you know, help you identify who you are at any given point on a day or any given day you sort of swap roles with what your tag says you are. When people have initially come in here [hospital], a lot..., that is all gone. They sort of feel...It is not gone really but they sort of feel like that has been ripped off them (7Sta1).

At the start, they were a bit uncomfortable, didn't know what to say to me, because I was always a fairly lively person, always running around, jumping on things, mucking around and that. But it's funny for me to swap roles, now that I'm pretty quiet and contained, and they just had to get used to that, that was their biggest thing (6Sci1).

Perceptions clearly emerged as an important aspect of identity separation.

Friends spoke of how they perceived that the injury had changed the person with SCI, but simultaneously recognised that many aspects of the individual had stayed the same. This situation of “change but no change” was confusing for friends.

Its [SCI] changed her a lot, it has, because she's not the same... that she was twelve months ago...oh she's got the same sense of humour, the same, she's still the loving person that she always has been. But just yeah, in some ways she's not, you know, you see her often get depressed on the odd occasion, not the odd occasion, it happens quite a lot I suppose (4Fr1).

The extent to which the changes impacted on the friendship was dependent on how

individuals perceived their identity or their friend's identity prior to the injury, especially in terms of the friendship and their *lifestage or developmental stage*.

It doesn't happen for all older people but he may have already however moved out of his main circle at the time when he had his accident and he may have been at the stage of a life transition and so his relationships may have been in the transient sort of stage anyway. It may have something to do with that, the stage that people are in terms of their relationships, as to how they are sustained (4Sta1).

Some people spoke of just living week to week prior to their injury with no idea of where they were going or what they wanted to do with their lives. The injury represented the point at which they started *developing an identity*.

I don't know; I was a single mum, I separated from my husband - we were divorced three years now, and he lives down here so... I had the boys on my own up home, Mum and dad helped, friends helped. I guess I was pretty quiet, I wouldn't talk much or anything like that, I was very shy – a big introvert. And yeah, I mean stretching to make the ends meet every week and stuff like that, and so now for me it's been very different because being down here it gave me a chance to reinvent myself (4Sci1).

However, it was not only the person who sustained the injury who engaged in a process of examining their identity following injury. Often, the friends also spoke of how the injury had changed them as a person or impacted on them psychologically or behaviourally.

Interviewer: Do you think that the accident has changed you as a person in any way?

Interviewee: Oh, yeah I'm selling my motorbike....

Interviewer: So that's a pretty big thing....

Interviewee: Oh yeah. So I've looked at other things and gone "do I really need it?" I think my son needs a father.

Interviewer: Yeah, so it's made you think about the importance of things.

Interviewee: Yeah, where before you just, what, you put it to one side, think, "well, can't happen to me," type thing, "I'm bullet-proof."...you start to think, well, you know, you're not that bullet-proof (3Fr1).

Reactions to injury by both the person and the friends were *individual reactions*, dependent on the *life experiences, personality* and *self esteem* of each

person.

So I was a bit of a social butterfly before, before the injury, not as much now, but just if I seen them out, like I could walk into a bar on me own and make a friend with anyone pretty much (6Sci1).

For the individual with SCI, a key factor in identity separation was the degree to which the individual identified and incorporated their '*disabled*' self into their perceptions of who they were as a person. *Body image* appeared to be particularly important. One participant (2Sci2) described how his body image influenced his view of himself and how he expected his injury would change the perspective of others. Whereas he was tall and imposing prior to his injury, he perceived that he was now much smaller in stature because he was in a wheelchair as opposed to being in a standing position. In describing this, he suggested that he perceived others to be threatened by this change because they would now look down to him rather than looking up at him. He perceived that this inherently changed the nature of the friendship. While the person with SCI often spoke of their disabled self in terms of their body image, staff noted the way in which identity changes psychologically and behaviourally in the individual influenced friendships.

I am thinking more from the friends side as to how they associate with that person and the differences in how that person reacts back to them in that like the changes in their mood, the way that they say stuff and it might not be the person that they originally knew and I think that makes it very confronting for the friends to deal with (5Sta1).

Functional ability, mobility, type of disability and level or severity of injury were all related to the experience of *loss* as felt by the individual and by the friend.

I don't, well just sort of to face the reality, because I suppose I didn't know anyone personally who was a paraplegic, so that was fairly... that's a confronting sort of situation, which is... just knowing that a huge change in [his] life, and it's so profound (15Fr1).

Thus, identity separation was clearly associated with the ability of friends and family to focus on *the person not their ability*.

Yeah, for your friends and your family, they have to try and treat you like a normal person, like too many people tend to think that your brain is dead, they just try and take your life over and organise you and do everything for you, when, without giving you any credit for being able to make a decision on your own behalf, and after a while it starts to annoy you, and after a while you start to let it happen. You know, you get so used to everybody doing everything for you, you just don't make any effort to do it for yourself. But just to treat everybody just the same as they were before their injury, because, you know, we are the same people really, just our arms or our legs or whatever don't work, but our feelings for each other are the same, and yeah, make sure that you do keep in touch and stay the same people (8Sci1).

The ability to maintain an identity was sometimes influenced by whether there were *other previous losses* that had already prompted individuals to question their identity. For example, one family member spoke of the challenge to identity where multiple losses had occurred.

She'd also, you know I mean... it's not just [her] accident that caused the change, I mean the fact that her husband had only left her twelve months before the accident meant that some changes had occurred in her life, and then the accident happened. And so in a way she's gone from being married, single, and now a paraplegic, so just these changes over that time, in her lifestyle over these last three years (4Fa1).

The majority of individuals highlighted the fact that their friendships would not be and were not affected by their injury because, despite the environmental and social separation they experienced, they were still the *same person*. Therefore, the sense of identity continuity was a basis for stability in friendships.

Oh it's just a proper friendship, you don't have to keep it going, it just naturally keeps going. Um... just because he's, you know, incapacitated doesn't mean, that's what I mean, he's the same bloke, he just can't walk. He can't, you know, he's not independent anymore but he's the same bloke. So there's no reason for the friendship to change (8Fr1).

In other words, there was a *perception of sameness in the friendship*.

Most of them just treat me like the same way they did I had me accident two years ago, nothing's changed, they haven't sort of thought oh yeah, you know, what do we do here? What do we do there? They just yeah, to me I'm just the same person I always have been (8Sci2).

How people defined themselves and their friends within their friendships was

particularly important in terms of identity separation. Many people spoke about the *indefinable aspects of friendship*, referring to friendships that “just are”.

It’s just one of those things, we’re just good mates, we’re fairly different people, but um, we just became mates at boarding school, we always have been, and... you know, we, I came from out there so we’d have a beer together every now and then, but you know, it was, hard to explain, we just knew we were good mates and we always have been, always will be (8Fr1).

Friendships were more likely to be maintained over time where the *definition of friendship* was similar across both individuals and remained so following injury in terms of *the history of the friendship, the length of the friendship, number of friends or size of the support network* and *the similarity* between them. At least in the short term, this similarity in definition of the friendship met the expectations of each party. Identity changes occurred in both the short and longer term context. Just because friends perceived a similarity between them early following injury, this did not necessarily prevent identity separation occurring at a later time.

The *closeness and level of friendship* and how friends perceived this closeness and its continuity from pre- to post-injury was similarly important. Some people perceived this history and continuity positively as it contributed to a positive sense of self and a positive feeling for the friend.

You build up a bit of history with people, and it’s, it just shows how, what’s the saying? It’s how you make a person feel after you leave is how you judge yourself, you know, like when you’ve left a person, if you left them in high spirits or good and they had a good time, and they reflect on that, that’s how they’ll treat you when you see them again (16Sci1).

Some individuals identified the fact that even though there was a perceived similarity between them as friends and that there had not been significant role separation (e.g., they still did the same things together in the same ways with the same frequency), there was something that was *somehow different* following the injury. Much like the intangible quality of strong friendships, this something that had changed could not be

readily defined but appeared much more likely to be related to identity separation than any significant environmental or role separation.

One key factor to emerge in the consideration of identity separation between friends was the degree to which they had sufficient *knowledge of the other person* on which to make a judgment. As noted by one rehabilitation staff member, “it was almost like their [person with SCI] experiences had brought them along a path that their friends had no knowledge of really” (2Sta1). *Understanding the person* and their subjective journey into the unknown world of SCI was difficult for friends, particularly those who had not travelled any traumatic journeys together before. Environmental separation prevented any joint experiences post-injury on which to base this understanding.

Only the other patients really know where you’re coming from, they really understand what you’re going through, like everybody else says they’ve got an idea, they think they know, but they don’t really, and the other patients do, because they’re going through exactly what you’re going through (8Sci1).

This knowledge and understanding of the person with SCI could not be objective in any way, but was based on the individual’s *perception of the other person*.

Broader social factors within which individuals defined themselves also emerged as important to the process of identity separation. Issues such as *equality*, *inclusion* and *discrimination* were all identified as potential factors. Exclusion from friendship and community networks, and perceptions of inequality forced the individual to assess not only who they were in terms of the friendship, but who they were within the context of the broader social network. Public awareness and understanding were considered to be important in allowing the individual to be themselves. “I think it’s good for people to understand that, that you know, not pity or anything like that, because I didn’t understand or have a clue, what actually was involved in being like this” (15Sci1).

Interactional separation

Perhaps the most commonly identified form of enforced separation experienced in the context of friendships was that of interactional separation.

Although sometimes influenced by environmental separation, interactional separation was avoidable through the use of technology, even when environmental separation was unavoidable.

Texting [on mobile telephone](laugh) and they'd ring; and I'd ring them... the first couple of months were hard because I had a 'tracky' [tracheotomy tube] in and I couldn't talk with it; so that was really hard...couldn't see them, couldn't talk to them. Um... yeah, yeah mostly [kept in touch with friends] through texting... writing letters and... Yeah it's been pretty easy to stay in contact actually (4Sci1).

Contact and interaction between friends could occur through a variety of media, namely *in person*, *telephone* or *internet access* and *email*. Many participants described the extensive use of telephone in their interactions which represented a significant departure from their previous primary means of communication which were typically in person. "I always had my mobile phone on, and they'd just give me a ring..." (6Sci1). As one family member observed "friendship continued...through texting, um, some of her friends don't text, it wouldn't have survived that, it was a few months before she was able to speak on a phone" (4Fa1). Internet access facilitated email interaction, but this was used less frequently by individuals within the context of the rehabilitation setting because of practical limitations. "Reason you get internet generally was to just check out the emails anyway, so you just wait until there's no-one on it, quite often you can't get on so you just come back the next day or go at a different time" (15Sci1).

Interactional separation was also influenced by identity and role separation to the extent that enforced separation in these domains made interactional separation

more likely. For example, in situations where the individual perceived that they had changed as a person, it was more difficult to initiate conversation and interaction, because they were never sure what they should talk about now.

Sometimes they [people with SCI] would talk about the friends that they have maybe lost, the people that don't hang around afterwards. Like so-and-so [friend] hasn't been to see me and you know some of them have been scared to come and see them as well. If maybe, especially the younger population, they are scared of, you know, what to say, what to do, how to act and all the rest of it, they avoid it and then the patient doesn't really know where these friends are coming from (9Sta1).

Interactional separation was characterised by *changing interactions* in that the quantity, content, quality and forum of *conversations* between friends often changed following SCI.

Oh yeah, we always have D&M's [conversations about deep and meaningful topics], all the time. Hasn't happened so much lately, I mean over the phone, I'm always calling to her over the phone about something, but yeah. I mean for me to come down here, we don't really have that, yeah those big long talks, because you do it on the phone, and you're just happy to be here with her when you're here, so yeah that sort of all just gets pushed aside (4Fr1).

One notable change in interactions related to the provision of *increased attention*, particularly from friends who were not previously perceived as being close.

These situations often prompted a *perceived over-involvement* with friends and the *need for timeout* from social interactions. "Oh we've been doing something every day for like the last..., I'm sick of being social at the moment" (11Sci2). Some individuals with SCI found this increased attention a little disconcerting and a departure from the "normal" interactions they had with their friends. Thus, ironically, increased attention contributed to separation by changing the normative "rules" of the friendship.

The degree to which *disclosure* characterised the interactions between people with SCI and their friends also emerged as an issue. People with SCI were often unsure about how much to disclose, or were not comfortable disclosing certain types of information.

You just say well, you know, sometimes you have a bad bowel day so you can't go... don't try to, don't go into explicit detail but don't try to hide the plus and minuses of being a paraplegic, you know. You know things like skin care and stuff like that I'll talk about that openly, I mean I, you try to sort of hide things to sort of I think it just makes... it's easier to be open and make a joke about and then people feel comfortable rather than "I don't wanna go there, yeah (15Sci1).

By disclosing their difficulties to their friends, some people with SCI felt that too much burden would be placed on their friendships, leading to role separation and thereby altering the nature of the friendship.

No I just ring up and say g'day and have a yarn, yeah. I don't tell them that there's anything wrong or anything like that. I just ring them up and have a yarn to them, and then, yeah, after I stop talking to them and get off the phone I feel good... yeah, but I don't land the problems of the world upon them. What they don't know doesn't hurt 'em [them] (8Sci2).

Some participants described a *lack of spontaneity* in their interactions, prompted by contextual factors such as the rehabilitation environment. In these instances, individuals often felt that interactions were too formalised or "false", complicated by the fact that individuals felt that they were constantly *on the sidelines* during interactions. Participants described conversations consisting of small chat and limited eye contact rather than typical conversations that were representative of those pre-injury. This sense of falseness could occur for either the person with SCI or the friend, as evidenced by the fact that, sometimes, friends would talk to the family member or spouse, rather than the injured person. On rare occasions, the uncomfortable interactions created *conflict*, representing a divergence from previous interaction experiences between friends.

He just sat at the end of my bed and just stared at me, because we had nothing to talk about, so it made me feel uncomfortable and I didn't want him in there. So I didn't like that at all, so yeah... But then when this happened, he came in, I made a comment that you know, I don't want people coming in all the time and feeling sorry for me and stuff like that, so then I think he took that the wrong way and didn't come in at all after that (6Sci1).

Interactional separation was most often characterised by changes in the

frequency and nature of contact between friends, especially during the early stages following injury. “About three and a half weeks after the accident was the first time I heard her actual voice” (4Fr1). *Frequency of contact* often increased, even to an intolerable level, but, in other instances, it was significantly reduced, leading to an extended period of separation. Pre-injury interactions were often characterised by reciprocal initiation of contact, but following injury, people with SCI often reported that *friend-initiated contact* had changed, either increasing or decreasing.

Oh just people you worked with. People you joked with, swore at, went through the same experiences with, almost on the same plane. One, two, three... four of the six staff [work colleagues] up there, other than me, we haven't heard a word from – and I thought at one stage “well that's pretty slack, they could have at least picked up the phone, they've got [wife's] number if they haven't got mine”, like that. But most of them are gone now, so it doesn't matter (3Sci1).

The change in who initiated contact was most frequently linked to the degree of environmental separation that was experienced. When people with SCI were unable to maintain their contact with friends themselves, some friends took on the role of primary initiator of contact.

Uh, he's been ringing me a fair bit lately. Yeah, I used to ring him on a regular basis... but since I've been in here he's been ringing me quite regularly, at least once or twice a month or whatever (8Sci2).

Visits to the hospital, however, required the friend to initiate the contact on every occasion. Thus, the person with SCI was reliant on the willingness of the friend to take on this role. Indeed, there was no instance where the person with SCI asked a friend to visit. Because of the environmental separation created by the hospital environment (e.g., “the distance between here and the hospital” (3Sci1)), many friends felt that their time spent together and the duration of contact had been reduced. Whether or not contact was perceived as being appropriate often depended on the *expectations of contact* held by each party. Sometimes the amount of contact was

surprising and helped the person to feel extremely valued and important.

There was a lot of people [friends] that said ‘oh I was just going up to Brisbane for the weekend, where is [person with SCI]?, I’ll go and see him’, and um, incredibly supportive, incredibly supportive, yeah. And in fact I used to think to myself, look if I was in hospital how many people would come and visit me? You know, it’s, like, well, am I, you know, it was just his work friends, his, he got so many visitors, and it was fairly constant because you sort of expect that at first don’t you? Then after the months go on, you know, you sort of think, oh, everyone will drop off, but they didn’t, they were incredibly supportive, he was very lucky (15Fa1).

Sometimes friends did not want to initiate or continue contact for fear of imposing.

Where with my family...I could have been having a tough time and they were still there listening and stuff like that sort of thing, with friends I would probably think, ‘it’s time to go’, if I was starting to, yeah, be doing it a bit tough I suppose. Not out of not wanting to be there, but just thinking ‘okay, might be time to leave’ sort of thing, so yeah (7Sci1).

Other times, the person with SCI found that contact with friends was too *time-consuming* within the context of the rehabilitation setting. “By the time the physio comes around, and the OT, social worker, all that, your day, your week is fairly filled up” (6Sci1). This interactional separation was often prefaced by altered priorities related to immediate need (see *immediate need* below). For others, the contact was a welcome *respite from therapy* and *relieved the boredom* of the hospital. “Yeah, plus every couple of weeks when he rings up, he always seems to ring me at the right time, just when you’re starting to feel a bit lonely, or a bit down in the dumps or whatever, he rings you up” (8Sci1). In most instances however, individuals wanted the *companionship* of their friend, which was often difficult to achieve in the context of environmental separation. “Whether you have a SCI or not, you know, some people need a lot of people around them” (2Sta1).

Although a large proportion of people with SCI and their friends perceived sameness in their friendships in terms of interactions, others reported that contact from their friends was non-existent, prompting feelings of *abandonment*.

Probably, maybe more so when working in the unit...um...when you were seeing clients very often and you developed quite a rapport with them. Sometimes they would talk about the friends that they have maybe lost, the people that don't hang around afterwards. You know some of them have been scared to come and see them as well (9Sta1).

Feelings of abandonment typically ensued when there was no justification or explanation for the lack of contact from friends. In many instances however, when interactional separation occurred, *justifications* for this change were often put forth by one party or the other to "let their friend off the hook". "The friend that I'm thinking of, he hasn't been in contact heaps, his wife had a baby only like a few weeks after my accident, so I understand that he was very involved in that I suppose" (7Sci1).

When interactions were *inappropriate* or *privacy* concerns were prevalent, one party often tried to rationalise or justify the actions of the other party in the context of time limitations or environmental separation, rather than attributing it to any change in the friendship.

I haven't really asked him sort of what he thinks or how it's affected him, but I don't think it would have done, because like I say, he's got his own family that keep him on the go, and his business, so yeah, he wouldn't have a great deal of time to sort of sit down and think about it, because he's got lots of other things that are happening as well (8Sci1).

In many cases, interactional separation was attributed to the *withdrawal* of the person with SCI, resulting in feelings of *displacement from friends* or simply a sense that the interactions were *somehow different*. These feelings were often related to how well the person with SCI was adjusting to their current circumstances and the friend response to that situation.

That's one thing the injury sort of has done to me, I've lost the ability to communicate, and the need to communicate, so whether I've, one might say I've withdrawn into me shell, but... there's very little to converse about in here anyway, one day rolls into another and going back to hospital routine, it's not the most stimulating environment (14Sci1).

Interactional separation could occur, not only in the frequency of interaction but also

in the *type of support* provided within interactions. Sometimes, people with SCI reported not receiving enough emotional support or, at other times, they received too much informational support, or practical support that eroded their feelings of independence. Some friendships were characterised by a perceived lack of *consistency of support*, most often experienced as *waning support* over time.

You tend to find that in the acute phase the friends are quite willing to be there and provide a lot of emotional support and that sort of thing and especially the friends tend to offer that emotional support to the patients family as well but after a while... the friends tend to back off a bit and I think it tends to be sadly because of a bit of not knowing what to do and not knowing how to handle the situation and not having the skills to cope with that.... (3Sta1).

The changing nature of the interactions and the resulting interactional separation often heralded a separation of roles within the friendship, thereby creating role separation also. Appropriate interaction would prevent this separation.

If there was a bit of a hill or something or other, and [he] didn't want sort of help to get up the hill, he wanted to do it himself, that was something, you know, you can offer help but you've got to be sort of diplomatic in how you offer help, you can't just presume that someone who's got a disability will actually want you to help them up a hill. That was a quick learning curve... sort of ask first before you help (15Fa1).

Interactional separation also occurred sometimes due to the *use of jargon* by professionals and the fact that people with SCI had become acculturated into a similar use of jargon, often alienating their friends who did not understand. This further highlighted and exacerbated the fact that the mutual knowledge shared between friends becomes less over time as the personal journeys that each follow diverge and the injured individual accepts interactions in this form. Further to this, it appears that staff often unknowingly facilitated this interactional separation.

Interactional separation occurred within a variety of social contexts. For some people, interactions between friends prior to injury were associated with a specific *activity orientation*. Interactional separation in these contexts was therefore enforced

by the inability of the person with SCI to participate in these activities. In other words, role separation often played a causative role in interactional separation whereby the contexts within which interaction could occur were no longer available.

The hospital environment impacted heavily on friends whose interactions were usually personal and consisted of an *emotion orientation*. These friends experienced interactional separation because of the lack of private space within which friends could have such conversations.

In hospital, I just had a phone, a bedside phone, and the nurses used to just come and hold it for me, and then eventually I got a headset, so they'd come and put a headset on and that made things a bit easier. But a lot of the time the nurses used to just have to stand next to the bed and hold the phone (8Sci1).

As identified in discussions of both role and identity separation, the nature of the friendship prior to injury plays a large role in the divergence experienced between friends following injury. This equally applies to the interactional separation experienced following injury. Interactional separation was more likely to occur within the context of friendships that were restricted in their *closeness*, although did occur for friends who were close prior to injury.

One guy just didn't come up at all, I'm pretty close to him but he didn't come up at all, and he's uncomfortable, and he thought I felt uncomfortable about him being there, so, and so now I've kind of lost a bit of contact with him. We're only distant friends now I guess, we only see each other once every fortnight or something like that, where we used to see him three, four times a week, so (6Sci1).

Hanna and Berndt (1995) found that interactions between acquaintances differed significantly to those between close friends. For some participants in the current study, their friendships appeared to make this shift from close friend to acquaintance and there is evidence emerging from the data to suggest that interactional separation is a principle cause of the friendship change.

In conclusion, the interactional separation of friends following SCI resulted in a number of negative emotional consequences for each member of the dyad, including *loneliness and social isolation, guilt and blame*.

People tend to raise it as an issue if looking at the sort of contact that they have, more so expressing it that feeling lonely, feeling isolated, feeling they have noone to talk to, feeling that they are not able to get out, not able to keep up, not able to do the things they used to be able to do so people don't as much say, um, in my experience, 'you know I really want to meet some more friends', it tends to be more 'I am feeling very lonely and you know I don't, you know I don't know how I am going to change that (8Sta1).

Priority drift

Although *enforced separation* characterised the process of *diverging life paths* after SCI, it was associated with a *priority drift* among different members of the friendship. *Priority drift* was a cognitive concept whereby the priorities that people placed on different aspects of their lives, including friendships, changed over time as individuals processed the contextual factors surrounding their injury and their enforced separation from friends. For some people, friendships had never been their major priority.

I'm probably the worst person in the world for an interview like this, it's a... yeah it's just not really a top priority in my mind, it never has been and never will be, it's you... you know I'm 58 years of age and I guess in all that time I've probably had half a dozen friends who I'd call true friends but... I would... most people I know are only acquaintances anyway, and, but you wouldn't really call friends (14Sci1).

Changes in the priority placed on friendship have been considered within developmental and lifestage contexts (Carbery & Buhrmester, 1998; Ueno & Adams, 2006), but less attention has been paid to how these priorities change as a result of life events, such as injury, rehabilitation and adjustment. Consequently, priorities for friendship have more frequently been considered within the context of congenital disability, where developmental milestones are recognised. Friendship priority

following acquired disability has received little attention. Although the role of normal developmental changes in the priority placed on friendship was noted by the participants, the fact that *priority drift* was enforced on people with SCI was important.

Probably happens in that life stage anyway, friendships change and friends devote more time to marriage, but I think it is more difficult for people who have an acquired disability that is quite severe because it, they are somewhat excluded from that process and the risk is that they get left on the sidelines, they get left behind and they feel like that sometimes. (4Sta1).

Priority drift was represented by the concepts of *immediate need*, *vulnerability to a new world*, *facing the unknown* and *reality shifting over time*. The codes that emerged defining priority drift are included in APPENDIX T. The acute crisis created by the injury placed an *immediate need* on the individual to manage the medical condition and hospitalisation experience as a priority. This new experience and the associated lack of familiarity with this situation heralded a *vulnerability to a new world* during the early stages post injury. As time passed however, individuals continued *facing the unknown* aspects of living with a SCI. Amid these additional priorities and needs, *reality shifting over time* occurred and, through this process, friendships often were prioritised differently.

Immediate need

SCI is a *medical emergency*, requiring prompt medical attention in order to ensure continuity of life. The early period post-injury was typically described with reference to ambulances, intensive care units, surgery and stabilisation of fractures, managing medical complications and ensuring adequate respiration. Above all else, these factors were considered by all participants to be essential at this point in time. The person's medical condition became a priority, based on an immediate need that overwhelmed all other priorities.

So many things were changing and it just seemed from one stage, like at the start, where I got told that she's not going to die or anything; she's just got a broken leg and a few things. And it just got worse; she didn't have a broken leg, she had a collarbone broken, her back was broken, her neck was broken, collapsed lungs, and it just seemed to get worse and it was going downhill, downhill, downhill (4Fr1).

This early period following injury was characterised by high levels of *stress* and *anxiety* for people with SCI, family members and friends.

I flew down to see her in ICU, five days after the accident, and that was yeah, the most horrific experience, seeing your best mate lying in a hospital bed with tubes hanging out of her left right and centre (4Fr1).

Perhaps the most salient characteristic of this immediate need was its *suddenness*.

One moment the person with SCI was going about their daily life and the next, that person was fighting for life.

The mechanism of injury tends to have a big impact on the friendship. If it is a sudden injury, something that is really unexpected, then I guess that is more of an emotional sort of thing. Friends might sort of analyse it in terms of well I did that last week and nothing happened to me (3Sta1).

After the immediate medical emergency passed, the focus of immediate need for most parties was *relief* as the individual had come *back from the dead* and was considered *lucky to be alive*.

She has been given a second chance to live and that is just the blessing beyond all blessings for us, and we'll deal with the medical situation step by step, that's okay (4Fam1).

This momentary reprieve was quickly replaced, however, by immediate needs associated with *recovery and rehabilitation*. At this point in time, there was immediate need related to the *ability of the family to cope* and the *ability of friends to cope*.

Sometimes I think the friendships or friends find it very difficult to come to terms with the trauma and the disability, particularly if it is severe. And I think particularly if perhaps they were involved in the same accident...that causes the biggest issues...and sometimes those are worked through and sometimes they aren't. And if it is I think people often go their separate ways later because it is so hard [to cope] (1Sta1).

This immediate need for support to cope was addressed to some extent within the

hospital and rehabilitation context for the family. However, this need was rarely addressed for the friends, despite the fact that many friends remained engaged in the process and continued to struggle emotionally. As a staff member noted, “we have patient education and family education sessions but nothing that sort of really caters to the friends” (5Sta1).

The focus of immediate need during the early stages was *on the physical* and *on rehabilitation*.

Towards the end I sort of had to prioritise, if my folks came I said I’ve got to go at one thirty because that’s when physio is and it’s important that I get the last of me skills, you know, getting towards the end I think I had a few weeks to go, this time and I can’t afford to be socialising, especially once they, once the gym shut downstairs and they had to allocate hour slots instead of half-day slots, that’s happened in the last three or four weeks, so it’s just a way of what’s happened, they’re being really tight on time, so you just can’t afford to not do it [go to the gym during the hour allocated to you] so, but people understand, it’s important, it’s more important than visitors at that point in time, they have to understand, yeah (15Sci1).

The injured person, family and sometimes friends are bombarded with information about physical implications. Social roles and community participation in the future have not even entered the picture as a potential goal, let alone a priority.

It is hard when everything is focussed on the physical crisis at the time, the physical illness, the physical condition, it is often something that becomes evident further down the track (4Sta1).

Furthermore, although the family may have some *involvement in rehabilitation*, this is rarely offered as an option for friends.

In terms of the structure or the hospital in terms of visiting hours and like that in a way it is not encouraged to be a part of and maybe sit in on a physio session while they are doing their physio or OT. You know I think it happens sometimes but it is probably in the structure of the hospital where it is not something that is encouraged (3Sta1).

The priority drifts to the immediate need and this focus on immediate need may serve to increase the enforced environmental, role and interactional separation of friends.

Trying to even meet the basic needs... to maintain regular psychosocial contact

with the patient and trying to meet their emotional needs is a struggle. Then add family on top of that and they are already overloaded. There is certainly no room to try and add friends in there (7Sta1).

As such, the focus at this point in time lay primarily with the person with SCI. The injured person may experience a degree of *self-absorption* as they struggle to cope with their immediate need to recover physically. Hospital staff are responsible for issues of *privacy* and, for this reason, do not offer information to friends. Friends described feeling a great deal of *sadness* during these early stages and indeed, some experienced grief reactions that in many other instances would be perceived to be worthy of intervention alone.

She was just very much into um... what would have happened if she died, you know, she nearly died, what would have happened, and we were saying but she didn't... you know, you've got to look at where she's going to go from here on in now, we've faced that issue and she got over that obstacle and we need to too, and we need to start moving on with her. I said, you know, everything looks really good and just reassured her that um, that they were really positive (4Fam1).

However, without the assistance of healthcare professionals, and with the *inability of the injured person to cope with the friend's grief*, friends were often left to their own devices. This highlights the very personal journey that both people with SCI and their friends experience following injury, contributing to the perceptions of enforced separation.

It varies, but people who visit you in the whole, I think sometimes it takes a bit for people to visit you, but when they're there it's usually...yeah, oh look I suppose I can think of one or two who were probably a bit teary and, you know, stuff that, you know, I don't need that, just yeah, happy the way it is but... they probably need it but I don't, but that's okay, yeah, one or two girls are a bit like that (15Sci1).

Maslow's (1943) hierarchy of needs model proposed that we meet our most basic needs first, in a hierarchial manner. As such, survival is at the bottom of the pyramid as is it a key life objective. Relationships with others sit further down the pecking order, suggesting that they are not a basic need. In the current study, it

appeared that this clash of priorities was experienced in the early stages of injury. Participants reflected this *hierarchy of need*, highlighting the *decreased urgency* associated with addressing friendship needs and the *time limitations* that prevent a consideration of friendships until much later in the recovery process. “Wouldn’t have a great deal of time to sort of sit down and think about it, because he’s got lots of other things that are happening as well” (8Sci1). Even finding time for spontaneous interactions with friends with the context of daily personal care was sometimes difficult.

Nearly always, but I mean you know, there’s always the odd time you ring up and they say look, and that happens now with his carers, they say look, [he’s] getting bathed or something, and um, either ring back later (8Fr1).

The shift in priority appeared to last well into the period of time following discharge and much of what people with SCI and their friends actually did resembled a process of *treading water waiting* for recovery.

Things take a lot longer to do, number one, number two is we’ve only, I’ve only been home three months, so we’re still sorting out...we’re still sorting... you know, the home’s very useable, but there’s still things being sorted out here, so... and you know, till we get all that done we don’t really have that much time to source new ways of, you know, getting around the injury and having fun together. I mean that’s a later step, it’s just not there yet, that’s all (15Sci2).

Indeed, in recognising that there are *varying needs for support* at this time, participants often adopted a *wait and see* approach in the hope that recovery would be forthcoming. The achieved level of recovery would then provide the basis upon which future interactions occurred.

My friends are pretty supportive, bike people are, well I mean... they’re supportive, I don’t know how they’ll go long term, but yeah, the bike riding was more of a social thing, in bike riding rather than, oh you know, family get togethers and stuff. But you know, that looks alright, probably more to me, up to me maintaining contact, a lot of stuff centre around bikes unless it’s a um... a social occasion, so I’m not sure where that’ll go, but it’s not worrying me particularly, we’ll just see how it goes (15Sci2).

Many people presumed that separation would become easier and/or less destructive if they had this piece of equipment or that piece of equipment.

I don't go to work as much as I used to, because I'm still waiting for my car to arrive, so from the first of February hopefully I'll be a lot more mobile, you know I feel that during the week I'm stuck in the house without my car, if I was to go to work every day it would cost me a hundred bucks, and it's just not worth it, I'd rather just work from home (11Sci2).

For friendships to be prioritised, there needed to be a *readiness* to redirect focus. However, it was unlikely that this would occur in the early stages following injury. People with SCI described a compromised ability to manage friendships and a *reduced capacity to cope* with everything at once. "I haven't really thought about it, you know, it's just... it's you know, just trying to cope with what's happened, I haven't really thought about other people. I suppose I should have" (3Fr11). Even after discharge, this inability remained an issue for people as they attempted to adapt to living at home with altered functional abilities.

He was still learning how to cope with the wheelchair, um, how other people would react to him, and how he'd react to other people, and especially the people that he knew, and he became very close friends with in the area, so it wasn't pleasant, and I do believe even now it's really not that pleasant (3Fr21).

Many described their *over stimulation* at this stage, being *overwhelmed* by the constant drain on their time and attention within the functional context of increased fatigue levels. At this point in time, many people with SCI felt that there was an *over-involvement* of friends and they expressed a *need for timeout* to take a breath and collect themselves. While over-involvement and a need for timeout were integral elements of interactional separation, the category of immediate need highlights the issue of friendship priority within the various competing demands on the time of the person with SCI. Indeed, the data suggests that causal links may be circular where high demands in the rehabilitation environment shifts the priority away from friendship and therefore results in perceptions of over-involvement. Alternatively,

repeated and ongoing interactional separation may result in a deliberate shifting of priorities.

So you start to think “I really enjoy their company, but I also want to have a bit of time to myself as well”, so you know, you need to start thinking, you know, it’d be good to have a few visitor free days at times and just have some time to yourself, to do your own stuff (8Sci1).

Within the context of rehabilitation, there was an inherent focus on the injured individual as well as a *family focus*, leaving the friend as an outsider to this process. *Family involvement* was high where friend involvement was limited. One person with SCI stated in terms of involvement in rehabilitation stated “family is always more often than friends” (5Sci1). A paradox emerged in that friends often wanted to be involved but were excluded to the benefit of the family. Indeed, during the early stages following injury and following discharge from hospital, friends often felt a *moral obligation* to ensure that they were seen to be prioritising the friendship

For staff involved in rehabilitation and community care, managing priorities also presented challenges. Some staff noted that friendships were not prioritised, despite their importance, because their work was dominated by the priority of providing an appropriate *level of care* within an environment of *economic rationalism*. “I mean if you had the resources, you could do a lot of stuff” (4Sta1). Family involvement was often necessitated by an insufficient level of care provided by personal care providers. As such, their continued involvement was prioritised to assist in activities of daily living. In this situation, friends take second place unless they adopt a caring role. “It is certainly put out for family and carers...there have been times when friends have talked to us...but they probably wouldn’t be considered our primary core people” (1Sta1).

Vulnerability to a new world

Vulnerability to a new world underlies the experience of people with SCI during the early stages following injury. Hammell (2007b) described how people with SCI do not have a template to follow in learning how to adapt to their new world.

At the end of the day the carrot is that I might get better than I am. Which is basically a sponge with arms and I feel to be such a drag...you want to be able to make life a bit easier..., but it'd be nice to have that little carrot at the end of the tunnel, you know, so, you know I might be able to stand up, I might be able to do this, or do that. But at the moment I'm going to leave with no other knowledge than the fact that I've broken my back, I'm paralysed and I could well be like this for the rest of my life, and I would like to think there's some light at the end of the tunnel and it's not a bloody train coming at me (3Sci1).

However, it is not merely the injured individual who is exposed to vulnerability within this new world. This situation equally applies to family members, friends, neighbours, and colleagues.

It was very difficult, yeah, not knowing exactly... I talked with my other friends of well but a fair bit of uncertainty...there was a fair bit of up and down I guess, a lot of uncertainty, a lot of unknowns...Yeah, definitely added a lot of stress and uncertainty, you can't just go down and go and visit him in hospital and see for yourself how exactly how he is, especially in those early months (10Fr1).

This vulnerability was characterised by its *inherent emotionality*. Being vulnerable is an emotional state with a raft of emotional consequences.

First time I seen her, after she was out of ICU [intensive care unit], was... my mum come down with me actually, my mum came down the first time with me. And yeah, to walk in, I was like standing outside because she was getting dressed and getting into her chair, transferring into her chair. For me to stand at the waiting room door where her room was and look in, to see her and the way she was, it broke my heart, it really did (4Fr1).

The hospital remains the frontline in terms of arousing vulnerability. "I flew down to see her in ICU [intensive care unit], five days after the accident, and that was yeah, the most horrific experience, seeing your best mate lying in a hospital bed with tubes hanging out of her left, right and centre" (4Fr1). It is true that most people, even when they have been hospitalised, have only remained in hospital for short periods of time. As such, most of us have no concept of what it would be like for a hospital to be

your home for protracted periods of time.

One minute I'm on a motorbike, and the next minute I'm in a wheelchair in a hospital, learning how to... how to, learning pretty much from the beginning on how to live a life, or how to continue living my life. Yeah, I... I suppose for anybody it's, you need to understand what you're going through to be able to process it, and work through it, if you've got no grounding it makes things infinitely more difficult (3Fr21).

We have no *familiarity with this environment*, we have no idea what it is like for the majority of our interactions to be with *healthcare professionals*, we have no idea of what our *expectations of hospital* should be, we have no idea what it is like to be on a multitude of *medications*. This world is foreign to most of us, including family and friends. "Well you're there all the time, the improvements that are there I, you know, I've got higher expectations than what I'm doing" (1Sci1). Family and to a larger degree friends are placed at an even greater disadvantage by having to interact with this environment but having little opportunity to really become familiar with it to the same degree that the injured person does.

Friends do, however, come face to face with a number of *harsh realities* that exist for both the injured individual and family members. *Confronting mortality and morbidity* is one vulnerability that was evidenced among all parties, even by friends who had not seen the injured person yet. "Traumatic! Yeah, hard, very hard to deal with. I'd hate to deal with it... it's one of those things that, yeah, you can't, I don't know if you can put a number on it, you know, it's reality" (3Fr1). The mere fact that the injury happened to someone that they knew well was enough to prompt consideration of their own mortality or morbidity.

I think that the people that really feel that they just couldn't bear to live a life in a wheelchair, they're the ones that are really threatened by it, because I think that, yeah, in some way they, yeah, they think oh, you know, I just couldn't bare that life, and have real trouble and I guess don't want to even start talking about it, so the best way to do it is to not see him, you know? (15Fa1).

Through this process, the injured person, family and friends came to recognise and *realise their vulnerability*, both within the current context of what was happening in this new world, as well as in the future. Although family rarely perceived that they had a choice in managing this vulnerability because of their filial obligation, friends were presented with the option of *face or flee*.

I think that is very hard. If you are really on your own then you really only have family I think. Even good friends probably umm, I mean they are still friends, but they are not going to help over the long, the long chronic sort of period of time, over years and things like that when you are living with a disability. It still comes back to family as probably the most important, important people around you (9Sta1).

There are no formalised rules that define what people should do in this situation (Argyle & Henderson, 1984), leaving friendships vulnerable to emotionally-driven actions and personal reactions.

“It is..there is physical stuff involved in there but by far sometimes, what they are dealing with is emotional more than physical” (7Sta1). There was a *fragility* to the emotional equilibrium of individuals and their friendships when confronted with this vulnerability. *Uncertainty* dominated the experience because of the lack of familiarity.

It was very difficult, yeah, not knowing exactly what to do. I talked with my other friends of well and they have a fair bit of uncertainty as well, there was a fair bit of up and down I guess, a lot of uncertainty, a lot of unknowns (10Fr1).

Uncertainty was equally experienced by friends in the face of a lack of familiarity with the situation. “Uncertainty on me as well, just being so far away... yeah, definitely felt fairly depressed after” (10Fr1).

Anger and *frustration* sometimes emerged in response to a perceived sense of unfairness. These emotions may indeed be felt by the person with SCI and directed at friends and family or alternatively friends and family may experience emotions such as these that are then directed at the injured individual.

Mums really good most of the time, she still hasn't accepted my accident, and

sometimes that comes out in a lot of anger. And...which gets turned around on me and the kids, and so that makes it really hard, but yeah (4Sci1).

Similarly, each party may experience anger and frustration that is self-directed or that is directed at staff.

I suppose frustration with doing things with not being able to do things, you know, like some things I just cannot do anymore, and I suppose a bit of frustration involved in, you know, you can see something that needs doing, but, and it's something that I used to always do (10Sci2).

Disappointment emerged when parties *identified potential losses*. The reaction to this disappointment and its impact on the friendship provided a benchmark against which the quality of the friendship was judged.

I would be disappointed I think if there was a change in any friendship from an accident like this, I think if you, well my personal opinion, if there was a change for the worse, then maybe it wasn't such a good friendship to start with (10Sci3).

Stress and anxiety was common for all parties as their coping efforts and resources were stretched. "It was pretty much a lot of pain, a lot of... a lot of anxiety, a lot of um, yeah very, very hard times" (17Sci1). *Uncomfortable feelings* are uncovered as individuals try to interact within the context of their vulnerability to this new world, potentially enhancing the interactional separation experienced between friends.

Whether he feels uncomfortable, in some respect spending time with me separately, it could be for all manner of reasons associated with whatever, I just haven't spent enough time together for ages. It is just tricky because I don't guess it's that, like if it is that, it would probably be a combination of that with other things, like you know like no single underlying cause (9Sci1).

Coping with this vulnerability to a new world was difficult for injured individuals and their friends because their perceptions of *control* had been eroded.

Every day is a different day, you can be up one day and down the next, which a lot of my friends found out when I went home, when I went down and, I'd just be talking to them or whatever, going to a party or something, and then I'd be. you know, the next minute I'd be spewing or shitting or whatever and that, and then I felt a bit low sort of thing, but it was a thing that I couldn't control" (19Sci1).

Rule breaking and *risk taking behaviour* were identified as coping efforts that were sometimes used in an effort to remove perceptions of vulnerability and foster normalisation. They were part of an overall learning curve, challenging boundaries.

I can remember one of the guys telling me one day when he got home, he went back home again to North Queensland to a small town and his parents were really nervous about him doing anything so they really wrapped him in cotton wool and he was probably early twenties, he had been living away from home prior to his injury but the first weekend he was and his parents just about had a spack [colloquial] attack and they took him down the pub for a drink and bought him home rolling drunk and he told them it was the best night out he had ever had but it also convinced him he could go out with his mates and survive and convinced his mates that they could take him out and he would survive and you know he does all sorts of things with them and he goes on the beach while they are surfing and he does other things and is very included in their activities (4Sta1).

Some people coped by just focussing on the here and now, *keeping busy just existing day to day* whereas others spiralled into *crises*.

And I think there are a lot of other issues that are more important at that stage and I think that they are more focussed on a lot of other crisis things and the relationship, they don't really notice that friends are drifting away because they are so preoccupied with other things and perhaps themselves not putting the time into maintaining relationships and by the time they are ready and looking for a relationship and things have settled down, their friends have moved on and the people who come from the country who are in Brisbane for long periods of time well life goes on for the people who are at home and when you get back it is just not the same (4Sta1).

Facing the unknown

Although *vulnerability to a new world* represented an emotional state typically encased within the early stages following injury, *facing the unknown* was a future-oriented state that had both cognitive and emotional components. Similar to vulnerability, *facing the unknown* reflected the *priority drift* and was associated with the concepts of *suddenness*, *uniqueness*, *novelty* and a *lack of explanation*.

I'm not in the real world yet; I won't know who's supportive at the moment and what happens in the future... I mean obviously it makes a lot of difference to know that you've got a home to go to, you've got a job to go back to, and you've got people that you know that... you know, how many I'll see in the

future I don't know (15Sci1).

Although vulnerability to a new world was experienced by most people to some degree, facing the unknown was moderated by the existence of *other injuries*, *previous life experiences* or *previous experience of disability* that, if present, could go some way to preparing people cognitively for the future.

If you look at the sort of at risk group of young people, in particular, they tend to have, it is their first experience of disability often and their friendships are with mates, they tend not to know anybody who has a disability so I think there is this societal you know values that people have about um people with disabilities that is a bit of an um..issue (6Sta1).

People with SCI and their friends who had some previous template on which to base their expectations for the future tended to manage the unknown much better than those who lacked this experience. As one client who had another friend with SCI prior to sustaining their own injury explained;

Yeah, it's been great actually, it's been really good, because he helps explain things, like you know a lot better than what the doctors and nurses, because he's been there and done that, so any time I've had any dramas or things that they haven't been able to explain, he'd ring me up and I've spoken to him about it. And he's sort of said, you know, "I've been there, done that" (8Sci1).

The ability of injured individuals and their friends to face the unknown in the context of their friendships was related to their *individual differences in expectations of the friendship*, *expectations of recovery* and *assumptions of need*. Often, this process resulted in *overcompensation* as reflected in the following quotes.

Yeah, I don't know, I really don't know. I suppose it's because I'm injured and whatever now, and I'm not yeah, and he just sort of feels the need to ring me every few weeks to say g'day (8Sci1).

It was really interesting the first couple of weeks that he got home, of course, you know, the barrage of people visiting, and um, everybody wanted to um, come on, get in the car and we'll go down the beach and we'll get that wheelchair friendly beach, you know, thing, and we'll put you in the water, and um... they were very, they were very keen to get him out and normalise him I guess. And he felt very um, pressured (15Fa1).

Previous expectations of friends were often used as the template on which to

base current expectations.

What I have heard though regularly enough to be fairly positive that is a common theme... people do say to me that it is not the ones that you expect to be there for them that were and often the ones that they expected to be there for them weren't and that often starts a conversation in terms of um... expectations about friendships and what people can actually deal with and who can actually deal with the injury and who can't. Often they are surprised... (1Sta1).

For some people, this template assisted them in *facing the unknown*, but for others the gaps were too large and their expectations were unrealistic, resulting in disappointment. Others used their *preconceptions of injury* as the template with which they faced the unknown.

You know, you can offer help but you've got to be sort of diplomatic in how you offer help, you can't just presume that someone who's got a disability will actually want you to help them up a hill. That was a quick learning curve, I don't know whether that's across the board or not, but...ask first before you help (15Fr1).

Some people avoided facing the unknown. As a family member commented, "perhaps some people don't want that knowledge, um, but I suppose if people really wanted to understand it [they could]" (15Fam1). Others avoided the unknown by *living in the past*.

The people I'm really close with are the people I went to boarding school with, that we sort of lived with day-in-day-out for four years, and you get to know them really, really well...mainly just talk about school, what we did at school (8Fr1).

Others utilised the *safety of the hospital environment* as a way of avoiding the unknown, but this increased their vulnerability when they were discharged. "When the day came to get out of there it was a bit of a rude shock, because you get a real security blanket in there, and it's hard to leave" (8Sci1).

Facing the unknown was a problem for friendships following injury because of the deficiencies in knowledge held by a variety of individuals, both internal and external to the friendship. Friends *lacked knowledge of the hospital experience* and

had poor *understanding of the injury*.

[friends said] He'll be walking, you know, um, I don't think, you know, there is no way that, you know, he is going to come home in a wheelchair, um, I think you're being very negative well this is from family and friends I think you're being very negative about the extent of this injury (15Fam1).

Friends often had poor *awareness of the current state* of the injured individual ("you know it is difficult also because it is how much the person wants their friends to know about something....there might be a lot of stuff there that they don't particularly want their friends to know about" (3Sta1)), *lacked insight* into the complexity of the situations they faced ("I don't think it was too bad, he, I think he had a pretty reasonable experience, compared to, you know, considering where he was at" (8Fr1)) and were *confused* by multiple messages and information from different sources.

You get two different messages from two different nurses; you get advice from one and you ask the same question to another nurse and it's totally the opposite of what the first one gave you. So you just don't ask for a while (1Sci1).

Injured individuals also lacked *knowledge of the friend's experience* and often viewed the friendship through *rose coloured glasses*.

Um... I don't know how it's affected him; it's not the sort of question I would ask him, but I know that he's there for my wife, um... and I know that he tries to understand what I'm going through (11Sci1).

Rehabilitation staff and families *lacked knowledge of the friend's experience* and *rehabilitation staff lacked a recognition of the friendship role*.

Really the focus tends to be on the patient and the family and the friends are fairly neglected I would think. Not devalued, but just resources don't allow services to be offered so much to them. What does happen is probably fairly informal and I think there would be very little offered in the community to them. It would be a sink or swim scenario (4Sta1).

Facing the unknown in the context of this limited knowledge evoked a number of emotions for the injured individual and their friends, which typically neither shared with the other. For some the whole experience was described as *just a blur*.

Sometimes they cry and stuff when they find out and stuff, but I don't really

see that, I'm sure my folks first came down that would have been very hard for them, I don't remember that in great detail, I'm sure that would have been hard for them (15Sci1).

Friends often held *fears of the injured person*

I know initially when we came back she, we were shopping at Coles and the step brother walked towards us, and he just stopped abruptly and turned, and she just said to him I'm not an alien, I'm just in a wheelchair, and he said yeah, yeah I know, um... yeah, yeah, I don't, oh how're you doing, but couldn't wait, you could see, he was like stressed out of his brain, can't wait to get away from her (4Fam1).

Sometimes the injured person held a *fear of burden* on the friends. "If I'm on my own like sort of thing, I'm not a hinder or a burden to anybody" (19Sci1). Some individuals used *denial* to mask changes in the friendship, whereas others experienced *apprehension* and *anxiety* about the friendship.

He was a little bit apprehensive about coming home because he knew that he would see acquaintances, you know, the people in the street that we used to walk the dogs with, you know, all those sort of people... he was very apprehensive about people seeing those sort of people seeing him (15Fam1).

Some friends externalised the experience by feeling *pity* or *ambivalence* for the injured individual. Others confronted the unknown with feelings of *empathy* or *regret*.

I suppose there's a certain element of sadness in there isn't there? I mean... you know, probably think about him more now than I used to, I often think, you know, is there something we can do to maybe help him more... I'll often think about it and... see like the last couple of times I've been down there, I've been down there I'll only go and see him for an hour or two, I thought, and he's got, he wouldn't have any money or anything, and I thought well if I went down I could buy a bed, put it in the spare room, I could maybe stay there for a couple of days (8Fr1).

Ultimately, friendships were presented with significant challenges in facing the unknown in the context of *unpredictable* or *ambivalent outcomes*. For instance, one friend described the injury and recovery in the following way. "He has some level of recovery, and is still recovering, so maybe some progress that he can still make, so he's not stabilised or in a stable condition, still making progress" (10Fr2). Sometimes friends were unable to acquire information about potential outcomes because of the

legal aspects of privacy and confidentiality. “ I mean there’s privacy act and all that, so I just think it’s up to you to maintain those relationships” (11Sci2). At other times, injured individuals and their friends merely utilised *wishful thinking* in the hope that any difficulties they experienced in their friendship would resolve themselves over time. However, for friends, facing the unknown was the ultimate *test of their friendship*.

Reality shifting over time

The concept of *reality shifting over time* reflected the more *gradual* and *ongoing cyclical process* by which priorities changed in response to disability and the variety of life contexts that the individual and their friends found themselves in following resolution of the acute need for treatment. *Reality shifting* was clearly linked to *time since injury*. Persons with SCI and their friends and family who participated in this study, often had not lived with their injury long enough to have reflected on the changes in reality that had occurred over time. Therefore, *awareness of reality shifting* typically emerged in data collected from rehabilitation staff and sometimes from the third interviews.

People are there in the immediate crisis time and then I think as people start to get involved and pick up the pieces of their own life, they move on and the person is still stuck here in hospital and things change, relationships change and it is very hard to pick up the pieces (4Sta1).

Reality shifting over time often resulted in perceptions of *waning support* within the friendship and friends drifting apart. “Especially during that initial acute phase, everybody wants to come in and everybody wants to see how that person is going and that sort of thing. I suppose towards the end of rehab[ilitation] with some people that tapers off a little bit because the novelty of where they are has sort of worn off to some extent” (5Sta1). This process usually occurred so gradually that, until

asked to reflect on it, individuals were not even aware of what had happened.

Probably in the unit when they talked about it, they were still getting a lot of support, like people were seeing them in crisis and they had rallied a little bit so they still had plenty of support but like three years later sometimes they would talk about how you find out about who your friends really are when you are down and out and things like that and they talked about how friends didn't know how to relate to them and they had drifted away and that kind of thing. (4Sta1).

Participants were often so preoccupied and *busy just existing day to day*, that they did not notice how their *intentions and behaviours* had diverged. Although it was rarely the deliberate intention of friends to shift away from each other, this tended to happen due to other demands.

I've only been home three months, so we're still sorting out, you know, [wife] is catching up in the garden because everything sort of fell apart a bit, and we're still sorting... you know, the home's very useable, but there's still things being sorted out here, so... and you know, till we get all that done we don't really have that much time to source new ways of, you know, getting around the injury and having fun together. I mean that's a later step, it's just not there yet, that's all (15Sci2).

The reality of living with SCI took precedence over friendships, causing a shift in the perspective of the two friends. By the time friends noticed their separation, the friendship had often suffered irreparable damage.

Furthermore, reality shifting was clearly linked to identity separation between friends. In cases where identity separation was minimal to begin with (i.e., friends were able to maintain a clear sense of the 'I am' and 'we are'), reality shifting was less apparent. Ironically, the *absence of friends* was detrimental to the process of minimising identity separation because no role model or benchmark existed upon which identity could be tested. This placed friendships that had experienced separation at even more jeopardy of dissolution.

I think for some of the clients that I have worked with, friends have helped to give people a sense that they are still the same person that they were prior to the injury so that they still can have conversations with people about things that they were interested in and they can still enjoy activities, there is still

possibilities and options open up for people so it is, I don't know if normalising is the right word but certainly getting a sense that they are still the same person that they were and they have had a disability that has meant some limitations physically but their sense of how they are is intact and can be as it was (6Sta1).

The longer that people lived with their injury, the more they changed as a person to adapt to that injury. Sometimes friends adapted in unison and the friendship developed strategies for managing changing realities. "I think the friends that have stuck [with the person with SCI] by the time they come out are usually the friends that will stick" (2Sta1). In other instances, realities became completely different, representing the ultimate priority drift, that of the friendship itself. "I think people often go their separate ways later" (1Sta1).

The process of diverging life paths

The processes of enforced separation and priority drift may not be the only processes that affect friendship following injury and it was not my intention to uncover all of those potential processes. However, these two processes were grounded in the data and were, taken collectively, explanatory of diverging life paths. Enforced separation and priority drift occurred as two parallel processes that influenced diverging life paths, with interactive effects between the two. In many instances the degree of divergence of life paths ebbed and flowed, depending on the degree to which enforced separation and priority drift were in play and the interaction between the two. Yet the interaction between these two categories was not consistent in direction or magnitude. Indeed, in many instances where enforced separation was high, priority drift was low. For instance in situations where there was environmental separation with the injured person in hospital and the friend in the community, the life paths of the some friends remained closer because the friendship was still considered a high priority (e.g. 4Sci). In other instances, priority drift may have been high even in

the absence of significant enforced separation (e.g., 15Sci). In other instances, the priority drift was minimal regardless of the current level of enforced separation (e.g., 19Sci1). The degree of divergence in life paths could then be conceptualised as the sum of these two processes separately as well as the interactive aspects of these two processes.

Environmental separation was often the most apparent separation in the early stages following injury, although interactional separation tended to appear quite early also. Role and identity separation, because they required some degree of cognitive processing and friendship involvement, were typically experienced at later times following injury. Similarly, immediate need was the most obvious early priority drift, accompanied by a vulnerability to the new world. Facing the unknown tended to emerge more towards the end of hospitalisation when the individual was approaching discharge. Reality shifting over time emerged more clearly with increasing time since injury.

Indeed, each level of separation could both alter and be altered by other levels of separation. For instance, environmental separation was often causative of interactional separation (because it is more difficult to communicate with someone that you are geographically separated from) but also interactional separation could influence environmental separation (i.e., no communication with which to identify ways to reduce the actual physical separation such as organising visits, etc).

In terms of priority drift, interactions were also evident. Immediate need and a vulnerability to the new world often prefaced issues of facing the unknown. Similarly facing the unknown was often pre-emptive of reality shifting over time. New realities then had the feedback effect of creating new immediate need and renewed vulnerability to new world situations.

Summary

In summary, the basic psychosocial problem that existed for friendship processes following SCI was diverging life paths. The occurrence of the injury represented a significant life event where friends could experience enforced separation, either through physical separation as reflected by the category of environmental separation or through a separation of roles and identity or alternatively through a breakdown or separation in their ability to interact in the ways considered “normal” for their friendship. Separation was enforced in the sense that neither party perceived that they had any significant degree of control over the occurrence of the separation. In this sense, the process was perceived to be externally driven for the large part, by contextual factors, even in situations of role and identity separation, processes which both have cognitive components to them. Enforced separation operated to create a divide between friends that could, if it persisted beyond a critical point in time, result in dissolution of the friendship.

Diverging life paths were also characterised by the notion of priority drift, where the degree to which the priorities placed on the friendship were challenged by other priorities. While priority drift was often a choice, it was rarely a conscious and considered choice, but rather one taken within the context of extraordinary competing demands and limited personal control. Indeed, priority drift was rarely an intentional action to dissolve a friendship. Rather, it was a gradual process, often occurring so slowly that awareness of change was difficult to establish. This occurred in the context of the immediate need created by the injury and its medical management, but also through uncertainty as friends were challenged by a vulnerability to the new world and facing the unknown of the future. The friendship faced a new challenge in

that it had no template (Hammell, 2007a) on which to base expectations and therefore there was apprehension and uncertainty about the rules for friendship. Over time, priority drift also occurred through a reality shifting that was inherently linked to the experiential challenges of the friendship and the processes of adjusting to injury. Participants were often so preoccupied and busy just existing day to day, that their intentions and behaviours had diverged.

Chapter 6: Results

Reconnecting life paths: Working and redefining

This chapter describes the basic psychosocial process (BPSP) of reconnecting life paths, the aim of which was to remove or minimise enforced separation and refocus priority on the self, both separate to and within the context of friendship. Reconnecting life paths involved *adjusting to the changes in friendships* and *confronting their unrealistic expectations*. The ultimate aim of this process was to create lasting friendships that could endure future challenges and offer the support expected within friendship. This entailed either a reconnection with existing friends or a realignment of friendship choices to expand the friendship network to include new friends.

I suppose it depends on the entities, um, no it's my belief that if you're a true friend, then the friendship won't change no matter what physical... things happen along the path, friends will always be friends, no matter where you are or what happens to you (3Fr21).

The process of reconnecting could be initiated by either the injured person or their friend, or simultaneously by both parties.

Any relationship that is not based on equality is pretty much doomed to failure like when you have got those sorts of things happening... I think there is also a period of trying to figure the relationships out and the relationships that survive are the ones where they figure out that sort of relationship and redevelop some sort of equality in the relationship. That is reciprocal too so that the disabled person feels that they have a contribution to make, they feel valued and that the able bodied person respects and values the disabled person as an equal sort of relationship (4Sta1).

Family and rehabilitation staff also played pivotal roles in the process of reconnecting life paths. In some instances, their role was dependent on the wishes and direction of the friends. In other instances, their role was opposed to the wishes and direction of the friends. For example, family did not usually contribute to a reconnection of

friendships if the friends themselves had decided they no longer wanted the friendship to continue. However, families could prevent reconnection in instances where friends were attempting to reconnect.

Family members were often the only source of communication and information for friends in the early days following injury and, therefore, played an important role in the process of reconnecting friendships.

My mum, my family called and said that I'd had an accident and I'm in hospital, and then they sort of freaked out and jumped in cars and they just forgot about the party and came down to see me (12Sci1).

Following the immediate post-injury period, family could assist in reconnecting friends both directly and indirectly. In some instances, a reconnection with family indirectly but simultaneously allowed a reconnection with friends. This situation was more likely in the context of married individuals where friendships were shared by the couple. In other instances, family members acted to *mediate and facilitate friendships* by providing support to friends. "There was the rush of support, which you know, there always is, um, but also a lot of um... I found I was doing a lot of the counselling [for friends]" (15Fam1).

It was discussed in the previous chapter that some family members established themselves as *gatekeepers or protectors*, thus potentially enhancing the divergence of life paths. In terms of reconnection of friendships, this gatekeeper role was sometimes facilitative in the sense of balancing the positive and negative implications of the friendship.

I think sometimes it might come out of the fact that they see these friends drift and the hurt it gives the person so and then they see how well they are all getting on together and you know what I mean, they see that their child doesn't have to take on much so I think it is like a protective mechanism (2Sta1).

Although in most instances, the injured individual did not agree with family involvement in their friendship, the role of the family in facilitating reconnection was important in terms of its timing. For instance, when their priorities were focussed on the immediate needs created by their medical situation, people with SCI often gratefully accepted the role families played in reconnecting the friendship, especially in terms of the *education and support* they could provide friends in terms of the injury itself.

Interviewer: So who have you talked to about things like if you found things difficult?

Interviewee: His sister mainly, because I was friends with his sister before I was friends with him.

Interviewer: Okay.

Interviewee: So that's been really good. Like initially she was a bit annoyed with me not being able to visit the hospital that often, to visit him, and then last year she got a fulltime job after being a student and she's gone, now she's kind of realised how difficult it is sometimes (9Fr1).

Rehabilitation staff sought to reduce the enforced separation of friends and facilitate reconnection through a variety of strategies within both hospital and community settings, although the implementation of these strategies was *ad hoc*, dependent on the particular staff member rather than any formal policy or approach, reflecting a level of superficiality and a misperception that friendships are easily managed following injury.

Certainly if something comes to my attention or social work's attention we address it and advise but not overtly. It is certainly put out for family and carers...there have been times when friends have talked to us. For example, there was a time when I found a friend crying at someone's door who was in the same accident with him and I dealt with him (1Sta1).

Regardless of family and staff involvement, many individuals focussed on reconnecting the friendship in the context of how it existed prior to the injury or doing what was perceived as '*normal*' for that friendship but, over time, found that the

friendship was fundamentally *different somehow* and that the process of reconnecting was more difficult than they had initially expected.

Some of them will say like the differences in the friendship before, before their injury as compared to afterwards. They will say oh yeah you know it wasn't the same because I couldn't do this or that or they don't understand this part... [they] will not go out because it is, you know, not the same. Whereas trying to get them out and saying you know it is the same, it is just a little bit different (5Sta1).

In some instances, the divergence in life paths had reached such a *critical point*, that reconnecting proved impossible, resulting in the process of letting the friendship go.

And you know I think to a certain extent sometimes it doesn't affect the friendship at all. Depends on how close the friendship was to begin with as well and other times, they just lose touch and it sort of ends the friendship (3Sta1).

However, other people found that they were easily able to reconnect the friendship regardless of the individual changes that had occurred for them following injury.

And so yeah, nothing has really changed between us, we're always pretty close without seeing each other too regularly, and we've just stayed the same, yeah, we still get on like a house on fire (8Sci1).

The effort expended on the process of reconnecting life paths appeared to be related to the extent to which the pathways had diverged and the need felt by the friends to address any divergence. Indeed, in some instances, reconnecting life paths represented a process of 'correcting' the divergence that had occurred in friendships so the friends 'aligned' as they had prior to injury. In other instances, the process involved an acceptance of the 'new' friendship within the context of its altered life paths.

The longer the delay before initiating the process of reconnecting, the more intrinsically difficult it became to find the *common ground* needed to address diverging life paths. However, many attempts to reconnect life paths were prevented

in the early post-injury period as a result of the environmental separation inherent within the hospital context.

The process of reconnecting life paths was strongly associated with the pathways that the friendship had followed prior to injury. Many people observed that it was easier to reconnect life paths if the friendship had a *long history* and was strong prior to the injury.

Yes it can be too tough and the ones that break down weren't...you know they were mates but they weren't like childhood mates or. You know they were friends but not friends. There wasn't that big of an obligation in the beginning. There was the obligation of that yeah your friend has had an accident we will go up and visit him once or twice but it is not the obligation that they...they didn't consider them lifelong friends, they haven't been friends since they were little, so they are not going to come and keep taking them out all the time (7Sta1).

It was noted that friendships that had experienced previous challenges often experienced less divergence of life paths than those friendships that were experiencing the unknown for the first time. In terms of reconnecting life paths, the important point to make is that it was easier to reconnect those friendships that had experienced diverging life paths if they had managed reconnecting after previous divergences.

Previous experience at reconnecting was valuable in that the friends found the process much easier.

We don't see each other that often, we haven't seen each other for a long time because of distance...and because I've travelled all over the countryside we haven't kept in touch, um, it hasn't been a um.. I don't even know the word, an every day, every week relationship, but when we do catch up then it's just back to the last time we saw each other, so um, yeah, but she's a fantastic friend... we were in high school together....We'd only recently in the last two years got back in touch quite frequently, actually the last nine months prior to my accident since I moved away we were in touch once a month, yeah (17Sci1).

Reconnecting life paths involved two main processes, namely *working* and *redefining*. Working and redefining were processes that occurred in parallel and appeared to be mutually exclusive. Although different in nature, they were both

utilised at varying time since injury to facilitate reconnection and there was little evidence of any interactive effects between the two processes. This contrasts sharply with the interactive effects noted between enforced separation and priority drift. For the large part, working and redefining processes were implemented simultaneously but independently and changed the expectations individuals placed on their friendships. The aim of these processes was to remove or minimise enforced separation and refocus priority on friendship. The process of *working* was a behavioural process consisting of proactive efforts by injured individuals, their friends and other network members to reduce the enforced separation of friends and realign their priorities within the context of their friendship.

You've got people in your life you can rely on I guess...push yourself, make an effort yourself, it helps you, because if you want to maintain that, you know you've also got to put effort in (15Sci1).

Working was the process of 'doing friendship' whereas *redefining* was the process of 'thinking friendship'. *Redefining* was a cognitive process that, although influenced by contextual factors, was principally intrinsic to an individual.

They need to rebuild their own identity again so sometimes maintaining the friendships outside can be a bit of struggle for them because they are struggling with themselves (7Sta1).

It was not only the injured individual who initiated the processes of *working* and *redefining*. Indeed, these processes were equally used by friends as a way of facilitating the process of *reconnecting life paths*. Table 6.1 shows the categories of reconnecting including those that delineate the processes of working and redefining.

	Contexts, conditions and causes	Covariances and contingents	Consequences
Reconnecting life paths	‘Normal’ for friendship Different somehow Previous experience Critical point Extent of divergence Common ground Long history	Adjusting to changes in friendship Confronting unrealistic expectations Family mediation and facilitation Family gatekeepers and protectors Family education and support Rehabilitation staff strategies ad hoc	Appropriate lasting friendships
Working	Perceptions Expectations Personal responsibility Cause of divergence Blame Justification Ongoing negotiated process	Effort Degree Intensity Timeframe Initiator Focus Shared equally Reciprocity	
Redefining		Self reflection Compromise	

Table 6.1: Codes (contexts, conditions, causes, covariances, contingents and consequences) for the categories of reconnecting life paths

Working

Working was a proactive behavioural process used by the injured individual and friends to reconnect. The process involved *breaking the ice, negotiating new and old roles and responsibilities, moulding the environment, and recruiting staff and peer helpers*. Appendix U outlines the codes that defined each of these strategies. *Working* was also a process in which other individuals, such as rehabilitation professionals and family members, could play important roles to facilitate the reconnection of friendships following injury. *Working* was prefaced by recognition on the part of either person that the friendship was important. “I’m not going to....., we’ve been

mates for thirty years, so I'm not going to lose them now, I'm going to make sure I keep in touch with them all" (8Sci1). Inherent in the process of working, was the notion that working required *effort*. "If you want to continue the friendship...you may have to do something to maintain it" (10Sci1).

Working differed across friendships in terms of *degree, intensity, timeframe, initiator and focus*. It was influenced by the *perceptions* that each party held about the effort the other party was making and the *expectations* that each party held about exactly who should be making the effort. As would be expected, working came naturally to those individuals who were the workers in the relationship prior to injury (e.g., 4Sci). In many instances, people who were working did not really see it was work (e.g., 8Sci). Although most people believed that working should be *shared equally* by friends, some individuals took *personal responsibility* for working.

Like because, you know, everybody always says 'oh yeah, they'll keep in touch' and they don't, and I just decided years and years ago that if we all had that same attitude well we wouldn't, so I thought I'll make the effort to keep in touch, and if they don't well at least I will, so yeah, and I've just done that all my life (8Sci1).

In contrast, some individuals with SCI thought that the friend should do all the work, leading to a decision not to work themselves.

Twenty people used to contact me and come and see me and that, but yeah, now no one comes, not even my bloody brother for the last three weeks, but I'm determined not to ring him because I don't see it should be my point to umm... to ring or contact them, because I'm the one that's sick. Maybe I'm looking at it the wrong way, I don't know (19Sci1).

Perceptions about the degree of divergence in life paths and the cause of divergence were important factors. Individuals were more likely to work towards reconnecting the friendship if the *cause of the divergence* was not perceived to rest with the friend, thus removing any *blame*. Even where one party was identified as the

cause of divergence, individuals were willing to work to save the friendship if there was sufficient rationale or *justification* as to why that divergence had occurred.

Eventually they start to come less and less often, which is quite obvious because they've got their own families and that to deal with, so when you first there they come up really, really regularly, and then as you're starting to make more and more improvement you just see them less, and less often. Which I expected would happen down the track anyway (8Sci1).

Regardless of who initiated the processes of working, there was an expectation of *reciprocity* in that both parties had to engage in the work required to reconnect the friendship.

I told him I really appreciate what he's doing for me, and he just said well hey, you know if the shoe was on the other foot you would do the same for me, which we would do, so you know, he's pretty understanding. And as it's gone on and he understands more, you know, more of what I'm going through, it's yeah, it's pretty good (11Sci2).

It was recognised that working was an ongoing process rather than a single activity and that reconnecting life paths may be significantly more difficult and time-consuming than the processes that led to the initial divergence.

I was going to say a single time doesn't really make a friendship, even though a single time could technically break the friendship, but um... or just damage it maybe (9Sci1).

As such, the process of working was an *ongoing negotiated process* that would be required over a protracted period of time.

Breaking the ice

I just think probably one of the things is that some people mightn't know how to handle it, but really once you've spoken to him the first time or to the person the first time you should be able to work that out (8Fr1).

The most important process in friendship reconnection was a behavioural strategy aimed at reducing interactional and identity separation and was labelled *breaking the ice*. This process was the most important because it was a *critical task*

that had to occur first in the reconnecting of life paths and was most effective when it occurred in the early weeks following injury. If friends did not initially break the ice in some way, the friendship was unlikely to be maintained at the time of interview completion. This process was essential in *fostering communication* between friends, and allowing the injured individual to maintain a connection to the “outside” world.

But it’s nice to just talk to people who are out there living, rather than being stuck in a hospital, being punctuated...with bowel therapy (3Sci1).

The strategy also focused on *relieving the boredom* that was often felt within the hospital environment, especially during the early periods of hospitalisation when the individual was confined to bed because of conservative management of their injury.

Interviewer: And so how did you find having visitors during those first few weeks?

Interviewee: Oh I loved it completely and utterly because um stuck in bed, not able to move of bed, the television was a ridiculous price because it was something like \$60 for a week or something... (9Sci1).

Breaking the ice typically occurred while the individual was hospitalised but could also occur once an individual was discharged if contact with friends had not occurred already. The process of breaking the ice was essential to the reconnection of friendships and was more effective the earlier it was utilised.

The fact that they have contacted me has been pretty important, if I hadn’t heard from them at all, then I would probably try and contact them. But basically all three of them got in contact with me quite early in the piece, it’s been irregular contact since, but that’s not really the point, you know, the point is they have contacted me (10Sci1).

Given the feelings of discomfort that friends commonly experienced when entering the hospital environment and interacting with their friend, it was important to have a technique to *alleviate barriers* to reconnection. Some individuals minimised interactional separation, even though still environmentally separated, by using other methods of communication to break the ice.

Texting; (laugh) and they'd ring; and I'd ring them, my boys ring me every night. And, the first couple of months were hard because I had a 'traci' in and I couldn't talk with it; so that was really hard, especially not to be able to talk to my boys; couldn't see them, couldn't talk to them. Um... yeah, yeah mostly through texting and a couple of them have been down a few times, and yeah, I mean they love coming down to Brissie [Brisbane city], and I love the company so yeah, no we're writing letters and... Yeah it's been pretty easy to stay in contact actually (4Sci1).

In cases where breaking the ice was delayed, there was often no turning back because the life paths of the friends had diverged too far for the friendship to be rekindled. "I really reckon that by the time they get out of hospital after 6, 7, 10 months the friends have either drifted or not drifted" (2Sta1). Although breaking the ice required *engagement in an actual interaction* between the friends, other stakeholders facilitated this process in a variety of ways. For instance, families often broke the ice initially by acting as a *conduit for information* between the hospital or medical staff and the injured individual as well as with friends. "Sometimes I know when they are still at school it is the parents that are rounding them up and getting over that initial barrier of friends keeping those links" (3Sta1). Similarly, breaking the ice required family members to *debrief and console* friends thereby normalising and validating their feelings and reducing the likelihood of interactional separation and making the friend more likely to personally break the ice earlier following injury.

Now there was one of, yeah, one of his work guys [friend at work], um, I used to say to them [friends] if you're worried about it [how to interact with person with SCI], you tell him. You know, the one guy did ring one night and said to me, 'look, you know, I just don't know what to say to him', so I just said to him, I just said, 'well look, he is really good, he's, you know, emotionally he's really good, you know, he'll have a joke with you and a chat, and um, it, why don't you just say to him, you know, I don't know what to say to you?' (15Fam1).

Family members often strongly encouraged the injured individual to participate in activities to break the ice based on their knowledge that friendships could only be

maintained when interaction and shared activity occurred. “The family identify, you know, I just think they [person with SCI] need to be getting out somewhere” (6Sta1).

When breaking the ice did not occur, it was often due to the lack of transparent communication. Strategies aimed at *denial*, covering up and putting on *facades* by the injured individual often meant that life paths further diverged, interaction separation was exacerbated and priorities drifted away from friendship.

Interviewer: So there are some frustrating things when you’re out with your friends you notice that as well; do they?

Interviewee: No, because I don’t, I try not to show it (2Sci1).

One participant who had significant disabilities as a result of his injury described how he found it difficult to break the ice with male friends. This process was much easier with female friends who could “look him in the face” (i.e., communicate openly about sensitive topics) whereas male friends tended to avoid emotional topics.

One of the most frequent strategies used to break the ice was that of *humour*.

For example, a friend related the following situation in relation to a bowel accident.

I told her how I felt, I said ‘look, it doesn’t worry me in the slightest’ I said ‘hey, it’s going to be a natural thing now, it’s going to happen for a long time now, so you either have to get used to it and get on with it or... yeah you can stay living and getting upset every time you have an accident in front of somebody’. I’ve been here what, seven days now, and she’s had two [accidental bowel motion] here, and we just sort of laugh about it now, yeah, laugh about it, so yeah, it’s moved over... Yeah, we laugh about it now, and it just yeah. I mean she’ll pass wind and you’ll just sit there and laugh about it, and you look and she goes ‘oh no, I hope I haven’t.. [an accidental bowel motion]’ I said ‘oh don’t worry!’ and laugh about it, yeah (4Fr1).

People with SCI also utilised humour to break the ice and foster *open communication* with their friends.

I mean I always brought the subject up first anyway, because I knew they’d need to talk it out to start accepting it. So whenever they were around I’d start talking about it straight away so, and you make light of it; you make light of passing wind in public all the time then nobody laughs – we all do it. But yeah, just yeah, that sort of thing, but they’d have a few tears but I always stayed positive around them and so that helped them to accept it (4Sci1).

Even those individuals who were more guarded about the personal aspects of their injury felt that disclosure was important to talk about some things to make their friends more comfortable and help them to understand.

Interviewer: Okay. And what do you think they understand about your injury?

Interviewee: Fair bit.

Interviewer: And how do you think they found that out?

Interviewee: Probably through talking to me, yeah (13Sci1).

The injured person often perceived that by *role modelling* the behaviour that they wanted, their friends would feel more confident in overcoming existing attitudes towards disability.

They, their attitude towards it is the attitude towards it, where, you know, I'm not going to worry about it, I'm not going to let it stop me from being who I am, so I think if I would have been a little bit more down on myself and quieter and not social or anything, they would have been a bit different. But I think more that, the way I've been, and the confidence I've had, that they've now seen past the chair, and they can't even realise what it is. And I normally transfer onto couches and stuff like that if we go anywhere, onto a chair in a restaurant or something like that, so half the time they don't even see the chair anyway, so it's just back to normal, it's fine (6Sci1).

This role modelling also assisted in reducing the interactional barriers where individuals felt that they did not know what to talk about anymore.

I think he's [friend] just got to get comfortable with what's going on, so once he's comfortable with me, and the more he sees me with other people and that he'll feel a bit better, and he'll... think he's just got cold feet at the moment, so he'll be alright after a little while (6Sci1).

Some related the need for friends to normalise the interaction

What do you say to somebody who's, you know, in hospital and confined to a wheelchair for the rest of their life?...go and visit them, go and just act naturally, yeah, they really, really enjoy the fact that you come up to visit them and yeah, just act naturally, just walk in and like nothing has happened, and just be your normal self (8Sci1).

Open lines of communication, *honesty* and disclosure (4Sci1, 17Sci1) were considered extremely important to ensure that inaccurate assumptions were not made about the injured person or the injury itself.

Oh, cathetering [using a catheter], I've always got to tell them why I'm cathetering and stuff like that, and how I go to the toilet and stuff, it's a pretty good party trick for the boys too, they like that. I'm pretty open with everything, like everyone understands kind of thing, so and I normally, I tell everyone everything of what I'm doing and how it's going, and how my bowels work, and I'm really open with that kind of stuff. I, the way I see it, I think it's better for them all to know upfront, instead of wondering and watching and talking and thinking, that kind of stuff. So all my friends know exactly what I've got to go through every day, so they're all pretty easy on it, and help me out kind of thing, so it's good (6Sci1).

Indeed, open communication and honesty was seen by most participants as being essential for breaking the ice and ensuring that friends felt comfortable in their presence.

Interviewee: But all my friends understand; I've explained what's happened and they don't care.

Interviewer: So how did you go about explaining that, do you explain it the same way to everyone; or do you tell more about it to some people than to others?

Interviewee: I just tell them, and they all understand, so I've got no problems with it (5Sci1).

Often, friends found it easier to break the ice in *groups*, thereby decreasing the individual pressure that they felt to maintain conversation and avoid awkward silences. One participant found that his friends would come in groups rather than individually and he believed they did this because there was "support in numbers" (2Sci1).

The group setting also allowed some friends to break the ice for other friends who were more isolated by environmental separation or more uncomfortable in the interaction.

Because my friend happened to know my passwords for the [computer] game that he also played, so when this all happened he got on and let them all know and that. So it was really nice that they sent this stuff [messages] all through, and yeah... (9Sci1).

Finally, it was important for people to recognise that *different individual approaches* were considered necessary for breaking the ice depending on the friend and the *nature of the friendship* or relationship prior to injury.

So the best way is talk to the individual I'd say, and work out what works, and also it's slightly different, different relationships are different, like I prefer the majority of people to ask, but specific people, like I've chatted to my sister, that I'd consider it, like if she feels for whatever reason that she needs to help push at any point, that's fine with me, um... the rest of the majority of people I'd prefer them to ask (9Sci1).

Negotiating old and new roles and responsibilities

The process of *negotiating old and new roles and responsibilities* was primarily aimed at reducing the role separation experienced between friends following injury. Different parties could facilitate this process of negotiating roles including the injured person, friends, family and, even rehabilitation professionals. Roles were defined in a broad way and included vocational, recreational and daily living roles as well as those roles specific to friendship, including the roles that were expected or enacted within that friendship during the process of reconnection. SCI, and its resulting physical impairments, often prevented participation in vocational, leisure and daily living pursuits, all of which were important roles the individual was likely to have held prior to the injury and may have been intricately linked to the friendship. Many individuals participated in leisure activities with friends or had made lasting friendships with people they worked with prior to their injury. Although the same type and level of *participation* in these roles was often no longer possible, many individuals were able to identify new ways in which they could participate in or re-establish important roles in these domains.

We used to go waterskiing a fair bit, and jet skiing together, yeah, and drinking. But we used to get up to mischief so, can't really do that anymore, but yeah we used to do a lot of jet skiing and waterskiing together, so yeah, I obviously can't do that anymore. Which is probably a good thing, because

now I just drive the boat and he can just ski behind it the whole time, instead of sharing, so he'll like that more, yeah (6Sci1).

Negotiating roles and responsibilities was often dependent on both the *geographic and temporal context*. Participants often began the process of re-establishing roles while still in the hospital setting. They utilised opportunities to leave the hospital environment and participate in social or recreational activities with friends, thereby minimising environmental separation and facilitating better outcomes because of reduced role separation.

You know, because that will help them to, you know motivate them to get out of here, to go to such-and-such's party, to get to the barbecue or you know it is somebody's twenty first and I have to get there or you know those sorts of things. So you really do want to try and facilitate that but there isn't anything formal (7Sta1).

For those who did not make the efforts to resume social and vocational roles early, the process was often more protracted. Following discharge from hospital, re-establishing leisure or vocational roles often took some *time to be realised*. For instance, during the first interview, one participant spoke of his plans to alter his role in recreational pursuits, but with some reservations.

At the moment I don't think it'd really make a big difference, obviously I won't be able to go on the weekend rides that they go on, but if I can drive, I could always drive a Holden, take the car instead. The people who are in the club at the moment... I don't think it would really bother them a great deal at all, we would start I suppose eventually to lose a little bit of commonality that we do have because I'll no longer be an active bloke (10Sci1).

By the time of the third interview (six months later), these plans had only just been realised, and the re-establishment of participation in these roles had fostered the continuation of the friendship.

Interviewee: Oh well, okay the guys in the bike club, I can't ride bikes with them anymore, but I drive behind them in a car.

Interviewer: Oh okay. So you found a way to be still included in that activity.

Interviewee: Yes.

Interviewer: So how did you work that out?

- Interviewee: Um... well I think initially I didn't consider myself well enough to join them, um... and then uh, a weekend, a particular ride was coming up on one of the weekends recently, and uh, it was one of those rides where you had to ... say [if] you were coming or not, and um... and I just [said] I'm coming too, and turned up in the car, and followed them down, or followed them to where we were going and followed them back...
- Interviewer: And so how did they take that then? Turning up in a car?
- Interviewee: I don't think it bothers them, the fact that I was injured during a club ride, um... normally if you don't have a motorbike you can no longer be a member of a club, but because I was injured during a club activity, um... they've been actually willing to keep me on as a club member, and they've even paid my membership fees for twelve months (10Sci3).

For those individuals who were able to return to work, friendships that were dependent on that role were re-established simply as a result of the reduced environmental and interactional separation. "They've [employer] said I can work my way back into work; which is good I know I can talk to people" (3Sci1).

Friends played important roles in *visiting* the injured person in hospital and these roles were very new within the context of most friendships because the injured person had typically been well prior to their injury. The adoption of these roles by friends was considered an extremely important aspect of working that assisted to reconnect life paths and indeed, in fostering a sense of belonging and adjustment for the injured person. Where friends did not adopt this role, friendships were typically compromised because both environmental and interactional separation continued throughout the period of hospitalisation.

It gives you a little bit of a lift, because you know that, whoever it is comes to see you, you know had been thinking about you, and wondering how you're getting along or how you're improving and all that sort of stuff, if they weren't considering how things were progressing for you, you wouldn't even see them at all. And to me the fact that he's come in to see me it means he's been wondering how I'm getting along, and it's nice, it's nice to know that people are thinking about you I suppose (10Sci1).

By re-establishing these important communication roles, it assisted the injured person to recognise the importance of their friends and enhanced the personal well-being of

the injured person by demonstrating that they had not been forgotten. This could be achieved without large time commitments.

You can do that with a lot of people, say I was just thinking of you, how are you going? Everything alright? And that's it, end of conversation, you don't have to have a big long conversation every time, unless you've got something interesting, been somewhere or done something you tell them, but just to hear their voice sometimes and make sure they're okay, that's basically the main part of it (16Sci1).

Similarly, this reconnection with friends was recognised as an important pre-requisite to re-establishing those friendship roles, thereby reducing the role separation experienced within the role of 'friend'.

So I was just on the couch and he couldn't believe that we were just sitting there, he was expecting that I was going to be out of action for at least two or three years, but it was just like old times just sitting there having a drink, so which has kind of made him a little bit more comfortable, so which is alright, which is good. But yeah, that's probably the best time (6Sci1).

Similarly, it was an important aspect of working to negotiate the roles that each friend played in relation to both the *initiator of contact* as well as the *frequency of contact*, thereby clearly establishing the roles that each party played in defining the boundaries of *reciprocity*.

We just visit; I mean I don't know whether it's more or less. We're not, you know we just go and visit people and it's not, we're not extremely social, we like our space as well, so we see people enough, I don't... we see them or they see us (15Sci2).

Decreased environmental and interactional separation occurred where the friend was able to instigate contact, especially where that contact was in person. "He rings me; I ring him; he comes around; I go around to his house" (5Sci1).

In some instances, friends play roles that injured individuals perceived were *beyond the call of duty* but were greatly appreciated and helped to consolidate friendship.

One of them offered to take time off to come and help, one from Mt Isa came down, he actually, well he took time off because he just took it off, as soon as

he heard what happened he didn't even ask me or anything, because I wasn't capable of talking anyway, he just took the time off and flew down on his own time, took two weeks off work and helped out with the business and helped out with my partner...He came down and gave two weeks of his life up just to help me out (16Sci1).

Friends also played a number of varied and important roles in being *motivators, realists and confidantes*. "And I used to try and get him mobile... just keep him motivated, you know... so I'd go and see him, you know, things like that" (3Fr1). By *normalising* experiences, friends also helped and were perceived to help to reconnect in ways that showed friendship rather than pity "I think it's good for people to understand that, that you know, not pity or anything like that, because I didn't understand or have a clue, what actually was involved in being like this" (15Sci1).

Empathy rather than sympathy was an essential component of all roles that friends fulfilled following injury.

Well obviously there has to be a degree of understanding on behalf of family and friends, and a degree of empathy toward the person. Because troubles can be easily changed in this world, as you're probably well aware... only family and friends, but also the nursing staff, the doctors, everyone you come into contact with, that I'm going to come into contact with in my life from now on, there has to be a degree of empathy, because if you don't have that how are you supposed to... get over the initial barrier (13Sci1).

Friends had to demonstrate empathy through these new friendship roles that often removed them out of their comfort zone and were significantly different to the way in which they fulfilled the friendship role prior to the injury, particularly for males. By adopting empathic roles, the boundaries and rules for reciprocity were established within the altered contexts of friendship. Expectations regarding the initiation of contact and the degree of 'work' that each friend had to do to maintain the friendship were facilitated by the degree to which each member could understand and empathise with the other.

Similarly, *persistence* was an integral aspect or ingredient necessary within

these new friendship roles, providing the foundation and motivation to maintain contact.

I'm a persistent bugger... I thought about it, he doesn't really need... you know, other people annoying him, things like that. But no, I just, I don't know... kept on contacting him and he contacts me, so yeah, as I said I'm a persistent bugger (3Fr1).

Participation in decision making was important to establish *equality of roles* and redirect some *control* to the person with spinal cord injury (e.g., "we'd both chat about where we wanted to go, and yeah, made a decision on where we could meet up" (18Sci1)).

Negotiating new roles within the friendship was important in terms of *jointly defining* the expectations and level of care that a friend should provide in comparison to others.

Yeah, like family have mainly sort of talked, they mainly worry about what you're going to do when you get out, you know. How you're going to live, are you going to go back to work, are you going to sell your house, and the support they can give you. Whereas your mates sort of, they haven't changed, you've been mates for years and then they don't try and, not organise you, they just come up and say g'day and cheer you up and tell you that, you know, they're always going to be there sort of thing. Whereas your family do tend to try and organise you, try and do as much as they can for you, and do all your legal stuff and answer your mail and that sort of stuff, whereas your friends just come up and they just sit there and talk to you, or give you a hand to have a feed, or just be their normal charming self really (8Sci1).

Some friends had *previous caring experience* that often assisted friendships through enhanced understanding of the roles. Indeed, some participants were able to play both caring and friendship roles and *maintain separateness* of these roles

Oh we sort of talked about it... I just when I asked her I just said to her look, the only reason I'm asking you is, you know, I don't want friends and family involved, but I can trust her to... change hats, and she said yeah, no I'll do that, and yeah we've kept that up. .. she's just managed to do it, doesn't talk about anything that's happened once it's over, once her hour is up yeah we just don't talk about it... I think in the beginning it was a bit hard to find time to see her as a friend as well as a carer, but we've pretty much worked that out now (4Sci3).

Other times, friends had to take on caring roles because of their mere *proximity*, thereby requiring the injured individual to accept the friend in that role.

It's very shocking when you see your friends sort of acting like nurses and sort of... they just came in and they went "Look at you," and I went "I can't, because if I move the shit's gonna go everywhere," and they go "alright". Then I had to talk them through it (12Sci1).

Most injured people were able to articulate to some degree the expectations that they held regarding the roles that friends should play in this area.

Well just random people in the community really, being in a chair is synonymous with being mentally handicapped and all sorts of fun stuff like that – but I won't get into those sort of funny stories. But um... it's... as well as... not to be overbearing with um... insisting to help, as though you can't help, as though you can't take care of yourself, but sort of... having the offer extended if you um... offer extended that if you... if it occurs that there is a curb that's a little steeper than the others, that it's fine to help or whatever, like so it's an interesting line between sort of yeah, not feeling too coddled (9Sci1).

This process often required the friends to establish the degree to which *sharing load* would occur.

I guess it's his confidence, like he would tell me when he required help, and so it just made it easy for me to go yeah okay, I'll push you. It's just being willing to accept that he will need help, or... like to start with it was more like oh, you're falling behind, what's wrong, what's happening, it's just getting comfortable with speeds of how he can move and things like that, how long it will take to get in and out of a chair, things like that, it takes time. I guess the most important first things that you need to know is just general accessibility, like if you're going somewhere... ramps, stairs, space between chairs, tables, poles, doors, door widths, just all the general accessibility, [he] would let me know afterwards what he required after that (9Fr1).

This was particularly important in terms of how much the friend actually assisted the injured person.

By negotiating friendship roles and responsibilities, the *function of support* required could be determined, whether that was informational, practical or emotional support. In many instances, emotional support was more important from friends than either practical or informational support. In instances, where other support was given,

it was important for the injured person to establish their role as the ultimate decision maker, without fear that the friendship will be harmed.

That's a friend who doesn't judge, whether you're doing the right thing or the wrong thing, some may advise, give you advice and say this, that, and the other, and you can take it on board but even if you don't take it on board they're not going to dislike you (16Sci1).

Many friends were clearly aware of their role in providing emotional support and companionship but articulated frustration at not being able to do more.

Interviewee: Oh... just support, there's not a lot you can do for him, you can just let him know that you're thinking about him a bit, and I, you know, I've been down where he is now a couple of times, and I visited him in hospital, and... I just kept up where I can with him, do what I can, if I can do something for him.

Interviewer: So something, do something practical do you mean?

Interviewee: Well I would, I just think that if I was laying there in a little flat in Birkdale, not able to get in and out of bed, that I'd appreciate someone ringing me every now and then (8Fr1).

In other instances, friends negotiated roles in providing practical support, more specifically to manage the home environment during periods of environmental separation or where home tasks needed to be completed. This role was established within the context of regular visiting for emotional support however as it was not perceived as the role of the friend to make a special visit to provide practical assistance around the house. This highlighted the importance of the context within which this support was appropriate.

Interviewer: So what does that mean; being there for people?

Interviewee: Oh just talk, talk, if you need any help with anything, there to help, help out, like he's popped around to visit us and he's fixed things in the house since I've been like this (11Sci1).

Similarly, it was important for the injured person to play an *active role*, within the context of compromised friendship resources, to *seek support* when they were experiencing low periods so that friends could *buffer those low periods*.

But yeah, like I've got like, I don't know, twenty or thirty people I keep in touch with regularly, so I ring them, yeah, just every now and again from

home if I'm feeling a bit down in the dumps or had a bad day at work or whatever, I just get on the phone and ring me mates up, same thing, just makes you feel good (8Sci1).

For the injured individual, important friendship roles related to asserting their needs within the context of altered abilities and environments. Injured individuals asserted their need for conversation to manage interactional separation, their need for physical contact with friends to reduce environmental separation and their need to be an important and contributing member of the friendship to reduce role separation.

I know a few of my friends haven't been to see me, they haven't rang me, I've rang them, just to make it easier for them, just to say you know, we're still mates and I know where you're coming from, and yeah, you know I'll give you's [sic] a ring just to say g'day (8Sci1).

Negotiating old and new roles and responsibilities differed across temporal contexts in the sense that, as time passed, individuals were able to more clearly negotiate roles and responsibilities and thereby articulate where increased attention or altered roles were unnecessary or untimely.

Certainly towards the end he felt much happier about saying look, I'm busy now, or I'm going to be in the gym or, ring me back another time, yeah' (15Fa1).

This process was clearly related to the injured person developing a clearer sense of their personal identity both separate to and within the context of the friendship.

Sometimes injured individuals used strategies such as *keeping the peace* and staying silent in response to role separation, but these strategies were typically ineffective in reducing role and identity separation over the long term. These strategies were often perceived by injured individuals to be effective in the short term however in maintaining the friendship by ensuring that any support provided was appreciated, particularly where extraordinary amounts of effort were demonstrated on the friend's behalf.

I sort of feel as a friend I don't really have the right to say "look I'm not just up to it," some of them have travelled a long way, you know, and I like friends who just turn up, I've never been one to ring first and "is it alright if I come around," you know, I just turn up, and I like them just to turn up, so if it's inconvenient at the time, well, if it's a good friend it won't inconvenience them, do you know what I mean? They're willing, if I'm doing something and I can't stop doing it then they should accept that and allow me to continue what I'm doing, or join in, or you know, talk to me while I'm doing it (10Sci1).

New roles emerged within the context of altered friendship activities and shared time between friends that helped to foster a positive but different friendship environment.

And then towards the end I was starting to spend some time at home, and going back there late at night, so I'd leave it till Friday, Saturday, Sunday, when I was on home visits, and I'd normally get them all around here or something like that. They'd all come together, so, which has made a lot of my friends on one side friends with my other friends on my other side, so we're all friends now, so it's good. So which is good, so a lot of my mates have made mates out of mates kind of thing, it's funny, because they'd keep knocking into each other. So yeah, so no it was good (6Sci1).

Although *making new friends* was the only way to negotiate ongoing friendship roles, this process was typically associated with peers who had been hospitalised together. These peers, however, appeared to play a different role to that played by pre-injury friends.

Because only the other patients really know where you're coming from, they really understand what you're going through, like everybody else says they've got an idea, they think they know, but they don't really, and the other patients do, because they're going through exactly what you're going through (8Sci1).

In some instances, injured individuals found that they could *substitute friendship roles* with other friends. These were often a surprise to the person who found that those people they thought they could rely on were not reliable whereas others in their networks who previously held peripheral roles stepped into the roles of the previous close network.

I've probably never felt a part of something before, whereas I do now. I never felt like... you know that I fitted into the town or anything like that. You know the number of people that I can call on now is... its quite wide (1Sci1).

Moulding the environment

In order to address environmental separation, active strategies were used to mould the environment and facilitate the reconnection of the life paths of friends. As with all other reconnection strategies, moulding the environment could be implemented by the injured individual, their friends, family or staff. Moulding the environment could involve direct efforts to modify some aspect of the environment that was specific to that friendship or indirect efforts aimed at fostering *broader environmental changes*. Even when strategies were not implemented, the importance of a facilitative environment for reconnection was recognised.

I don't know, it's so formal when you go into hospital and see someone in bed, if you know, if it was more common areas, like somewhere where, like just say like some chairs out in a garden or something like that outside, where they don't have to be in that environment, where they're around the sick people all the time, I think would be a good thing to do that.... (6Sci1).

Environmental challenges often occurred within *temporal contexts* and played an important role in delaying reconnection processes. Many friendships found positives within these situations however, comforted by the knowledge that there was a plan in place that would remove those environmental challenges.

So looking forward to getting back there [home], I'm just stuck here for a bit longer than I'd like because I'm waiting for the renovations to finish. ...That's good [when renovations are finished], because my friends get to fly down and stay for free, and we get to hang out so... (4Sci1).

Efforts were often made to mould the hospital environment, particularly in terms of *rules and infrastructure*, in an attempt to establish greater personal *control* over friendships and enhance the *flexibility* and *choice* that would facilitate reconnection.

- Interviewee: Visiting hours...should be longer...If they come in at 7'oclock at night you've only got an hour, 8'oclock that's it, you're out.
- Interviewer: So what time do you reckon you could stay up to and still be woken up at 7'oclock in the morning?
- Interviewee: I wouldn't get up at 7'oclock; I'd tell the nurses to bugger off (5Sci1).

The hospital environment was moulded successfully by some injured people to facilitate opportunities for communication.

She has maintained friendships that she made in here that do live out west and they still email each other and you know ask about each other and those sorts of things. So you know they do maintain those , especially nowadays with email and all that sort of stuff, it kind of makes it a little bit easier for some people who can use computers, to do that because she talks to me every week about, you know 'I spoke to ...blah blah blah [names of friends contacted by email] (7Sta1).

Often this required the individual to *think creatively* about how to *use resources* that already existed in that environment.

Well one thing I did have to seek out myself was....., some friends that I have overseas, that I couldn't really contact by phone, and I had their email address. I was fortunate, I had a friend who did some study through the hospital here and told me that there was a library sort of hidden away downstairs, and it was for students, but when I went down there they allowed me to. Like I was the only patient who wheeled myself in there in a wheelchair and asked them if I could get on a computer, and they were lovely, they looked after me, but I could see that that doesn't often happen, sort of thing. And I suppose, yeah, it was good for me to be able to email, I had a brother and his wife and child in the Philippines at the time of my accident, and I really wanted to be in contact with them, and they wanted to come home, but I didn't want them to have to come home sort of thing, so it was good to find that I could get on the internet and email them, sort of thing. Yeah, so my only suggestion I suppose would be to somehow be able to access computers, I know there was an internet café downstairs that was \$2 for ten minutes, and with my lack of typing with one arm, \$2 would have got me, yeah, two lines down the page and that would have been it. So that's the only thing, that's one thing, I don't know if there's anything else (7Sci1).

For the most part attempts to mould the environment centred around *seeking information* that facilitated participation and modifying planned outings to ensure that the environment was suitable.

We're just a little more cautious when we go out or do things, and make sure we go to wheelchair friendly places. So they work around that, if we want to

go out to dinner somewhere they'll make sure they ring first and make sure they've got disabled toilets and ramps and that kind of stuff at the place. (6Sci1).

Efforts to mould the environment sometimes took the form of *social action*. For instance, one family member advocated to council and businesses for renovations enabling access to community facilities that allowed her daughter to access outings with friends (4Fam1). Similarly, *public awareness and education* was considered to be an extremely important means of environmental moulding, by facilitating acceptance and belonging following injury.

What can you do? If people have their own prejudices about whatever then it usually goes back to their childhood, doesn't it? That's a very difficult thing to get out of the system, unless they get educated about it...That they could get educated by coming to places like this and understanding the person's perspective (13Sci1).

One of the most important strategies related to moulding the environment was the information that was gathered to support people in negotiating the environment. For some people, this process involved *asking specific questions* of health professionals or *looking for direction, information and resources*.

If we're going to go anywhere they [friends/health professionals?] go and have a look at it before we go there, they'll ring up or go down and check the place out or whatever before we go there, so that we know that when we get there that we can get in there...I haven't really been, there's nowhere close that I could just go in my wheelchair. But apparently there is, apparently there's a lot of good places to go to, that are fairly reasonably close, but I've just got to find, you know, get to know where they are first, so that when they come out next time we can get in a maxi taxi or something like that (8Sci1).

The *social environment* was an important area for moulding and one that many parties tried to manipulate to facilitate friendships. For instance, some people found it extremely important to mould their social environment to include only people with positive perspectives so they could maintain their own wellbeing.

I avoided all negative people in hospital, I didn't talk to anyone that was negative and down in themselves, or down on me. And there was only about three or four people in there that I spoke to, because they were the only

positive people in there, so yeah, definitely. And that's why, those people that were in there, if I watched, they didn't have any visitors come in to see them and stuff like that (6Sci1).

Sometimes, modifying the social environment involved *protecting friends* from the aspects of the injury and subsequent disability that would cause discomfort.

Because I respect the friendship so much and I knew that I would sort of almost consider it over if he was told about something like that [personal aspect of injury], I didn't want to give a chance for the friendship to be over, so even though he has most likely guessed, as lots of people have, that haven't been confirmed specifically, and that might have, because he hasn't been told that much (9Sci1).

Services and financial support often contributed to reconnecting friendships by moulding the environment. Friends and family themselves often facilitated reconnection by encouraging interactions with favourite objects or activities, the presence of which assisted in reducing identity separation. "So I thought well maybe I could, you know, get him out to the football or something like that, that's the sort of thing that he'd really enjoy" (8Fr1).

The thing is that often people will need assistance or someone to take them there or transport or whatever...If you could arrive on your own or with someone who was there for you, to be your carer or whatever and you arrive there, whatever it is, then you have a bit more ability of interacting... It should be someone there for the client to help them get to where they are going wherever that may be whether that is transport you know, looking after their bladder or whatever. You know someone there in the background that does the work for them and they can still get out and about and I suppose some of the um people who have that assistance like and I mean it is their personality, the really high level quads who have care you know 24 hours a day, they are there to help them, because they need someone to help then 24 hours a day but they just sit in the background and that person can you know get to places, continue on with whatever they are doing whether that is a work related or social or the rest of it (9Sta1).

There was evidence of attempts by staff to mould environments in a way that would support reconnection between friends. For instance, staff often demonstrated *flexibility around hospital guidelines*, encouraging participation of friends in rehabilitation activities ("in terms of just everyday rehabbing [rehabilitation] sorts of

activities, friends are sometimes invited to join in occupational therapy sessions” (4Sta1)). Indeed, friends who engaged in the rehabilitation context appeared to remain connected. “I got to go to physio and that and they're even better in there too” (4Fr1).

Rehabilitation staff sometimes implemented *ad hoc interventions* to facilitate friendships indirectly. This typically involved using family members as mediators and facilitators in those relationships. As such, this strategy involved using the *linkages within networks* to share information and enhance public awareness, thereby facilitating acceptance and understanding.

The way I did it [educate families] was probably in an indirect way in relation to talking to the families about ways that they could...cause the families often express anxiety or concern that you know John his friends don't seem to come. You know what I mean so I would maybe talk to the family...not necessarily the person with SCI, they don't often express it, it is more the family are worried because you know it is hurtful whereas the person themselves won't often express it. So encouraging the family members about how they might encourage and maintain those friendships so part of that may be about when they went home for weekend leave you know what I mean or do you think you have given them enough information or are they worried about anything in particular or and getting them to sort of sit down and talk through with you who do they think are their main friends and what, do the friends have any issues generally and just whether they want to talk someone I am happy to (2Sta1).

Recruiting staff and peer helpers

Within both hospital and community environments, people with SCI often actively recruited peers and staff to act as helpers in the process of reconnecting life paths. Most of these helper relationships emerged within the context of the hospital and rehabilitation environment where individuals experienced environmental separation from their natural support networks. The relationships formed with peers and staff varied in the *duration, depth and intensity*, the *function* it served, the *valence* and *emotional importance* of the relationship and the *perceived need* for that

relationship. For the most part, these relationships fulfilled a *specific purpose* (i.e., as a helper), were *environmentally defined* and were typically *time limited*.

These ‘helpers’, especially peers with SCI, played a significant role for many people in reducing the interactional separation they felt within the hospital environment. Many people gained enormous benefit from talking to peers about their *hopes and dreams* for the future and how to achieve them within the context of their new limitations. Therefore, peers played an important role in “maintaining hope for the future” (2Sci1). Indeed, individuals specifically sought out those peers who could provide positive role models.

You just, you just pick who would be one of those ‘down’ sort of people; you don’t hang out with them, because they bring you down; so you just find the positive ones, go have a chat to them (5Sci1).

Peers were often sought in a role that was perceived as unique because only those individuals could really understand what it was really like being injured.

Interviewer: So when you were having one of those down days, did you talk to anyone about how you felt, what you were thinking?

Interviewee: Yeah, only the other patients, yeah. There were a couple of the other patients I was good mates with, and we used to compare notes a bit. We used to be able to sit around and talk, yeah, no never spoke to anybody else about it...Because only the other patients really know where you’re coming from, they really understand what you’re going through, like everybody else says they’ve got an idea, they think they know, but they don’t really, and the other patients do, because they’re going through exactly what you’re going through. So you can sort of talk to them and say ‘I don’t feel too well today’, or ‘What’s happening here’, and they say ‘Yeah’, you know, ‘We’ve been through that’ (8Sci1).

For some individuals, the presence of a pre-injury friend who had experienced a disability was helpful. The friend with a disability provided important information and *reassurance* to the person with the SCI.

Yeah, it’s been great actually, it’s been really good, because he [friend with disability] helps explain things, like you know a lot better than what the doctors and nurses, because he’s been there and done that, so any time I’ve

had any dramas or things that they haven't been able to explain, he'd ring me up and I've spoken to him about it. And he's sort of said, you know, 'I've been there, done that' (8Sci1).

It was in these instances that friends who had previous experience with disability often came to the fore as stronger friendships.

Just I think, just because we've known each other for so long, we've just been really good mates for many, for too long, and so yeah, we just keep, we just ploughed on regardless. And I think it has helped, the fact that one of our, another one of our, you know, our school mates has been in the same boat, and so we all stayed really close to him over the years, and so yeah, I think that was, you know, that's been a good experience for everybody else. And because we've always been really, really good mates, we were really close, and we just yeah, me being in a chair hasn't done anything to change that (8Sci1).

Indeed, even for those individuals who did not seek to develop friendships or alliances with their peers in hospital, the benefits of these relationships were still recognised.

Yeah. Yeah, particularly the guys in my room, and the guys outside; and I think that's more a case of... you would probably never socialise with these people outside – but then I'm a snob and always have been. Truck drivers and various other ferals [colloquial language for working class person], but [we are all] caught under the same umbrella with the same injury, with the same problem with the same prognosis, and the same problems affect all of us to a lesser or greater degree – there's a camaraderie in here that you wouldn't have anywhere else (3Sci1).

For some individuals, the main role played by peers was to *relieve the boredom* of the hospital environment.

Interviewer: So you've made friends with some of the people you've met here in the spinal unit?

Interviewee: Yeah.

Interviewer: Yeah? Okay. So how has that worked? Is that the same sort of friendship that you have had with your other friends? Or is it different?

Interviewee: Oh it's different, because it's a completely different sort of situation.

Interviewer: And so what sort of things do you talk with your friends in here about?

Interviewee: I don't know, anything really, anything to keep our minds occupied (18Sci1).

The degree to which these relationships were perceived as friendships and the intention of individuals to maintain these relationships varied. People acknowledged that these relationships served a specific purpose within a specific environmental context. They recognised that these helpers differed from their pre-injury friendships.

- Interviewer: Okay. So what does their friendship mean to you?
Interviewee: Won't be like all my other friends.
Interviewer: So what do you mean; why not?
Interviewee: I've got enough friends; don't need any more.
Interviewer: Okay.
Interviewee: But like I'll keep in contact with them, ask how they're going and that, that's about as far as it will go (5Sci1).

For others, these relationships were perceived as being more central to their social network and an important, ongoing source of support and friendship.

- Interviewee: No, I've maintained all, yeah more, if not, I've made more friends, yeah I suppose.
Interviewer: You were talking about the hospital patients and the staff, so you see them as your friends now?
Interviewee: Yeah, I've definitely built some good relationships with staff and patients, so yeah.
Interviewer: So will you be keeping in touch with anyone from here when you go home?
Interviewee: Definitely a few patients (7Sci1).

Some felt that despite developing good friendships with peers, once discharged the environmental separation that they would experience would prevent them from maintaining that friendship.

- Yeah, they'll [peers] move back out to the gulf country and I won't see or hear from him again, so you know, but he's a nice distraction while I'm here, you know, someone to talk to (14Sci1).

In some instances, the families of peers also emerged as a source of ongoing and beneficial friendships.

- Oh I have met one person and his fiancé, and mum and dad, and his sister. [His] family, they've been a big help to me, especially in the last week I suppose, you know. They've been great. It's good because I can talk to them and get things off my chest a bit, which saves me building up, so I think that's been helping me in the last... probably in the last week, you know, sort of having somebody that I can talk to and I can trust, I know that they're not

going to blabber [talk to other people] sort of thing, and that's what I like in a friend, you know, that's what I like in people, if I say to them something about me I don't want every tom, dick and harry to know about it (19Sci1).

The friendships developed with peers during hospitalisation were seen as an important way of filling the temporary void created by environmental separation from friends and family.

Family can only be there so much of the time, even if you have that, a lot of people don't have that too but, but friends, um... yeah... the ones that you think that will stick around and support don't, and then you find you meet new friends in hospital, which are, for me that's been a huge thing for me, meeting people in hospital in similar circumstances, and gaining new friendships, that's so important for me to have that (17Sci1).

Although their approach to facilitating reconnection with pre-injury friends was usually haphazard and superficial, rehabilitation staff frequently recognised the need for peer relationships. They often engineered opportunities for people with SCI to develop peer relationships.

You know you don't want to make one area too heavy with high dependency quads [people with quadriplegia] but we will quite often look at who is going to be good for someone else. Who we think will be very supportive for someone. In particular, if they have been in acute [ward] with someone already so if they have come in at a similar time and you quite often find that you will get very similar things coming in the front door at the same time. You know, we have never really had triathletes in here but we have got two now that came in under very similar circumstances and almost about the same time. So we are trying to sort of introduce those two at the moment because they have, you know, a similar outlook and stuff.We try to keep them together if they got on well. Because a lot of the time because it is a very traumatic experience in the beginning, they have kind of bonded that way but so have the families. The families tend to bond as well up there [in acute ward] so they get, that can be a very supportive beginning for them (7Sta1).

Rehabilitation staff at times, also actively *recruited external agencies* as helpers to facilitate friendships. "Sporting Wheelies [an SCI community organisation] is probably the other thing ...in terms of formal supports that would be one that we use" (6Sta1).

Although the importance of peer interactions could be anticipated and indeed expected within the context of such a traumatic life event, the emergence of *friendships with staff* was unexpected. Indeed, some individuals spoke of personal interactions with staff that substituted for the interactions they would have had with friends.

I had my hair dyed at the hospital and it went a hot pink, and it was terrible, I was so devastated. And one of the nurses really felt for me, anyway she finished work about one in the afternoon, she rang me up later on and said 'look, I'm in town, do you want me to get you a hair colour?'. I said 'no, I've already raced across the road and got one'. She said 'oh, have you anyone to put it in?' and I said 'not yet, but I'll find someone', and she said 'right, I'll be there in half an hour'. She turned up with pizza and her fifteen year old daughter, and we all had pizza and dyed my hair; and then she did that again a few months down the track on her day off. Came in with pizza and dyed my hair; oh they're just an incredible bunch of people, because they're not like normal nurses, you know you go into hospital for a few days and leave; they're... its one big family in there. There's no difference between your nurses, your cleaners, tea trolleys, the doctors... there's just no difference; physios [physiotherapists], OTs [occupational therapists], they're all at the one level; they all treat you the same, you treat all of them the same (4Sci1).

These relationships challenged the typical perception of *professional boundaries* and client relationships and, although these boundaries were recognised by some injured individuals, it did not diminish their perceptions that the friendships would perhaps persist over long periods of time.

Interviewee: Then the male nurses, I became friends with a few of them, and the physios [physiotherapists] and all that kind of stuff ...One physio, [I] stayed really good mates with the physio, and two female nurses in there [hospital], I became really good friends with in there, I make sure I go out of my way, three of the nurses I make sure I go out of my way when I go in there to see them and say hello and that kind of stuff to them. So yeah, I became really good friends with them, they sat in there and talked to me, and they'd spend most of their shifts in there with me, chatting to me, telling me their problems, I was Dr Phil [talk-show host] because I watched a lot of it in hospital, so I was Dr Phil King.

Interviewer: So like any of those people that you met in hospital, would you keep in contact with now and include in your activities?

Interviewee: Oh yeah, definitely, but you can't for a while because it's a

privacy act or something. You can't keep friends with the nurses or the physios, just because you can't have that, I don't know what it is, but like I've been explained that, but yeah I'm sure later on down the track, you know, it will be, it'll be yeah, like either bump into them or wait a year or six months or something like that (6Sci1).

Redefining

Unlike *working* processes which were behavioural in nature, the concept of redefining represents a cognitive process that was a necessary step in adjusting to the changes that were faced personally and socially within friendships. This process could occur quickly when individuals accepted the need for self-reflection and comparison. For others, however, this process occurred over a longer-term, becoming apparent only during later interviews. Redefining involved *redefining friendships and priority setting*.

Redefining friendship

In most instances, friendship was experienced differently following injury. Even in situations where friendships remained strong and appeared the same to those involved, the occurrence of injury did create a need to redefine the friendship and to reconsider where the friendship sits in the total life picture of those involved. Inherent in the process of redefining friendship for people with SCI, was the need for redefining the self and those around them, both separate to and within the context of the friendship. *Redefining self* involved a redefinition of values, the *importance of disability, self-esteem* and *self-efficacy* as well as a *comparison to others*. This was a psychological process that was not easy to manage, particularly if the differences between the old self and the new self were quite large

Psychological, accepting what the accident's done to me, I guess basically coming to terms with what I was and what I am has been rather difficult – it still is, so in those terms, yeah, it's fairly... still fairly difficult to accept, I've

been a fairly independent sort of person, if I couldn't do it myself, I would very rarely, or find it very hard to ask anybody else to do it for me (14Sci1).

The redefinition of self was an integral component in addressing the identity separation experienced and in managing reality shifting over time.

In redefining self, others were often used as points of comparison or reflection.

In this sense, redefining oneself occurred through processes of interaction.

You just feel like spending time with friends sometimes. To take you out of yourself maybe, because, it's interesting, as an example of... yeah, of that like sometimes, if I've been here I'm not happy with just reading or whatever, but I might not have spoken out loud for a day even, so if you talk on the phone or something, or if someone comes in your voice sounds weird for a little bit, and so it's taking you outside yourself, I don't know whether there's an inbuilt need to talk or any... (9Sci1).

Further, the way in which others interacted with the person influenced how and to what degree redefining the self was successful in *facilitating adjustment* as well as the degree to which this redefinition influenced how others interacted with them.

I think if you're a negative person, you're not going to hold your friends. If you're going to be negative about it and feel sorry for yourself you're not going to win any friends there, I think if you're positive and if you're happy with yourself, then people respect that, and that's where people will go out of their way to help you, and try to do anything for you – but if you're going to be negative they're going to try and avoid you up there a bit. Because they think “oh I don't want to go back over there, he'll go into depression again and he'll tell me about how bad he feels about himself again” kind of thing, so I think you've just got to be positive. If you're negative it's just crazy, because you won't hold any friends at all, because no-one wants to hang around with someone that's negative and not happy (6Sci1).

In redefining self, *values* were a key focus, because it was the values of the individual that determined not only the importance attributed to friendship but also the importance of how the individual would cope with challenges to the friendship over time and in the context of their current situation. Individuals reflected on their values of what was important to them, how they integrated *hope*, how they sustained *motivation* and *pride*, how they managed *responsibility*, how they utilised *spirituality* and how they remained *mentally active*. Inherent within this redefinition was a

capacity for *learning new things*. “I’ve had to learn patience as well” (11Sci1). Many times, the interaction with others was what focussed learning about self.

I think it’s just a natural liking for each other, someone you’re willing to get very close to, you learn a little bit about them, a little bit, well, usually quite often learn a bit about yourself at the same time as you have to adjust your thinking a little bit to their way of thinking (10Sci1).

For some individuals, they perceived that they were the same person and therefore attached no significance to a need to redefine self. In many instances, this was validated by friends who reaffirmed their value as the same person that they knew before.

They knew I’d get better, they knew the type of person I am, if I showed you one of my texts it’d show you that they say nothing will hold you down because we know the type of guy you are, you know (16Sci1).

At face value, their friendships seemed to resume as they existed prior to the injury. For others, a redefinition of self involved articulating how they had experienced *personal growth through adversity* and how this had made them a better person, frequently placed greater emphasis on the importance of their friendships in their lives. For one person, they described how they had become a changed but stronger person.

I’m not sure; in a way breaking my back has made me stronger; it... just like if we were like in a seminar situation at the hospital, I mean before there’d be questions I’d be dying to ask but there’s no way I would; and now I just come straight out and ask. And... Yeah, and I don’t know, it just felt easier because these people didn’t know how quiet I was before, so they got to meet me as who I wanted to be, so it’s easier to keep that up now....So my friends all notice the change in me, but I mean it’s not a bad change; yeah I’ve just got more guts to do things. It’s amazing how much stronger it can make you, because you’re out there to prove it to yourself that you can do everything, and yeah, so it’s weird how it works that way – or with most of us anyway (4Sci1).

For another, the aspects of self that related to others were the most important value that they held and this was perceived to remain unchanged.

Interviewee: I wouldn't say shy, so outgoing, yeah, very sport, I played lots of sport, grew up playing lots of sport, had two elder brothers so we were very competitive brothers, yeah, so I've enjoyed all sports. I suppose I liked to think of myself as friendly, willing to sit and yak to anyone, yeah, doesn't matter who they were, I'd be happy to sit and have a chat to them.

Interviewer: Do you think there's been any changes since your accident?

Interviewee: Obviously in the athletic, sporty-type field sort of thing, there's obviously sports I won't be able to do anymore now, but that's cool. And in terms of relating to people though, no, just the same I think, yeah (7Sci1).

Clearly, redefining self occurred on a *continuum* and in the context of the *developmental stage* of the individual as well as their *previous life experiences*.

Redefining self was often adopted or at least articulated more clearly by younger individuals who were still in developmental stages of identity formation, whereas it was often the older individuals who felt that they were the same person and therefore had no need for redefinition.

For the injured person, redefinition of self had to address how they now incorporated their disability into their identity, how they accepted their limitations and their permanence, what aspects of disability they incorporated into their identity and how they managed positive adjustment. Some had managed this successfully because they had good functional recoveries.

I was in the, in acute for two weeks, I was in there two weeks and then they moved me to the one I'm in now, which is just the basic one but I'm an impostor now, I shouldn't be in here anymore, I got too good (16Sci1).

Again for many older individuals, this process was described as being easier because they could more clearly separate the person from ability, perhaps because their identity was more established prior to the occurrence of the injury.

The redefinition of self could not be divorced from a consideration of self esteem and self efficacy within the context of other life experiences.

I don't know; I was a single mum, I separated from my husband - we were divorced three years now, and he lives down here so... I had the boys on my

own up home, Mum and dad helped, friends helped. I guess I was pretty quiet, I wouldn't talk much or anything like that, I was very shy – a big introvert. And yeah, I mean stretching to make the ends meet every week and stuff like that, and so now for me it's been very different because being down here it gave me a chance to reinvent myself. So I got to be, not loud, but I came out of my shell a bit more and well, hey I broke my back so I'm on disability so it won't be as hard to make ends meet when I go back home. And it's been good, yeah I send money home to mum and I'll actually have money to play with for the first time in my life (4Sci1).

Individuals redefined their belief in self, their confidence and their perceptions of control.

It's actually... um I believe made me healthier mentally, um... because I don't sweat the small stuff, and um, I feel... the other day, but I feel like a – I'm 26 but I feel like a teenager again, I feel immature, I feel like doing.. spontaneous stuff, just having fun with people, just um, enjoying each day, and I take each day as a day and not as what's going to happen in three months or five years time, so that's definitely changed me because I used to think oh three years down the track, I needed the plan, but now I don't, so that's a huge change for me (17Sci1).

This process was also articulated by some friends who found that their exposure to disability and loss forced them to re-examine themselves in light of the situation, often reflecting on how they would cope if it had been themselves who had been injured.

Redefinition of self utilised some specific strategies that involved reflection and comparison to others. Indeed, both the injured individual and the friend utilised strategies of downward comparison with other people in the rehabilitation setting, to highlight the positives and address issues of vulnerability and facing the unknown. Individuals often used this process of comparison to empower themselves relative to others and therefore redefine themselves in a more positive light and from a *new perspective*. This, in turn, helped to determine how others then defined the person also and subsequently how they interacted with them.

As I said before, just me being myself, being my old self. So it's made them all feel a lot more comfortable with me, because they're not tiptoeing around me, because I'm still mucking around and grabbing them and hiding their

drinks and stuff like that, so they're not, so I'm just back to my own self kind of thing. So then they just forget all about the chair, and then they think it's just me sitting on the couch, so then they all start, they'll punch me in the arm or punch me in the leg if I'm giving them the shits. They were all very, treating me like I'm like glass, like if they hit me I'd break kind of thing, but now they're all belting into me and that, so it's good (6Sci1).

Friends also provided a point of comparison themselves in the redefining of self. Friends played a normalising role in the lives of people with spinal cord injury and therefore facilitated the redefinition process. In talking about how friends assist the person to redefine themselves, one staff member suggested.

Normalising...totally knowing that it is a self esteem thing..that they are not going to be rejected and that they are still part of that group and that they will be accepted..um..it is all about being normal and still the person that they were before..that is really the core of it (1Sta1).

Friends offered a *sounding board* during the redefining process, a way in which the injured person could receive feedback within the context of the acceptance and unconditional regard of a friend.

When using comparison processes for redefining self, individuals redefine their perceptions of those around them, including friends, family, staff and other patients. *Redefining others* often evoked an appreciation of the other individual, as an individual but also as a point of comparison and reference. By seeing other people as separate entities, this helped to let go of blame and in turn, foster acceptance of self.

Well at this stage, quite frankly, the people who we'll deal with will either stick by us or they won't; and quite frankly if they don't – good riddance, I'm not interested. But those that are the real friends will stick by me because they see past this six wheels and a reclining mechanism – and a strange voice. See my body is broken to bits but my brain is still in tact, so that's got to be an advantage, somewhere, somehow (3Sci1).

Where prior to injury, many people fail to really reflect on others around them, sustaining a spinal cord injury provides the space within which the individual can refine themselves and others within a safe context. In redefining others, knowledge

and perceptions of the person were called upon to inform or provide the *reference point*. Others were redefined in terms of their expectations of the individual.

Yeah, for your friends and your family, they have to try and treat you like a normal person, like too many people tend to think that your brain is dead, they just try and take your life over and organise yourself and do everything for you, when, without giving you any credit for being able to make a decision on your own behalf, and after a while it starts to annoy you, and after a while you start to let it happen. You know, you get so used to everybody doing everything for you; you just don't make any effort to do it for yourself. But just to treat everybody just the same as they were before their injury, because, you know, we are the same people really, just our arms or our legs or whatever don't work, but our feelings for each other are the same, and yeah, make sure that you do keep in touch and stay the same people (8Sci1).

Others were redefined in terms of the perceptions the individual held about how the injury had impacted on them or the degree to which it should have impacted on them.

This helped the individual to remove any blame or guilt for the effects on the friend.

I don't think it's a... um... a life altering situation or anything like that, I mean just a good friend that gets hurt, you feel concern for them but it's not going to sort of wreck your life or change your life particularly, you know, friends yeah they're sad and stuff, but you know, it doesn't change your life, or it shouldn't, I mean I make some people ride a bit more conservatively and realise, maybe realise that life's a bit more fragile than you think it is, but... you know, that's the main one really (15Sci1).

Alternatively, it assisted to redefine others in terms of the *sacrifices* they made for the friendship.

But this is something, I mean he is really, really stingy; he won't pay or part with anything if he can help it. One of the bottles that I've been after off him for quite some time he actually sent me while I was in the hospital as a get well present, now that is just... really out of character for him, he normally doesn't do things like that at all, so to me that just sort of proves how close we actually are, and how much we value each other's friendship (10Sci1).

The individual also felt at times that the friend perceived them as a person in the same way and therefore there was no need to change how they perceived their friend.

I think it's the same as it's always been. Yeah, no I think he sees me as... He looks past the injury. Yeah, sees me for the same person I was (14Sci1).

It is through interaction with others that the redefining of others can occur.

Dimensions that were frequently redefined in this process were *dependability*, *reassurance* and *trust*. These were features that were expected of others in their interactions with the individual as well as tolerance of difference.

You're not really going to have any friends at all, because you'll be annoyed with everybody sort of thing. And I really haven't found anybody yet that there isn't something about them that just really gripes me and I want to strangle them, but you learn to put up with it, you learn to tolerate it, I probably do things that drive them nuts too, but they tolerate it from me. Once you start expecting them to do things or to come and see you and they don't, and then you start getting cranky with them, and friendships can be destroyed (10Sci1).

However, in order to maintain friendships following injury, it was the redefinition of the dyad itself that was most important. For the person with SCI, redefining involved an examination of both *pre-injury and post-injury friendships*. Pre-injury friendships were redefined in the context of common interests and the degree to which these common interests remained relevant following the injury.

Interviewer: And why do you think has helped you to maintain that friendship with her?

Interviewee: I don't know, I guess... we've still got the same interests and stuff so (18Sci1).

As another participant stated,

Yeah. We still share the same thing with cars and... although [friend] hasn't had bikes for years...certainly as time goes on my lack of mobility will be an issue. But that will be the only issue, if there is one. They were friends before, they're friends now, so they'll probably be friends forever (3Sci1).

During the process of reconnecting, the two friends actively redefined the ways in which they interacted. This redefinition involved a *realignment of the friendship terms* to suit the new context.

Interviewee: I've told them [friends] that when I go home it's on a call first basis or I don't open the door.

Interviewer: Why did you feel that was necessary?

Interviewee: Mainly for me, because I don't know if I've just had a bowel accident, I don't want them walking in half-way through me cleaning up, or um there might be days that I just need some 'me' time. Um, days I'm learning stuff, learning how to do

things, I don't want people looking over my shoulder, yeah, stuff like that. And I've just explained that to them, that I need 'me' time (4Sci1).

Similarly, redefinition involved the process of making a *commitment* to the friendship, and redefining the *true meaning of a friend*.

Interviewee: Like I said in that first sentence, well uh, pretty well sums it all up doesn't it? Like supporting your football team, you don't just dump them because they didn't make the finals; you support them in the bad years as well as the good years, don't you?

Interviewer: Yeah. So that's what friendship is about?

Interviewee: Oh it's got to be, doesn't it (13Sci1).

Different types of friendships were redefined in different ways following injury. Some types of friendships required little redefinition, as evidenced in the following comment about internet friends.

And like when I get back to [home town] I'll get broadband set up and keep in contact and that, yep – as well as playing the game. But yeah, it's just interesting... like, for example, I'd consider these people friends, even though I don't know the real names of the majority of them, and I don't know what, like 95% of them look like, but I still consider them friends – and some of them good friends (9Sci1).

In redefining friendships for both the injured individual and their friend, it was not merely the dyad that was redefined, but that dyad within a *temporal context* prior to and following injury. Friendships were redefined within the *environmental contexts* within which they occurred. Specifically, friendships that occurred within certain environments were redefined in terms of the expectations of that friendship following injury.

Sometimes right across the other side of the country, it's difficult to maintain good friendships, and you'll find that I suppose those people who were really good friends will keep in contact, those who were acquaintances or work mates will drop off, it's just one of those things that happens (10Sci1).

The redefinition process involved redefining the functions of and roles within that friendship, thereby finding ways to reduce role separation. For instance, prior to

the injury, friendships were often defined in terms of *shared activities*. Following the injury, however, those shared activities often emphasised the divergence and separation that had occurred between the friends. Therefore, in redefining the friendship, the friends attempted to locate a *common basis* on which the friendship could be maintained. For some people, the friendship was re-defined in more intimate terms, emphasising the fact that the importance of that friendship had been intensified by the injury.

Yeah, you know, eighteen years... but really the friendships' really only developed since the accident, I mean it's always been there but not to the extent it is now. And yeah, so whilst the friendship has always been there, but because of work commitment and... yeah, work commitment, that type of thing, we were in the type of job where it was very difficult to have friends, because you're either on shift or they were, you know, so your time off very rarely coincided. So it was pretty much a... ships passing in the night type of friendship, so yeah, so I'm surprised really that we had any at all (14Sci1).

Sometimes, friendships were difficult to redefine because they were *abstract* in nature, particularly those that were superficial. Different types of friends had different needs and friendships performed different functions prior to injury, so were redefined in different ways following injury.

If I can't do something completely, I won't do it sometimes, because I don't think I could completely specify or quantify what I'd consider a friend is, like also... what I find, you can also have a sense, a greater sense of a friend, because different friends fulfil different needs, and so you don't need one friend to fulfil all the needs, so you'd just... if they're missing in one sense you'd go find it elsewhere (9Sci1).

Fundamental problems in the friendship were highlighted as a result of this process, often resulting in a need to *abandon the friendship* because it was no longer consistent with the life direction created by the SCI.

Interviewee: I think people who are in a culture where a lot of their friendships were based on things like smoking pot etc or whatever then they themselves choose to remove themselves from that yes that they see this [SCI] happening to them as like [for] a reason.

Interviewer: a huge life changing event.

Interviewee: and then decide that a lot of those types of friends that they had before, well they don't really want them anymore, don't want to be around them now...yeah we have seen quite a few like that (2Sta1).

Sometimes, problematic friendships were merely redefined in such a way as to lessen their importance.

I'm grateful that they come, would it make any difference if they didn't? Probably not. I mean the world wouldn't shake and rattle if they didn't, um... yeah, basically that's the truth (14Sci1).

For some people, rather than addressing the interactional separation that had occurred between friends, an important aspect of the redefining process was the justification of post-injury contact. Redefining the friendship allowed people to *reassess the nature of the friendship* and, by doing so, reach an *acceptance* of the interactional separation.

I mean... you know the bike riders for instance, I mean, some I've talked to, contacted quite a bit, some haven't, but given the situation, you know, that's... that's understandable, it's not like I've been close to them, I've just gone for a ride with them, so some different people react different ways and it doesn't mean they won't talk to me again, not the case, but you know, if you're going for a ride, but you don't have a big social connection outside of that it's not like you've got to pretend that you're great friends or anything like that, so that's cool (15Sci1).

The redefinition process allowed individuals to explore their friends' *motives* and define their expectations of that friendship.

When you start expecting things from your friends that it all starts to fall apart. I mean everybody has got something about them that you may not like, and if you don't learn to live with that then you're not really going to have any friends at all, because you'll be annoyed with everybody sort of thing (10Sci1).

The process allowed individuals to redefine the balance within the friendship, by identifying avenues through which equality, reciprocity and sharing could be re-established as an inherent function of that friendship.

There are no limits on if you need them at any time pick up the phone and say look, what's the chances? Or, can you do this? You know if they can they

more likely will, and they knew I've done it over the years for most of them at one time or another, helped them out somewhere or did something or whatever, and they always pay it back, and there's no, not that you'd expect them to pay me, it's just that it happens that way, they know you need help or you need something then they're there, so that's basically what I think a friend is (16Sci1).

I have seen some really really strong bonds over the years that have survived over decades at times. I think those are very important friendships and you know some of them appear quite tight while they are in the unit and then perhaps it doesn't go any further after that and other people really maintain good relationships, there is a lot of email, a lot of telephone contact, people arrange to go into respite places together (8Sta1).

For others, it related to the priority they placed on disclosure of information related to their injury and their current situation. It provided a basis on which justification of contact could occur.

He [friend] wanted to find out everything and I didn't really want to share with him everything, but... yeah they seem happy with what I'm telling them and they don't see any point in finding out exactly every detail about every part of me; and yeah, no, they know that I share with them the things that they need to know; and what I'm comfortable with sharing with them, and that's all that they need to know (4Sci1).

In these instances, friendships that had changed since the injury were *rationalised*

I really enjoy their company, but I also want to have a bit of time to myself as well', so you know, you need to start thinking, you know, it'd be good to have a few visitor free days at times and just have some time to yourself, to do your own stuff (8Sci1).

Priority setting

The final redefining strategy was priority setting, which was an active cognitive process designed to address priority drift within friendships. Priority setting was a process that was often identified retrospectively as a strategy that should have been applied early following injury. However, for most people, this was a strategy that was used once the immediate needs, vulnerability and uncertainty associated with SCI had abated. In some cases, the prioritising of other areas over that of friendships occurred for extended periods of time. Even in these cases, many individuals still

believed that if they could address these other aspects of their life, reconnecting with friendships would be possible.

I've only been home three months, so we're still sorting out, you know, [spouse] is catching up in the garden because everything sort of fell apart a bit, and we're still sorting... you know, the home's very useable, but there's still things being sorted out here, so... and you know, till we get all that done we don't really have that much time to source new ways of, you know, getting around the injury and having fun together [with friends]. I mean that's a later step, it's just not there yet, that's all (15Sci2).

Contextual factors, such as *living status* and *location*, were important determinants of whether or not people were able to be certain about the future, thus allowing friendships to regain priority. For some people, there was a strong determination to *organise their own environment* in such a way that they could *set new priorities*.

I don't know whether we'll stay here or not, I would prefer to get back to [town] and resolve a few issues there, and if possible move on from there (14Sci1).

Interviewee: I'll remain as an in-patient up there [ward] for a short while, the shorter the better. It sort of depends a little bit on what equipment that I've ordered has arrived and if I can manage at home, hopefully they'll let me out, I'll start pushing people's buttons to let me out once I get up there, the biggest hurdle is getting there.

Interviewer: You sound like you've got a plan then.

Interviewee: Oh yes, yeah and it doesn't necessarily coincide with what the hospital here thinks either (10Sci1).

The priority setting process was *cyclical*, changing as reality shifted over time. New priorities emerged as people redefined what they *valued* and what was most deserving of their *attention*. For some, this process highlighted solitude whereas for others, it highlighted connections with other people.

It [drinking] just doesn't interest me anymore, it's not, I'd prefer to go out till 11, 12 o'clock and not be nursing a hangover all day the next day, it takes, a lot harder to get over one when you're like this, where you could get up and go for a run or go shopping, or walk around somewhere and you'd get over your hangover a lot faster, where here you're kind of restricted and you've just got to kind of tough it out, as you are, so yeah (6Sci1).

Oh, just, it's [SCI] just slowed me down a little bit, it'll come good... I won't probably do as much as I did before, because I don't need to, it's just because I like doing it, but I might just slow down a little bit, spend a bit more time smelling the roses I suppose (16Sci1).

I've been given a second chance, and I look at life now and think you're so much more fragile, and there are so many people out there that are taking life for granted, taking friendship, relationships for granted, um.. you know, but I value my friendships, and relationships, and my family even more so now than ever before, yeah (17Sci1).

Priority setting necessitated the *balancing of competing demands* and was often characterised by *compromise* within the context of a *hierarchy of needs*. Within the hospital setting, people with SCI sometimes made decisions to prioritise visits from friends over therapy.

Interviewer: So how did you organise times for them to come and see you, I hear you were pretty busy, so how did that work? Did the visits fit in with that schedule?

Interviewee: I just wouldn't do physio [physiotherapy].

Interviewer: Oh okay, so you skipped something to see your friends.

Interviewee: Yep.

Interviewer: So how often in a week would you do that?

Interviewee: Oh, every couple of days (5Sci1).

In contrast, some people with SCI chose to prioritise therapy over their friends.

Towards the end I sort of had to prioritise [therapy], if my folks came I said I've got to go at one-thirty because that's when physio is and it's important that I get the last of my skills, you know, getting towards the end I think I had a few weeks to go, I've really got to this time and I can't afford to be socialising, especially once they, once the gym shut downstairs and they had to allocate our lots instead of half-day lots, that's happened in the last three or four weeks, so it's just a way of what's happened, they're fixing up downstairs, and there's a small premises, they're being really tight on time, so you just can't afford to not do it so, but people understand, it's important, it's more important than visitors at that point in time, they have to understand, yeah (15Sci1).

Often, friends themselves assisted in the priority setting process, although they rarely identified their own role in this process. From the perspective of the people with SCI, friends were an important *trigger* that enabled them to maintain their motivation and commit to their priorities.

No, well yeah, they [friends] just pick you up, you know, when you're having a day when you're really down and depressed and you're sort of not dealing with the injury or whatever, your mates come in and start talking to you and you just feel alive again. You think there is life after spinal injury, that there is a reason to keep going, rather than just feeling really down or really tired, or really cheesed off at the hospital. You get a different perspective when your mates come along, you think 'oh yeah, one day I'm going to get out of here and we're all going to see each other again', and yeah, there is life after the hospital (8Sci1).

The process of priority setting was *achievement-oriented* in that it was usually aimed at providing a structure within which to consider competing demands and, by doing so, achieve the best possible outcomes for all parties. In a context defined by uncertainty and immediate medical needs, the process of priority setting determined the way in which people *allocated their time* and the perspective from which they examined their friendships. Thus, priority setting was based on a personal process of identifying *goals for the future, forward planning* and *making decisions*. This process involved consideration of the importance of friendships within the current life context.

Successful priority setting was most obvious when individuals with SCI *sacrificed* their real wishes for the benefit of the friendship, but still managed to balance their competing priorities. In this way, priority setting was providing the opportunity to reconnect with friends and redefine the friendship in a way that benefited all parties.

Interviewer: So what do you do then if I whole bunch of people turn up to visit you and you just don't feel up to it?

Interviewee: I put up with it.... Um... heh... it's something I suppose that they've made the effort, even though I'm not really feeling up to it, it's a valuable thing that you don't want to brush off so, well that's the way I feel about it. Relatives a little bit are obligated to come and see you, you know, it's just something that family does. Friends on the other hand, I mean there's no strings attached and there shouldn't be, so the fact that they've made the effort to come and say g'day means a lot even though you may not be up to it. So rather than fob them off and say 'I'm not really that well', I would rather put up with a bit more pain perhaps, or whatever, to... I know eventually by looking at me they'll get the hint that I'm not really coping too well sort

of thing and they'll pull the pin and leave. But yeah, it's a bit of a two way street sort of thing, and you know, I sort of feel as a friend I don't really have the right to say 'look I'm not just up to it'. Some of them have travelled a long way, you know, and I like friends who just turn up, I've never been one to ring first and [ask] 'is it alright if I come around?' you know, I just turn up, and I like them just to turn up, so if it's inconvenient at the time, well, if it's a good friend it won't inconvenience them, do you know what I mean? They're willing, if I'm doing something and I can't stop doing it then they should accept that and allow me to continue what I'm doing, or join in, or you know, talk to me while I'm doing it (10Sci1).

Priority setting was an active process focussed on *getting on with it*, within the context of *individual readiness*. As such, priority setting was about *looking into the future* and *finding a place for the friendship* within that context. Sometimes, that process involved people with SCI incorporating friendships into considerations of other life domains with the assumption that friendship will naturally co-occur with resumption of 'normality'.

I'm just quite happy to go home at the moment and get my home life sorted out, and get my routines worked out, and then, so I can get back there as fast as I can and get back into working and living like a normal human being again. (11Sci1)

For others, friendships were considered as a separate priority deserving of specific attention. The focus was on *finding positives* rather than negatives and *fostering hope for the future*. This involved family members and friends also recognising these priorities and looking towards the future and the ways in which all network members can move forward together. As one family member stated when speaking of a friend...

She was just very much into um... what would have happened if she died, you know, she nearly died, what would have happened, and we were saying but she didn't... you know, you've got to look at where she's going to go from here on in now, we've faced that issue and she got over that obstacle and we need to too, and we need to start moving on with her (4Fam1).

Summary of findings

The findings portrayed SCI as a significant life event that often precipitated diverging life paths among friends. The divergence of life paths either reduced or magnified over time, sometimes in an episodic manner. Furthermore, this divergence of life paths could occur at a number of levels, namely physical, cognitive, emotional and behavioural and was contingent on the direction the friends' life paths had taken in the past as well as contemporary personal and environmental factors, including the developmental stage of life at which the injury occurred. In many instances, friendships may have already experienced diverging life paths in the past, even without the presence of injury. However, following the injury, changes in the friendship were usually attributed to the injury. The basic psychosocial problem of diverging life paths was characterised by *enforced separation* and *priority drift*.

Enforced separation was defined as the physical, cognitive or behavioural separation of the friendship dyad. Separation was a temporal process in that it could be diminished or exacerbated over time. However, the separation was always sudden, precipitated by the fact that the injured individual was hospitalised for medical treatment of their injuries. Enforced separation occurred at a number of levels namely *environmental separation*, *role separation*, *identity separation* and *interactional separation* and was characterised by differences in valence and timing, but usually had consequences that included anxiety, denial and resignation.

Environmental separation was an inevitable consequence of hospitalisation, but varied in degree depending on the response of the context. Issues such as proximity, geographic isolation and displacement from family, friendship and community networks were critical to the experience of separation. Separation usually created feelings of loneliness and social isolation as well as withdrawal. Lack of

community access, inappropriate transport options, limited public awareness and a lack of spontaneity in community options meant that this environmental separation continued following discharge from hospital, and could even worsen.

Environmental separation occurred at some level for all friendships, but greater variability was evident in role, identity and interactional separation, which were not an issue for all friendships. Role separation involved perceived or actual changes in the roles of either the injured individual or their friend or both. The altered functional abilities of the person with SCI often meant that previous friendship activities were no longer possible. Friendships were usually based on common interests and orientations, entrenched within recreational or vocational contexts. Following injury, the functions and roles of the friendship were often dramatically different, thereby impacting on both the injured person and their friends. The impact was also felt by the family, who played a significant role in facilitating friendship and protecting the injured person.

Identity separation was created by the fact that the identity of either party or the identity of the friendship itself was challenged by SCI. Different individuals responded in different ways to identity separation. The injured individuals had to negotiate altered identity related to their new disabled self and changed body image whereas friends struggled with trying to understand the implications of the injury for themselves and their friendship. Identity separation depended on the degree to which each member of the friendship could perceive sameness in the friendship, regardless of the level and severity of the injury.

Finally, interactional separation was a behavioural process, often associated with environmental separation, but was more variable across friendships. Interactional separation was characterised by the degree to which 'normal' communication channels

between friends were compromised. Although environmental separation was a significant cause of interactional separation for some friendships, other friendships utilised alternative methods of communication to reduce interactional separation. Whereas interactional separation was often accentuated in the early period following injury, role separation and identity separation typically emerged at a later time as the individuals cognitively processed the implications of the sudden event.

Enforced separation was paralleled by the concept of priority drift, resulting in changes to the place of friendship in the lives of the parties. Priority drift also occurred within a temporal context, and was characterised by significant challenges, including the *immediate need* to address the medical emergency of the injury itself, and later by *vulnerability to a new world, facing the unknown* and *reality shifting over time*. The immediate need to undergo medical treatment for one's injury itself was exclusive of friends to a large degree. Typically, the family was the focal point during hospitalisation and this period was characterised by high emotions. These challenges often meant that friendships were not prioritised during this early stage.

Vulnerability to the new world typically occurred early following injury and was linked to the unfamiliarity of the hospital environment as well as the fragility, lack of control, uncertainty and inherent emotionality associated with this new world of doctors and physiotherapists. For friends, this period was often characterised by a need to confront mortality and morbidity and a realisation of their own vulnerability, something that was usually foreign to their experience of life.

Facing the unknown was a medium-term challenge to the friendship that occurred as individuals started to unravel the meaning of SCI for the individuals and for their friendship and its implications for the future. Being discharged meant leaving the safety of the hospital environment, but also the end of a journey that had excluded

the friend. At this point, some friendships became distant as parties overcompensated in the face of the unknown.

Reality shifting was a longer term challenge associated with priority drift that was both gradual and ongoing. It was linked to time since injury. Some friendships waned because the friendship was no longer an integral part of the daily reality of living with a SCI and individuals were unaware of the change in their priorities over time. In other situations, although still wishing for the friendship to continue, friendships were stilted by a need for people with SCI to just exist day to day. Although individuals often intended to make contact with friends, this was often not possible, resulting in greater divergence of life paths.

Each of these processes of enforced separation could result in the dissolution of the friendship, either through continued enforced separation beyond a critical point in time (which was unique to each friendship) or through the gradual process of priority drift. In some instances, these processes were episodic in nature, in that enforced separation and priority drift 'ebbed and flowed'. Periods of enforced separation often changed as a result of contextual changes (e.g., discharge from hospital, new living status). In contrast, priority drift often changed as competing demands changed over time.

A process of *reconnecting life paths* emerged as the means by which friends addressed their diverging life paths. Reconnecting life paths could be managed either by realigning the friendship or by accepting the divergence. Reconnecting life paths occurred at a behavioural level through the process of *working* at reconnecting and a cognitive level through the process of *redefining* the friendship. The degree of divergence of life paths and the different levels at which the divergence occurred

determined the degree to which behavioural and cognitive efforts were made at reconnecting.

The process of working was characterised by a number of strategies aimed at reconnecting life paths within the friendship and addressing either enforced separation or priority drift. These strategies included *breaking the ice*, *negotiating old and new roles and responsibilities*, *moulding the environment* and *recruiting staff and peer helpers*. Each of these strategies could be utilised by the person with SCI, the friend, the family or rehabilitation staff.

Breaking the ice was an essential strategy that had to be initiated early following injury to facilitate the process of reconnecting, before divergence reached critical points at which friendships would be likely to dissolve. The process of breaking the ice was focussed on reducing interactional separation and establishing a basis on which friends could develop a shared knowledge and understanding of the injury. Disclosure and the use of humour were key strategies associated with breaking the ice. In many instances, families acted as conduits for information in the early stages following injury, facilitating the ability of friends to understand the injury prior to direct contact with the injured person. Sometimes friends sought the assistance of the family in breaking the ice in this way.

Reconnecting also involved either re-negotiating previous roles in the context of disability or finding new roles that were more achievable in the context of this “new world”. This strategy was aimed at reducing role separation and priority drift by facilitating participation and inclusion of the person with SCI. Often, this process required friends to take a more proactive role in facilitating contact with the injured person, providing reassurance and sharing control. The occurrence of SCI, the ensuing disability and the environment within which individuals with SCI now existed

inherently challenge individual perceptions of control. Friendship was one domain within which the process of negotiating roles allowed people with SCI to regain that control. The outcome for the negotiation process was an accepted equality of roles between each member of a friendship dyad. This equality was established not necessarily within 'equal' roles per se or those roles that existed pre-injury but within the context of roles that were accepted by both friends, allowed reciprocity and perceptions of shared control and importance in the direction of the friendship.

Moulding the environment involved active efforts to change aspects of the physical, social and political environment. Specific attention was focussed on the rehabilitation environment, with the aim of reducing environmental separation and priority drift. Moulding the environment involved strategies such as challenging hospital rules and routine, seeking and using a broad range of resources (e.g., friends seeking information from staff to better understand SCI), taking social action and facilitating public awareness and education.

To facilitate reconnection, friends recruited staff and peer helpers in their efforts to address enforced separation and priority drift. Peer helpers were individuals who had SCI, including those people who have lived with SCI for many years and provide formal peer support to newly injured individuals as well as those individuals who are hospitalised at the same time. This reconnecting strategy required an expansion of the friendship and support network to include those staff and peer helpers as friends or as facilitators for existing friendships. This network was very different to that which existed prior to injury. This process was clearly related to altered conceptualisations of the friendship as being embedded within a very different social network. This broad social network was integral to maintaining a friendship in the context of acquired disability. Staff and peer helpers held different roles to those

of pre-existing friendships. These roles however, were both functional in the sense that they had a specific purpose and contextual in the sense that these supports were readily available in the hospital context. These helpers played important roles in identifying options, hopes and dreams for the future, but at the same time, facilitating a broader conceptualisation of what is meant by the term 'friend'. As such, this strategy was one which was perhaps a hybrid strategy, utilising processes of both working and redefining. In essence, recruiting and using those staff and peer helpers and adopting them as friends, albeit friends with different roles, required a conceptual shift in how friendship was defined.

In a similar fashion to working, redefining was characterised by a number of strategies aimed at reconnecting life paths and addressing either enforced separation or priority drift. Redefining included *redefining friendship* and *priority setting*, both of which were typically cognitive in nature (although priority setting did have a behavioural component). Unlike working, redefining occurred for the most part within the context of the friendship dyad. This meant that family and rehabilitation staff were rarely privy to the process of redefining, and did not contribute in any direct way to that process. Essentially, redefining was a strategy used by the friends themselves. However, it was also necessary to redefine the self and others as separate entities to facilitate the redefinition of the friendship. Although the process of redefining was influenced by outside forces, it was generally a more personal process than the other strategies. Redefining the friendship was integral to reducing the impact of identity and role separation by facilitating an acceptance of the disabled self and altered body image, fostering self esteem and renegotiated self efficacy, allowing upward and downward comparison to others and realising personal growth through adversity. Furthermore, because friendships are so often linked with the developmental contexts

within which they occur (e.g., adolescent friendships differ from friendships following marriage) and redefining is a strategy most clearly focussed on identity, this strategy itself was inherently linked to the development context within which it occurred.

Priority setting was specifically focused on repairing the process of priority drift (e.g., immediate need, vulnerability to new world, facing the unknown and reality shifting over time). This process was both present- and future-directed but often cyclical and episodic in nature, dependent on the array of competing demands that the individual and those around them were currently facing. To some degree, this process was also dependent on the priorities that individuals held prior to their injury but was also dependent on a 'readiness' to prioritise life domains beyond those associated directly with the injury.

Chapter 7

Discussion and Implications

The current study developed a grounded theoretical framework for understanding friendship processes following SCI. The framework integrated categories, concepts and hypotheses about the main challenges experienced by friendships and how these challenges were addressed by people with SCI, their friends, family and rehabilitation staff. The complexity of the framework underscores the importance of the grounded theory method, as it would not have been realised using a positivist methodology.

Figure 7.1 summarises the basic tenets of the theoretical framework. This diagram illustrates the ways in which this theory captures aspects of the friendship process that have previously received only limited recognition in rehabilitation and disability literature. The theory captures the dynamic and fluid nature of the friendship process. The processes of enforced separation and priority drift present avenues by which the life paths of friends diverge. The diagram shows how working and redefining are avenues by which the life paths of friends are reconnected following injury. The diagram illustrates the episodic and non-pathological nature of this divergence and reconnection in that friendships are constantly facing contextual pressures that cause separation and reconnection. As shown in the diagram, friendship pathways appear to move through cycles of divergence and reconnection as forces of separation are confronted and strategies are implemented. To some extent this movement occurs naturally for friendships.

However, SCI represents a significant catalyst that escalates the intensity of the separation and magnifies the need for reconnection. It may exacerbate existing

divergences or create larger new divergences that are specific to the hospital context and the post-injury world of disability. The diagram recognises that the friendship process is embedded in a variety of contexts, each of which have some influence on the nature of the friendship. However, there are features of the rehabilitation environment that can create greater separation, but could also facilitate the reconnection process. The added separation created by the rehabilitation setting is associated with a rapid and dramatic divergence of pathways that hinders reconnection, particularly as the period of separation increases. To reconnect, it is essential that the first strategy involves some method of “breaking the ice”. This strategy pertains more to the cognitive and behavioural forms of separation rather than the environmental form and it represents the gateway to the strategies of redefining and working. These strategies will ultimately enable the friendship pathway to regain a relatively stable course, either fully reconnected or redefined in such a way that continuation is possible. Alternatively, divergence may continue through the processes of reality shifting until such time as reconnection is no longer likely.

Why the current findings are important

The findings of this study are significant for a number of reasons. First, the developed theoretical framework offers a model of friendship process that, to my knowledge, has no parallel among literature within the substantive area of acquired disability. The longitudinal design of the study has ensured that the theoretical framework can account for change processes over time, a benefit previously unrealised among the range of cross-sectional studies conducted in the field.

Second, the study has identified, conceptualised and integrated similar constructs to those found in existing cross-sectional studies within the SCI friendship

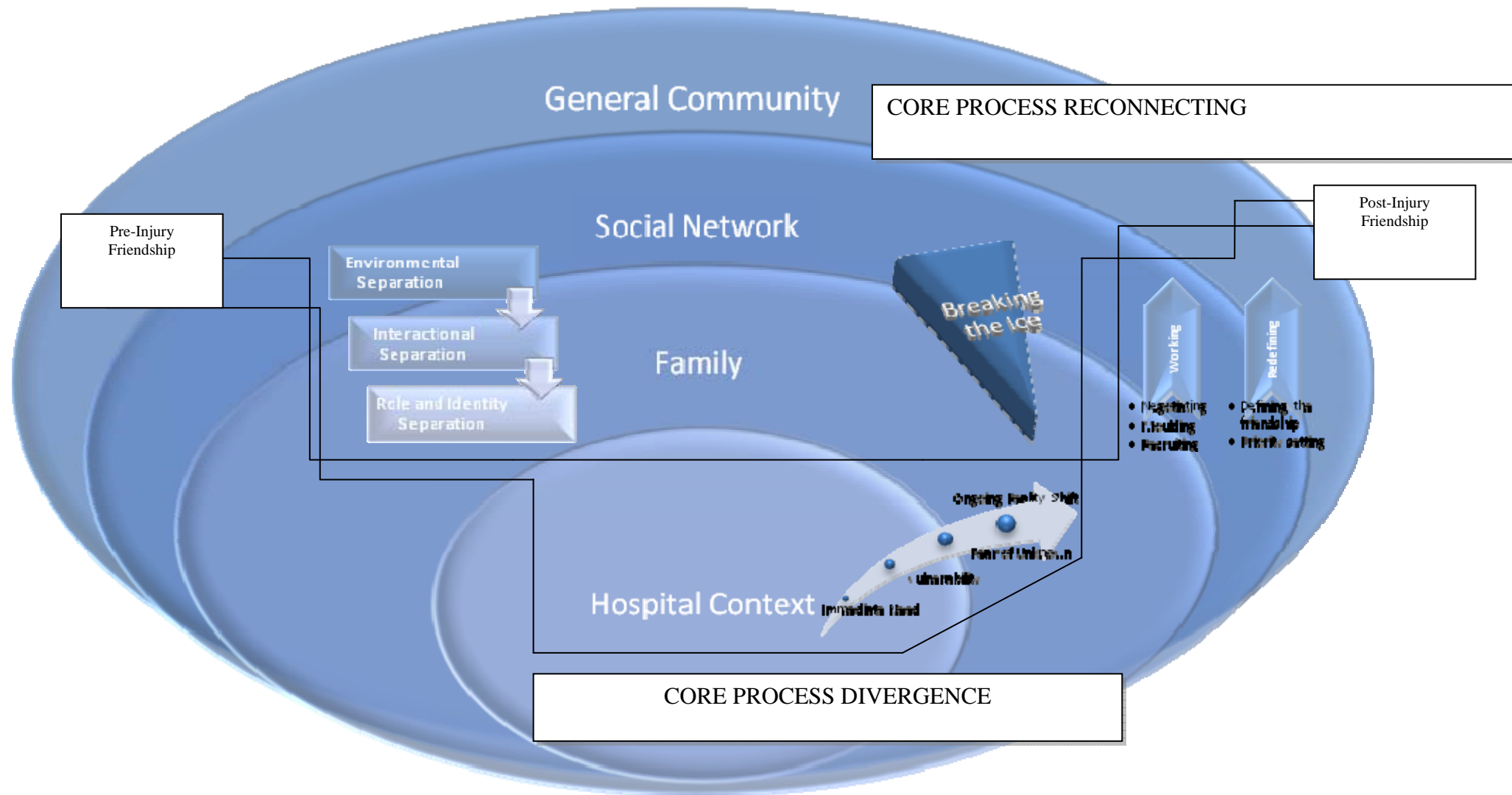


Figure 7.1: A model of core friendship processes following SCI

and adjustment literature. Thus, the findings confirm current knowledge in this area, but offer the advantage of explaining the ways in which important concepts interact over time.

Third, the theory developed in this study can account for variations found in previous research, particularly those associated with demographic factors, such as gender, age, marital status, and environmental factors, such as living location, availability of resources and community access. The theory provides one framework within which this variation can be explained both simply and usefully.

Fourth, this study is one of few that have investigated the perspectives of multiple stakeholders. Existing research has tended to focus on only one group, typically one member of the dyad, or in the case of childhood friendship, that of the parent. Consistent with constructivist notions, the current study recognised the multiple realities of injured individuals, family members, friends and rehabilitation staff. The explanatory framework developed in this study can account for these perspectives.

Finally, the current study offers the first theoretical model of friendship following acquired disability. The findings of this study can act as a template for improvements in clinical practice. Although many researchers have proposed theories, few have facilitated the translation of those theories and research to clinical settings. The theoretical framework proposed within the current study was grounded in data collected from both hospital and home settings, utilising information collected from multiple stakeholders from within those settings. The study has resulted in several key recommendations for implementation within the clinical setting.

In this chapter, I will show how the theoretical framework relates to and extends previous findings in both the SCI and friendship literature. I will then

examine how the theory can account for discrepancies in previous research. Finally, I will review its implications for research and practice. Remaining gaps in knowledge, both theoretical and clinical in nature, will be highlighted, providing the impetus for further research in this area.

Extending previous research

Aspects of the framework both confirm and extend previous findings in these fields, providing links between concepts that have previously been considered in isolation. The framework sets friendship within a systemic context, highlighting not only its interactional nature, but also its inherent complexity.

The SCI literature

The current findings support the contemporary body of psychosocial literature that recognises the role of relationships in the lives of people with SCI (Carpenter & Forman, 2004; Carpenter et al., 2007; Chan, 2000a; Kreuter, 2000; Pearcey et al., 2007). Indeed, the current findings support the claim of some researchers that friendships can improve following SCI (Bocarro & Sable, 2003; Isaksson et al., 2005; Kreuter, 2000). Pearcey et al. (2007) highlighted the fact that relationships play an integral role in assisting the recovery process following injury and assisting individuals to reintegrate into the community. The current findings support this notion, highlighting the role that friendships can play in buffering low periods, redefining perceptions of self and establishing valued social roles.

In her recent review, Hammell (2007a) discussed the notion of life paths in the context of individual adjustment following SCI. She noted that injury disrupts both an ongoing life and a sense of self and that it is important for individuals to be able to

connect their past with their future, to attain a sense of continuity and to be able to envision a future self. The current study supports this proposition through both the identified basic psychosocial problem of diverging life paths, but also through its identification of reconnecting life paths as the basic psychosocial process by which this problem is addressed. The concept of life paths is expanded in the current study, but in the context of friendships as well as within the individual. Thus, this study has recognised both the temporal and the interactive nature of the adjustment process. The current findings have highlighted the fact that separation can occur at multiple levels, including physical, cognitive, emotional and behavioural. Life paths diverged due to different physical circumstances, different thoughts about friendship and life, different feelings about friendship as well as different behaviours that guided friendship.

Each of the categories within diverging life paths (*environmental separation, identity separation, role separation, interactional separation, immediate need, vulnerability to the new world, facing the unknown, reality shifting over time*) and reconnecting life paths (*breaking the ice, negotiating new and old roles and responsibilities, moulding the environment, recruiting staff and peer helpers, redefining friendship and priority setting*) have all confirmed and extended to some degree, parallel concepts in the SCI literature.

For instance, the notion of *environmental separation* supports existing literature regarding the impact of physical and attitudinal barriers on relationship maintenance and formation (Kendall et al, 2003; Kreuter & Butt, 1999; Kreuter, 2000; Manns and Chad, 2001; Quigley, 1995; Song, 2005). However, the current study extends these findings in that rather than being merely descriptive in terms of physical and attitudinal barriers, the category of environmental separation outlines a process by which divergence occurs in the life paths of friends. Existing notions of physical

barriers to relationships have typically focussed on geographic isolation and lack of proximity associated with hospitalisation (Kendall et al., 2003). The current study has also described the impact of the social environment created by the hospital setting and the failure of staff to recognise the role of friendship by preventing parties from paying any attention to friendships and inadvertently increasing the environmental separation that friends experience. Further, although the current study supports the fact that hospitalisation prohibits the re-establishment of relationships, it also suggests that environmental separation continues to occur beyond the acute period.

Beyond the hospital environment, barriers such as transport, living status, the availability of personal care and physical accessibility of the community are often discussed in the literature as barriers to participation (Chapin & Kewman, 2001; Datillo et al., 1998; Tasiemski et al., 2000; Whiteneck, Meade et al., 2004). However, these factors are infrequently mentioned in relation to friendships or even relationships more generally, following SCI. In exploring friendships among people with intellectual disability, Emerson and McVilly (2004) found that the setting in which a person lives may be a more significant determinant of the form and context of activities with friends than the characteristics of the participants. As such, friends can only do as much as the environment allows them to, without making substantial modifications to that environment. Jongbloed, Backman, Forman and Carpenter (2007) further supported the notion of environmental separation, suggesting that difficulties in participation are caused by non-accommodating environments, inadequate income support, lack of opportunities and little political influence stemming from an unfair distribution of societal resources.

The current study further expands these notions however by placing them within a temporal context. Environmental separation occurs not only because these

barriers exist, but because the change of pace and lack of spontaneity associated with functioning following injury often means that timely access to these resources cannot be established, thereby separating friends. Reliance is often placed in other parties such as rehabilitation professionals to facilitate the timely involvement of friends and reduce this environmental separation. However, as found in the current study and supported by Caplan and Reidy (1996), the involvement of family and other support members in rehabilitation is often valued as long as it does not affect how the rehabilitation professional functions or add to the perceived hassles for clinical staff. In these instances, environmental separation may actually be exacerbated as rehabilitation staff attempt to manage and control the level of other involvement.

When discussing role change following injury, many researchers have highlighted the extent to which the role participation of the individual with SCI is markedly varied (DeSanto-Madeya, 2006; Schopp et al., 2007) and how they are not only prevented physically from fulfilling previous life roles (Noreau & Fougereyrollas, 2000) but also psychologically (Kennedy et al., 2006). The notion of role separation emerging from the current findings clearly extends this notion to the level of the friendship and beyond to the broader network. Role separation occurred because there were changes in roles not only for the injured person, but also for their friends and family. Indeed, where changes in the social roles of others have been found and reported in other research (DeSanto-Madeya, 2006; Isaksson et al., 2007; Larsson Lund et al., 2005; Larsson Lund, Nordlund, Bemsprang & Lexell, 2007), they have more commonly been limited to descriptions of changes in family roles (e.g., Chan, 2000a; Chan, 2000b; Rintala, Young, Spencer & Bates, 1996). This study adds to this literature by highlighting the role change that can also occur for friends and the processes by which the friendship negotiates these social role changes.

For instance, Mackelprang and Hepworth (1987) as well as Pearcey et al. (2007) found that others, including friends, often provide additional assistance following injury. This over-assistance constitutes a form of role separation where individuals in the network take on larger or more varied roles than those they held prior to injury. Indeed, in the current study, it was found that many friends took on caregiving roles. This changes the dynamics between friends and may cause people with SCI to feel that they are perceived by others to be incapable (Isaksson et al., 2007).

On the other hand, both Pearcey et al. (2007) and Isaksson et al. (2005) suggested that it is the relationships with others that help individuals with SCI to view their own spinal cord injuries positively and to take on new life roles. This process is similar to that of *negotiating roles and responsibilities* identified in the current study. For example, Quigley (1995) examined the impact of SCI on the life roles of women and found that women used adaptation and negotiation and the development of a new role as self advocate to facilitate the re-establishment of their life roles and thereby reduce role separation and establish equity in their relationships. Through this new role, they also attempted to manage aspects of the environment that challenged both their identity and their independence. This strategy paralleled the concept of *moulding the environment* presented in the current study whereby individuals with SCI, in their new role as self advocate, challenged both structural and attitudinal barriers in order to reduce environmental, role and identity separation within the context of friendships.

Thompson et al. (2003) and Hammell (2004; 2007a; 2007b) discussed the importance of identity in the context of adjustment following SCI. Kennedy, Duff, Evans and Beedie (2003) suggested that in terms of identity, a discrepancy frequently emerges between 3 aspects of self, namely the 'ideal', the 'as I would be without the

injury' and the 'as I am' currently. Similarly, Hammell (2007a) suggested that there are varying challenges to identity following injury, prompting the need for redefining self or the need to find a new 'I am'. Other research suggests that those who manage to find new personal meaning and identity are those who are most positively adjusted following injury (Fronck, 2005). Collectively, these findings highlight the impact of SCI on individual identity but do little to elucidate the ways in which this is reflected in the social relationships of those individuals. The current findings extend these findings because they consider them within the context of a relationship, not merely as an individual process of adjustment. The current study discovered that the concept of identity separation represented challenges to identity not only for the injured individual but also their friends. This concept was further extended by the current findings as it highlighted not only the identity of the individual with SCI but also the friend's perception of the identity of the person with SCI and the injured person's perceptions of the friend's identity as important. These challenges to identity and the separation of identity between friends changed the dynamics in friendships and impacted on the priorities attached to the friendship as well as the ongoing nature of both interactional and role separation.

When DeSanto-Madeya (2006) spoke of the fact that people with SCI frequently devalue themselves and feel that their identity has been challenged, she suggested that individuals responded to a need to redefine self in terms of their abilities and strengths. Antle (2004) suggested that perceptions of self-worth and sense of self are inherently related to the social support one receives from others. In the current study, this notion is extended to the friendship arena. The redefining friendship process often focussed on the strengths and abilities of the friendship or the aspects of that friendship which could be normalised or easily adapted. This was

important for both individuals and the dyad itself to 'feel normal' and perceive some sameness in the friendship. Further, the current study suggested that this is not a finite process but a constant and ongoing process of redefinition within a variety of contextual domains and constraints. To ignore transformation of self and that self in the context of their interactions with others is to discount the major impact of disability. Redefining friendship allowed individuals not only to find a new 'I Am' and 'I can' (Hammell, 2007a), but also a new 'we are'.

For friendships, the category of interactional separation highlighted a major area of divergent life paths. Friends were frequently unable to communicate in ways that were considered typical for that friendship. Sometimes this occurred because of perceptions of withdrawal of friends or avoidance of contact. In other instances, this was precipitated by environmental separation. While many researchers have highlighted the need for effective communication in the rehabilitation setting (Forchheimer & Tate, 2004; Hayes, Potter & Hardin, 1995; Parrott et al., 2000; Siosteen, Kreuter, Lampic & Persson, 2005), this has rarely been considered within the context of friendships and more typically relates to the facilitation of open communication between rehabilitation professionals and people with SCI. However, Parrott et al. (2000) suggested the one of the key components of altered interactions and communication following SCI relate to feelings of uncertainty within those communications that are experienced by the injured person, their family and friends. The current study identified that during the early stages following injury, all individuals within the network of the injured person experience feelings of *vulnerability to the new world* and the central factor associated with this vulnerability is perceptions of uncertainty.

Indeed, Brillhart and Johnson (1997) found that friends feel uneducated about SCI (a concept outlined within the category of *facing the unknown*) and uncomfortable in the presence of the injured person (a concept outlined in the category *vulnerability to the new world*). This frequently resulted in friends avoiding contact that was considered normal for that friendship and subsequently interactional separation. Similarly, DeSanto-Madeya (2006) spoke of the vulnerability to a new world experienced by people with SCI and their family members, filled with unfamiliar words, equipment and complications. Further to this, she speaks about facing the unknown in terms of societal understanding of injury, the fear of the unknown and the stereotypes and expectations that will guide the journey of facing the unknown. The current study extends these notions of vulnerability to the new world and facing the unknown beyond the immediate family unit to friends who have no benefit of any inclusion in that new world.

The current study identified the need for a process of *breaking the ice* to facilitate interaction between friends and reduce the enforced separation and priority drift experienced. McColl (1995) suggested that support offered to help with a current problem may in fact have its ultimate effect at the onset of some future stressor, while the support exchanged in both the near and distant past may exert its effect in a current stressful situation. The importance of breaking the ice related to its ability to help with future perceptions of support and this was a crucial first step in the friendship. If this did not occur early enough (i.e., before separation had reached a critical point) then it had implications for later friendship maintenance. One of the key strategies used to break the ice was that of humour and this strategy was used by a large proportion of participants in the current study. While humour has been identified as a coping strategy used by people with SCI (Lude, Kennedy, Evans, Lude & Beedie,

2005), it has not previously been discussed in the context of interactions with others and relationship maintenance.

In much the same way that negotiating roles and responsibilities and recruiting staff and peer helpers were key categories in the current study, Manns and May (2007) found that Mentoring and Family were subcategories of identifying information pathways along the continuum of care. Manns and May (2007) found that individuals with SCI sought mentoring relationships along the continuum of care to assist with the acquisition of information. Indeed, the current study supports the notion that mentoring relationships and peer support are sought for information purposes, a finding further supported by Sherman et al. (2004) and Veith et al. (2006). In addition, the current study suggested that peer helpers are recruited to assist with friendship also, whether that is friendship and interaction that they provide each other as peers or whether that is assistance with maintaining existing friendships. Peer helpers have previously been identified among many groups as principal forms of support for people with disabilities (Boschen et al., 2003; Emerson and McVilly, 2004), but less frequently as facilitators of enduring relationships with existing friends. Hampton and Qin-Hilliard (2004) found that, in assessing quality of life, individuals made comparisons both internal (with oneself) and external (comparing with others), a process within which peer helpers were extremely useful. This finding has been supported in the current study where peer helpers have assisted individuals and friends to minimise the impact of the injury in the context of the friendship itself.

Manns and May (2007) further found that family were integral to the relaying and processing of information, despite their own unmet needs for information (Meade, Taylor, Kreutzer, Marwitz & Thomas, 2004). The current study found that family members often played key roles as conduits for information. While Manns and

May (2007) spoke principally of this role in relation to relaying information between health professionals and the person with SCI, the current study found that they had negotiated important roles in relaying information to other family and to friends from rehabilitation professionals and the injured person. Furthermore, they relayed information from friends in the community back to the injured person during periods of environmental and interactional separation between the friends. This assisted to break the ice to some degree, smoothing the way for more seamless resumption of contact at the appropriate point in time, typically following discharge from hospital.

In order to maintain friendship and decrease enforced separation and priority drift, both injured individuals and their friends needed to prioritise the friendship as an important dimension of their life. The category of priority setting identified in current study parallels the notion of moving forward in a new way of life as found by DeSanto-Madeya (2006). She found that, over time, individuals with SCI gained a new perspective and learnt to live with the changed life. The current findings extend this concept by outlining the importance of identifying the priorities that remain and the degree to which friendship is a part of that. Indeed, Weitzenkamp et al. (2000) suggested that people with SCI priority shift in identifying the determinants of their own quality of life, devaluing goals that are less attainable. While this must be balanced with the competing demands on time that are inherent in priority drift and the possibility that reality shifting over time results in decreased friend support (Boraz & Heinemann, 1996), the current study suggests that priority setting is the basic process by which friendships are maintained in this context.

Perhaps the findings that most accurately parallel those represented by the theoretical framework developed are reported in a recent qualitative study conducted by Isaksson et al. (2007), examining the social networks of women following SCI.

The current study supports and extends the findings of that study through the concepts of interactional separation, vulnerability to the new world, establishing roles and moulding the environment. Within this study, Isaksson et al. (2007) found that some relatives, friends and work colleagues were more engaged in the women than they expected (similar to the increased attention described in the category of *role separation*). Even though the women soon after the injury were insecure (as demonstrated in the category of *vulnerability to the new world*) about how they should interplay with others in encounters (resulting in *interactional separation*), they soon came to support persons they perceived insecure (thereby *negotiating new and old roles and responsibilities*). These researchers found that the women, fairly soon after the injury, explained to others around them what kind of help and support they needed to participate in occupations. Within the current study, this was achieved by individuals during the process of negotiating new and old roles and responsibilities. In order to maintain and facilitate continued friendship, people with SCI often set boundaries and guidelines for the types of assistance they required. This shifted some of the locus of control back to the injured person, a key ingredient for quality of life and participation (Boschen et al., 2003).

Isaakson et al. (2007) defined this as a process where the feelings of the women soon after the injury were characterised by insecurity about how they should act in human encounters, feelings of entrapment or a sense of incompleteness, manifested as concerns regarding the acceptance of others and resulting in interactional separation. After a while the women felt dissatisfied being passive and started to search for how they could regain participation. Within the current study, these active efforts to acquire appropriate levels of participation parallel those efforts inherent in the category of 'working'.

Furthermore, Isaksson et al. (2007) highlighted that the gap between how persons acted against the women and how the women wanted them to act changed the women's own acting in an attempt to alter their surroundings, a notion parallel to that offered within the category of *moulding the environment*. For instance, in the current study, when participants felt that their interactions with friends in the hospital setting were characterised by feelings of pity, they often protected friends from many aspects of their injury in an attempt to normalise the interaction. Isaksson suggested that the use of these strategies assisted people with SCI to focus on the life skills needed to live as independent and self-directed persons. Furthermore, this process highlighted the fact that others in the social network, including friends, influenced these changes in the women's acting. This resulted in the development of solutions to handle conflicts, insecurity from others and unexpected treatment and thereby increase participation in occupations that were meaningful for them. Where the current findings support many of Isakssons' findings, they extend these findings in the sense that both the theoretical concepts developed and related within the current theory were grounded in data sourced from both men and women, suggesting that there are parallels in their experiences and the friendship processes that they follow after injury.

Taken as a whole however, the literature regarding social support and friendship following spinal cord injury is in its infancy and therefore the capacity to make comparisons between the current findings and the SCI literature is hampered. A related substantive area of research exists within the context of traumatic brain injury rehabilitation however, that offers further avenues for comparison and a body of literature that is more developed in terms of examining friendships. This body of literature has more clearly started to address the topic of friendship and recognise the contributions of some of these factors. For example, Paterson and Stewart (2002)

highlighted the importance of an individual's perception of their social being and their expectations related to this, a concept that parallels notions of redefining, both the self and the self within the context of the friendship. Indeed, they suggested that redefining oneself following injury was particularly important in terms of social support and integration.

What clearly emerges in terms of the current findings is that they extend the existing fragmented body of SCI research by identifying how these categories are related to each other. For instance, it is not merely the fact that friends are separated geographically following injury, but the fact that this separation has implications for their ability to interact with each other, define the roles that each will play in the relationship now and delineate exactly what the friendship means in this new life context. It is only once we begin to integrate the existing findings within some parsimonious framework, that we will have an adequate base on which to develop interventions. While the existing literature provides support for many of the concepts that emerged in the current study, there has been no systematic effort within this body of research to integrate these concepts and therefore, no clear mechanism by which interventions can be structured.

What does emerge however is that the current findings confirm and extend the contention by Pearcey et al. (2007) that rehabilitation professionals play an important role in maintaining and forming relationships through their interactions at critical times following injury. While Wu and Williams (2001) suggested that peers with disabilities are much more influential socialising agents than rehabilitation professionals, the current findings suggest that rehabilitation professionals clearly had roles in facilitating the reconnection of life paths within friendships. Specifically, rehabilitation professionals clearly played roles in reducing environmental and

interactional separation and by moulding the environment to facilitate friendship. They assisted individuals with SCI in negotiating new and old roles and responsibilities, facilitated the redefinition process, and assisted individuals with priority setting.

Friendship literature

The specific social support offered within the context of friendships, as evidenced by the discussion above, is rather weak within the SCI literature. While the literature discussed above lends support to many of the categories identified, it rarely considered these notions beyond the scope of the injured person, or at best, their family. There was no study that considered the topic of friendship specifically. When considering the broader friendship literature and extrapolating to the contexts of people with SCI, it becomes clear that many of the factors involved in friendship maintenance and deterioration more broadly may be particularly relevant to people with spinal cord injury throughout their life. Indeed, this was the case as several findings that have previously emerged within the broader friendship literature are supported by the current findings. However, there remains a significant advantage within the current findings of extending this literature.

First and foremost, the current findings lend support to the existing literature identifying friendship as a valued and important relationship that assists most individuals when faced with a variety of life situations (Ahrens & Campbell, 2000; Arora et al., 2007; Boydell et al., 2002; Stoll & Paulsen, 2004), facilitating coping (Morgan et al., 1997; Weingarten, Weingarten & Miranda, 1997) and adjustment to those situations (Allen, 2006; ; Demir & Urberg, 2004; Sandstrom, 1996; Voss, Markiewicz & Doyle, 1999). For instance, while Ognibene and Collins (1998) found

among a group of young adults, that secure individuals perceived more available support from friends and sought social support from friends more often, the current study found that friendships held vital roles in buffering the low periods experienced during the period of rehabilitation and adjustment following SCI.

In addition, while the existing friendship literature identifies the importance of friendships for people during significant life events, it also highlights the importance of significant life events for challenging friendship. Indeed, friendship deterioration has been described as occurring as a result of changes in personality, distracting life events, conflicting expectations of friendship, changes in life circumstances and betrayal (Sias et al., 2004). Blieszner and Adams (1998) found that problems with friends stem from structural features internal to dyad, factors external to dyad and changes in the extent to which lives intersect and day to day interactions. The current study supports the existence of these difficulties in friendships and defines these different levels at which this separation between friends occurs more specifically. For example, identity separation and reality shifting over time were factors internal to the dyad that resulted in diverging life paths. Environmental separation and aspects of the environment that resulted in competing time demands (and thereby priority drift) were factors external to the dyad. Changes in day to day interactions were represented by the category of interactional separation.

Cohen, Gottlieb and Underwood (2001) suggested that the key factor is to recognise that the support process is so individualised that what happens within friendships (i.e., whether it is strengthened or whether it deteriorates) depends on where people start from (Ledbetter, Griffin & Sparks, 2007). Indeed, the relative nature of the current theoretical framework developed recognises this individuality and accounts for pre-existing differences in the individuals, the dyad and the

surrounding support context. Contrary to the suggestion of Cohen et al. (2001) to identify the individual characteristics of those who benefit most and least from the support process, the current findings suggest that this is unnecessary and perhaps frivolous as we will never be able to account for all of this variation by examining individual characteristics, whether these are demographic or injury-related. Alternatively, the current findings suggest that an examination of the degree of enforced separation and priority drift, along with an examination of the use of reconnecting strategies of working and redefining would be more useful in identifying how the support process can be enhanced.

Previous research has identified that friendships patterns are strongly influenced by a range of structural and attitudinal contexts (Dugan & Kivett, 1998) including practices of the human service and rehabilitation systems which often curtail opportunities for friendship development (Lutfiyya, 1991). The identification of environmental separation in the current study highlighted the importance of these environmental contexts, suggesting that it is important to identify not only the objective nature of these contexts, but individual and dyadic perceptions of these contexts and the degree to which they diverge. Further these contexts should be explored in the degree to which they displace the relationship from its historical trajectory.

Rose (1984) identified four basic patterns that contributed to friendship deterioration, namely physical separation, new friends replacing old, friend revealing or doing something that met dislike criteria, and interference due to dating or marriage. In describing physical separation, Rose (1984) suggested that moving to a new house or city was often a cause of separation because contact had been lost altogether or maintaining a long-distance friendship was difficult for most people,

who frequently lacked the resources to visit or call their friend. Indeed, Griffin & Sparks (1990a) also highlighted the difficulties that this geographical separation can present for friendships.

In other cases, the physical separation resulted from individuals moving along different developmental paths (e.g., one friend being older than the other, so the transition from high school to college was not a shared experience). Further, Rose (1984) found that some individuals cited other less drastic physical separations that were sufficient to dissolve their close friendships, such as a change in jobs, a change of classes, no longer sharing locker space, or switching from one sport programme to another.

The current findings suggest that environmental separation is not always detrimental to a friendship however. Rather, the degree to which this was destructive to a relationship depended on the number of other domains that were affected also (e.g., role separation, immediate need, reality shifting over time). Indeed, Wiseman (1986) suggested that the end of a friendship is more likely to occur not merely because friends have been separated for some length of time, but more because they find when they meet again that they have both have changed so much in the intervening period as a result of different lifestyles, that they no longer have anything in common. Indeed, in the current study, friends were often able to cope with the environmental separation, knowing that it was temporary in nature, especially in instances where reconnecting strategies such as breaking the ice and moulding the environment were utilised. Ultimately, if integration into public and private social worlds is achieved through the use of reconnecting strategies or only subtle divergences in life paths, then isolation from others is avoided in the domain of daily life (Altergott, 1988).

The current findings support the proposition in the literature that friendship is quite a different relationship to that offered by family. Existing research suggests that, because family relations are, by definition, permanent and intimate, continued closeness may be taken as a matter of fact or even of obligation (Decker, 2007; Wiseman, 1986). In contrast, friendships are both elective and more transitory (Badhwar, 1989; Wright, 1984) and therefore the expectations for amount, quality, or even continuation of interaction in a variety of life events may be low (Chappell, 1994; Decker, 2007). Further to this, the voluntary aspect of friendship means that it receives little of the societal support that other relationships enjoy. Indeed, the findings of the current study attest to this abyss of support and structure for friendship as the rehabilitation context offered little in the way of supporting or even recognising friendships.

As such, friendship only answers to the certain expectations which are individually developed and defined within the context of that friendship (Wiseman, 1986). This finding is also supported by the current study, reflected in the degree to which perceptions of enforced separation and priority drift result in the divergence of life paths. Specifically, the role separation experienced in the current study was explanatory of the ways in which the friendship itself defines and negotiates the appropriate roles for each party to take. Equally supported in the current findings however was the notion that the intimacy and closeness that is an integral part of friendship and creates these mutual expectations regarding friendship roles, makes both participants vulnerable to betrayals of trust (Wiseman, 1986). Thus, the friendship bond is exceedingly fragile when compared with other, more institutionalised relationships such as marriage. Indeed, where many participants

spoke of friendships that dissolved following injury, none spoke of family relationships that had experienced the same difficulties.

Wiseman (1986) suggests that unwritten contracts exist among friends concerning the expected friendship roles and expectations of reciprocity of aid. He described this in terms of banked resources that are voluntarily maintained, can be withdrawn upon need, but may never be used at all. Role separation following SCI, as outlined in the current study, may place people in situations where their traditional roles within the friendship are challenged and reciprocity becomes unbalanced, at least for a period of time. The friend may have to play a greater role in listening to problems, offering solutions, aiding with self-improvement, and generally giving a sense of security. In these instances, differential status or power may emerge (Adams & Blieszner, 1998; Griffin & Sparks, 1990a). Alternatively, the friend may choose not to fulfil these roles, only to compromise the expectations held by the injured person. The current study found that the degree to which these role changes are accepted within the friendship lie in the degree to which they can be justified or attributed to external causes (e.g. other commitments).

Lutfiyya (1991), in a study of friendships of people with disabilities, discussed the importance of shared ideas and expectations about a friendship including its mutual, exclusive, and voluntary nature, the rights, obligations and responsibilities of friends to each other and the positive regard and affection. This supports the current finding of reconnecting life paths through a negotiation of roles and responsibilities and priority setting in relation to the friendship. Wiseman (1986) termed it a social miracle that, for the most part, friends do manage the balancing act for which the position calls, maintaining stability of perceived personality and behaviour, fulfilling expectations about reciprocal behaviours and minimising demands as well as

forgiving those who fail to meet expectations. Indeed, the current study concurs with Wiseman (1986) because nearly all friendships were able to negotiate new and old roles and responsibilities to facilitate the maintenance of the friendship, although the current study does suggest that these friendships may not necessarily have been operating at the same level of closeness and contact as they previously were.

The other aspect to role separation identified in the current study was related to the degree to which individuals following SCI could maintain common interests with friends, participate in activities and occupy social, leisure and vocational roles that were either typical for the friendship or acceptable to each member of the friendship. This supports the literature that identified shared activities and common interests as key functions of the friendship bond (Cole & Teboul, 2004; Vaux, 1988). Many friendships whose only friendship roles prior to injury related to participation in shared activities, often experienced high degrees of role separation following injury. For these friendships whose primary function was fun and activity, termination or dissolution appeared possible in the long term where the pleasure/cost ratio may have deviated too far from an ideal point (Rose, 1984). While final dissolution of friendships was not particularly evident in the current study, Rose (1984) suggested that termination is a process involving multiple steps and it is quite likely that many of the friendships in the current study that were experienced high degrees of separation and priority drift, will ultimately result in those friends parting ways.

In defining differential status and power as a form of role separation among older adult friends, Adams and Blieszner (1998) also suggested that low solidarity and a lack of homogeneity was a contributing factor to friendship dissolution. The current study found that identity separation often occurred following injury as the injured individual negotiated altered identity related to their new disabled self and changed

body image while friends struggled with trying to understand that implications of the injury for the friendship. The current study found that identity separation was significantly impacted on by the degree to which each member of the friendship could perceive sameness in the friendship, regardless of the level and severity of the injury. This included the degree to which equity was established within friendship maintenance behaviours, a factor identified by Dugan & Kivett (1998) as extremely important for friendships.

An interesting point to note however is that discussions of identity occur much more frequently in the clinical and adolescent literature than they do in the general adult friendship literature. Wiseman (1986) did however suggest that the friendship dyad has an internal dialectic which can be the basis of problems between friends or the eventual demise of the relationship, highlighting that the addition of a major undesirable trait or the seemingly complete change of a friends' personality is particularly detrimental (Sias et al., 2004). This can result not only in the loss of the friendship relationship but also the loss of an enjoyed identity reflected in a once-valued friend. The current study reflected this notion by suggesting the identity separation can result not only in the loss of the 'I am' but also the loss of 'we are'. Indeed, as suggested by Wiseman (1986), this can occur without any real awareness of the significance the change may have for a friend or the friendship. Indeed, he suggested that people expect the desirable and attractive traits of their friends to transcend specific situations in all important cases. The current study expands this notion however by highlighting the fact that it is not just real change in identity but also perceived changes in identity that can create challenges for friendships. Indeed, regardless of changes in the identity of the injured individual or the friend separately,

if both parties perceived that the other was essentially the same person and there was a perception of sameness in the friendship, then identity separation was minimised.

The other factor that may change in the context of altered identity is the 'like criteria' that individuals utilised to evaluate friendships (Rose, 1984). If these criteria change as a result of changed identity, an individual may begin to look for different things in friends. Alternatively, friends may change and no longer meet the like criteria of the injured individual. The current findings suggest that these changes in criteria may not only be linked to identity but also to priority drift, where some criteria become a greater priority for friendships and others become less significant. Rose (1984) also suggested that some friendships are challenged by the revelation of an act or behaviour that constitutes a 'dislike criteria'. While she identified acts such as hostility, substance abuse, violence and criticism as behaviours that may fit into dislike criteria, the most common instance of this in the current study related to discrimination, equality and inclusion.

Indeed, Church (1998) spoke of differences in networks and friendships that were related to the visibility of the condition following disability. He suggested that friendship was affected not only by how people define themselves but how they define those around them. Cohen et al. (2001) found that social integrated people have more diverse self concepts (i.e., greater depth within their identity and life roles). They suggested that this diversity makes managing aspects following injury in any one domain easier or less crucial to the friendship as a whole. Those individuals in the current study who had extensive life experiences and much broader identities associated with a wider range of life roles indeed experienced less divergence of life paths with their friends. Similarly, where friends were accepting of a range of people

(particularly those who had previously been exposed to disability), identity and role separation was minimal.

The current study also suggested that individuals with SCI and their friends underwent a process of reconnecting that involved a redefinition of the friendship, at an individual and dyadic level. Similarly, Rose (1984) suggested that when friends are separated environmentally, a cognitive shift need to occur within one's concept of 'friend'. Where there is no physical presence of the friend, a new definition must emerge that allows for the continuation of the emotional bonds without the need for regular contact. While friendships whose history was characterised by irregular contact could achieve this redefinition easily, friendships who previously involved high levels of contact were also able to achieve this in many instances over a period of time. Indeed, Rose (1984) suggested that the development of effective strategies for maintaining a stable level of emotional involvement in the absence of irregular contact may take time to develop. What remained important was some degree of interaction that enabled this redefinition to occur. Further, this process required individuals to prioritise to some degree the friendship and ensure that the enforced separation did not reach that critical point of no return, a point which was similarly identified by Rose (1984).

Although aspects of interaction and communication had received little support or attention within the SCI literature, difficulties in communication between friends have received significantly more attention in the general friendship literature (Griffin & Sparks, 1990a; Lee & Ishii-Kuntz, 1987; Tichon & Shapiro, 2003) as well as within the literature exploring friendships among children with (Bauminger, Shulman and Agam, 2003) and without disabilities (Cutting & Dunn, 2002; Dunn & Cutting, 1999). Bauminger et al. (2003) point to the importance of interaction and the interactional

separation that occurs for children with disabilities based on observational data that represented a significant advancement in the friendship literature for assessing interactions. These researchers however merely explored these interactional difficulties in a rather static and confined way. The current findings highlight a much more dynamic process of interactional separation.

Similarly, Dugan and Kivett (1998) highlight the importance of friendship in situations such as later life where interactions with people such as co-workers, neighbours and kin may be diminished. In order to maintain acceptable levels of interaction, friends must cross paths and have a pattern of life that allows for continued interaction. Indeed, Cohen et al. (2001) suggest that the materialisation and benefits of social support are strongly influenced by many personal, relationships, situational and emotional characteristics of the interactional context. The current findings support this notion highlighting the way in which environmental separation related to hospitalisation as well as the lack of flexibility and privacy within the hospital environment contributed to varying degrees of interactional separation.

Sias et al. (2004) suggested that friendship deterioration is often characterised by an avoidance of discussion among friends in an effort to disengage. While the current study did not find any evidence of direct avoidance of interaction per se, there were distinctive changes in interactions that were perceived by some as avoidance. However, the greater difficulty in interaction appeared to lie within the ability of friends to establish some accepted equality in their social exchanges, including reciprocal disclosure, a difficulty previously outlined by Cohen et al. (2001). Further to this, the current study found little dialogue between friends about the friendship itself. Indeed, this finding has also been reported by Rose (1984) who found little negotiation between friends about how the relationship was to end. This

failure to monitor the friendship was cited as a source of regret in many explanations of what, if anything, they would change if they could relive the friendship. Indeed, many individuals in her study wished they had made more effort to maintain the friendship or wished they had been more open with their friend about the importance of the relationship to them.

The ways in which interactional separation occurred within the current theoretical framework deserves special mention. Hanna and Berndt (1995) suggested that there were probably three ways in which social selectivity resulted in compromised interactions with friends. These included partner selectivity (choosing contact with some friends over others), time selectivity (choosing to allocate greater amounts of time to certain friends) and emotion selectivity (devoting less emotional energy into interactions with certain friends). While these authors found that emotion selectivity was the principle way in which college students managed interactions, the current study suggested that each of these strategies were used to some degree, particularly within the context of time limitations and competing demands experienced as a result of *immediate need*. And although it did become apparent throughout the data that many social interactions were not necessarily beneficial (Chronister et al., 2006), there was very little evidence of social interactions that were conflictual in nature per se.

Dickson-Markman (1986) discussed the issue of self disclosure within friendships and, in concurrence with the current findings, found that it was an important dimension along which interactional separation occurred. She suggested that the valence of the disclosure was particularly important in the context of friendship history, length of friendship and previous expectations which she relates to different stages of relationship development. The current findings suggest that, in

many instances, interactions return to a level that is reflective of early relationship development for many, which is uncomfortable in the context of the relationships history yet predicted by the fact that usual topics of conversation varied as a result of varied degrees of mutual knowledge. Breaking the ice was an important strategy for facilitating disclosure within the friendship. Indeed, many participants offered disclosure within the context of humour that deflected an overly emotional tone and fostered positive valence in the interaction. Indeed, factors such as positivity, supportiveness, openness and interaction have been identified as key considerations for friendship maintenance (Oswald et al., 2004) and are equally important dimensions of the concept of *breaking the ice*. Further, Cohen et al. (2001) spoke about the benefits of receiving support and disclosure from network members without explicitly requesting it, suggesting that this level of interaction reinforces a preservation of self esteem and a sense of intimacy and dependability in the relationship. There were indeed instances in the current study where individuals outlined the need to receive interaction from others without wanting to specifically request that interaction and support.

The current study suggests that the resulting enforced separation and priority drift within friendships is one unfolding process that may vacillate for many years following injury. Rose (1984) suggested that it is difficult for individuals to distinguish temporary changes in friendship from absolute finality of the friendship while they are occurring in a relationship and that endings are often only identifiable in retrospect. In some instances, friends are replaced by new friends without any specific event or recognition that the friendship is no longer functional (Rose, 1984). Indeed, other researchers have offered evidence to support the notion of priority drift and in particular reality shifting over time (Rawlins, 1994) as contributory factors to

friendship deterioration over time. The current findings support this proposition and extend in the sense of applying it not only to the two extremes within friendship but also to the little day to day changes that may eventually result in reality shifting significant enough to seriously challenge the friendship. For instance, many participants in the current study did not realise the degree of separation or priority drift that had occurred between their friends and themselves until many months following injury.

Accounting for discrepancies in literature

A key strength of the theory developed in the current study is its ability to account for the equivocal nature of the existing literature. The theory transcends inconsistencies in the definitions of friendship. Further, it accounts for seemingly contradictory findings in relation to the levels and types of social support reported by people following SCI and the ways in which friendship integrates within developmental contexts.

As highlighted in Chapter 2, definitions of social support and friendship are plagued by conceptual 'murkiness' and inconsistencies (Fehr, 1996; Langford et al., 1997; McColl et al., 1995; Wiseman, 1986). Some definitions are more structural in nature while others are functional or perceptual. Studies have often utilised different definitions of friendship, or not defined friendship at all, leading to different conclusions. The current study found that the processes of the theory applied irrespective of the specific definitions individuals attached to friendship. Savin-Williams and Berndt (1990) noted that researchers have seldom distinguished between the number and quality of friendships in their studies. In addition, there has been little differentiation among types of friendships, so it is virtually impossible to

know whether the friendships studied are "best friends," "close friends," or simply "friends."

Researchers have usually focused on the structure, processes, and phases of same-sex friendships (e.g., their talk and conversations) (Neff & Harter, 2003). In other instances, the focus has been on the relationship between objective characteristics of friends and respondents (e.g., the number and/or availability of friends or on the degree of similarity between respondents and identified friends) (Matthews, 1983). Being and having a friend constitutes a complex, multi-dimensional experience, yet some authors focus on only one aspect of that experience (Lea, 1989). As stated by Carbery and Buhrmester (1998), research has, by and large, been conceptually limited to asking subjects to name the people they can turn to for instrumental, informational and emotional support, in times of stress.

The current study has revealed that the life paths of individuals within a friendship can diverge as a result of enforced separation or priority drift, regardless of how they defined their friendship at the outset. There were no instances in the collected data for the current study where there were discrepancies between friends about the existence of the friendship itself, although discrepancies did exist as to the nature and depth of the friendship. Importantly however, several participants did not have friends participate and it is possible that those friends who did not participate may have perceived a discrepancy in their description as a friend.

In a similar vein, the processes associated with reconnecting life paths, namely that of working and redefining, occurred regardless of whether one friendship dyad was defined in a different way to another. The variability existed in how reconnecting occurred, not the existence of reconnecting per se.

A large proportion of the literature examining friendships consists of studies aimed at identifying demographic (e.g., Buhrmester, Furman, Wittenberg & Reis, 1988) or contextual differences in friendships (e.g., work friendships versus school friendships). The current theory transcends both demographic (e.g., gender, age, marital status, culture) and injury-related variables (level of injury, completeness of injury, comorbidity, visibility of impairment, mobility and functional levels). These factors contribute to the theory in that they modify the degree to which enforced separation and priority drift, but are insufficient alone to explain variation. The friendships upon which the current theory was developed represented male and female same-sex friendships, friendships of both older and younger people as well as work and school friendships. Further the theory illustrated how friendship became a defining feature of the relationships that formed within the hospital environment (e.g., existing pre-injury friends and friends with disability). The processes explicated by the theory remain intact regardless of these variables, thereby supporting the ability of the theory to transcend individual factors.

Similarly, the current theory explained differences in geographic, socio-political, temporal, relationship and rehabilitation contexts. For example, Young, Murphy and Strassor (2000) found that perceptions of support were greater in rural settings following injury. These communities offered cultures of involvement and support, positive attitudes and willingness to assist. Thus, although environmental separation was geographically unavoidable during hospitalisation, this separation tended to be resolved once an individual returned to the community and other forms of separation were less likely to occur. For instance, the individual would be less likely to perceive interactional separation because friends in the community would continue to interact with them. Examples within the current study suggest that

environmental separation is common for people from rural areas as friends move away for either short or extended periods of time. In these instances, it appeared that the friends developed strategies for maintaining interaction (e.g., using alternative forms of communication) and a different perception of what is expected in terms of interaction (e.g., friends accept that they will speak once a month instead of once a week). Equally, role separation would be reduced as individuals continued to be included in activities with the community and identity separation would be reduced because the rural culture is so strong, it becomes a part of who you are and remains with you.

The seemingly contradictory findings in relation to the levels and types of social support reported by people following SCI can also be explained by the current theory. Some research has shown that despite high levels of satisfaction with social support (Benony et al., 2002; Tasiemski et al., 2005), some individuals lack access to someone they can ask for assistance (Boschen et al., 2003; Chan, 2000a). Using enforced separation and priority drift, the current theory can explain how satisfaction could be maintained as long as role separation was minimised and friendship roles were mutually satisfying. Individuals negotiated the roles and responsibilities of each party within the friendship and justified those instances where roles could not be fulfilled.

An important feature of the theory was the ability of the individuals to redefine friendship in such a way that did not challenge their identity, thereby allowing them to feel satisfied with the support they received from friends, even when it did not meet all of their needs. This process involved individuals redefining what the friendship meant to them and redefining themselves in the context of their altered body image as well as their altered social contexts and communities.

Findings in the literature related to the effectiveness of different types of support can be accounted for by the current theory with reference to the notions of the temporal context within which support occurs. Alternatively, these findings could be explained in terms of the degree to which the individual prioritises different types of support within the context of their immediate need and its subsequent impact of functioning. For instance, Post et al. (1999) found that although emotional support from family was beneficial in terms of psychological functioning and life satisfaction, emotion-oriented support from friends was related to poorer social functioning. Among college students, Buhrmester et al, (1988) found that emotional support competence was strongly related to satisfaction in friendships. The degree to which emotional support impacts negatively on social functioning following SCI when compared to other populations may be explained by the degree to which this support reflects a separation in roles or identity or interactions between friends and the ways in which each party views that support. If emotional support is seen as pity, then people with SCI may perceive this as a change in the roles of the friendship. In further support of this notion, the overwhelming nature of lots of emotional support at the wrong time was seen as a problem in maintaining expected roles within the friendship.

The current study found that within friendships at any point in time, both positive and negative aspects were present. The degree to which this balance between positive and negative challenged the friendship itself depended on the degree to which enforced separation and priority drift caused feelings of anxiety and discontent within the friendship and whether this extended beyond a critical point of divergence. Participants clearly delineated instances of perceived negative support (e.g., overinvolvement, pity), but initiated working and redefining processes to address

these. For example, in instances where friends showed pity or threatened perceptions of personal control, the individual with SCI could break the ice using humour (e.g., making a joke about their functional impairments), or by clearly explaining to friends the role that they wanted the friend to play (e.g., asking the friend to walk beside them rather than behind the chair).

In summary, many of the difficulties in the current friendship and social support literature are created by the methodologies used to examine them. When measuring social support and friendship in the context of statistical methods, many of the intricacies and complexities uncovered within the current theory are hidden. As such, quantitative methodologies are often limited in their examination of complex contextual constructs such as friendship and only serve to simplify the thinking of practitioners. The failure to appreciate complexity results in discrepancies in the conclusions made by different researchers. The current findings suggest that these differences across studies may not actually be discrepancies, but may simply represent variability in the complex theory of friendship processes as identified in the current study.

Translating the Theory into Practice

The qualitative tradition in research is becoming increasingly accepted as a research approach that can inform clinical practice (Carpenter, 1997; 2000). Further, basing health and policy decisions on rigorous research that involves the intended recipients or beneficiaries of that service or policy is increasingly becoming the norm in terms of translational research (Carpenter & Forman, 2004). The current study has supported this position and has highlighted the benefits of the grounded theory method for understanding complex psychosocial issues following SCI. In terms of

clinical practice, several lessons appear to be critical. The first lesson is that friendship is a valued and important relationship, one that has traditionally received very little attention within the rehabilitation context, but is deserving of specific focus. Just because the friendship is not a perceived source of immense physical or psychological distress (i.e., it is not pathological in any way), this does not mean that it is not an important focus for rehabilitation. Holistic and client-centred rehabilitation is about consideration of the whole person (Crisp, 1989). Indeed, the current findings suggest that, particularly during the early stages following injury, friendship may not be something that friends have focused on. However, once the person has met the range of immediate needs and returned to the community, ongoing friendship is a valued part of the individual's participation in society and considerable effort is likely to be expended on reconnecting with friends. If the value of friendship was recognised during hospitalisation and the impact of SCI on friendships was discussed openly, some of this effort may have been prevented.

The second lesson is that friendship is highly individualised and complex. Therefore, unless we understand individual notions and processes of friendship, we will not understand friendship. The complexity of the framework and its ability to explain and recognise the delicate nature of friendships and support will assist practitioners in avoiding simplistic interventions (Cohen et al., 2001). However, this lesson also requires rehabilitation professionals to avoid reliance on a-priori assumptions about friendships (Boydell et al., 2002). Quigley (1995) suggested that the use of life histories during the rehabilitation phase may be a useful way for rehabilitation professionals to access individual notions of recovery, connecting the past with the present and enhancing community re-entry and adaptation. Indeed, this method could equally be applied to the examination of friendship and would facilitate

recognition that friendship is an integral part of a picture that existed prior to the injury. Further, it is a part of the person's life that will continue beyond the rehabilitation phase and should, therefore, remain as intact as possible during this period of enforced separation. The life history method, when utilised with the person with SCI, friends and family, would assist to identify divergence in life paths and earmark the need to use reconnecting strategies.

The third lesson is that of timing. As the current findings have demonstrated, prolonged separation and priority drift can have implications for the maintenance of friendships if they persist past certain critical points. These critical points appear to be different for different friendships. However, once this critical point has been reached, it appears to be particularly difficult to reconnect the friendship. Indeed, some people with SCI spoke of using no other reconnecting strategies once they felt separation or priority drift had reached a certain point (e.g., 19Sci). As such, attention must be paid to friendship early following injury to prevent the enforced separation and priority drift persisting past those critical points. Furthermore, the process of diverging life paths is not static. Just because a friendship does not display signs of divergence at one point in time, does not mean that divergence will not occur over time. Reconnecting and divergence may alternate as circumstances change. Thus, the need to assess individual notions of friendship over time is essential.

The fourth equally important lesson for practice lies in the need to assess context. The current findings highlight the contextual nature of friendship and the impact that environments, people and experiences can have on friendship processes. For instance, an understanding of the perceptions of environmental separation between friends needs to be accompanied by an understanding of the ways in which the environment, whether physical or social, is acting to heighten this level of

separation. Similarly, an assessment of the level of interactional separation cannot be made in the absence of an understanding of how the environment itself is preventing opportunities for interaction. Further, any assessment of immediate need (a form of priority drift) cannot occur in the absence of an understanding of the multitude of competing demands influencing both the person with SCI and their friend. To develop effective interventions, Cohen et al. (2001) suggested that assessment of context is mandatory, including the characteristics of the setting, the kinds of information available and the kinds of interactions possible for relationship formation, maintenance and the expression of support. The current study has suggested that this assessment should include reference to the divergence between friends within their context, rather than merely an objective assessment of the setting.

The fifth and final key lesson for guiding intervention must lie in the recognition that intervention can occur at multiple levels. The current study demonstrated that although friendships are typically considered dyadic, they cannot be separated from the physical or social contexts within which they occur and these contexts are multiply layered. The fourth lesson above highlighted the need to assess context but it is also important to target intervention at the multiple layers within those contexts. For instance, families are an important player in friendships as are rehabilitation professionals and interventions could also feasibly be targeted at these individuals, not merely the person with SCI or their friend. Although, for many years, it has been accepted that it is important to assess the needs of support persons and then consider their needs in intervention planning (Coyne, Ellard & Smith, 1990; Hobfoll & Stephens, 1991; McColl, 1995), this focus has rarely extended beyond the direct needs of family in their caring role. Interventions in rehabilitation and in friendship specifically, can occur at multiple levels, namely the individual, the dyad,

the family, groups and community. Further, the interventions can be focussed at multiple levels within each area. For instance, interventions at the individual level can be targeted at the physical, cognitive, behaviour or emotional level. Similarly, interventions at the community level can be targeted at community awareness or policy. The current study has suggested that these multiple foci interact to determine the divergence of life paths as well as the strategies that are used for reconnecting friendships. Thus, it is likely that interventions should focus on the physical environment, the cognitions of all parties, behavioural and emotional supports, community processes and policy changes.

Specific strategies must be developed that either act specifically to prevent divergence of life paths or to facilitate the reconnecting of life paths. Table 7.1 below highlights multiple suggested approaches and strategies for facilitating friendships, organised according to the theoretical process upon which the strategy would have its intended effect. Multiple individuals including the person with SCI, friends, family and rehabilitation professionals could implement various aspects of these strategies.

Table 7.1: Categories of diverging and reconnecting and relevant intervention strategies

Diverging and reconnecting categories	Suggested strategies
Environmental separation	Flexibility in visiting hours for friends Inclusion of friends in the rehabilitation process Flexibility for person to leave hospital setting for friendship activities Reducing length of stay through transitional support services Providing community education and awareness about the importance of visiting injured friends Social action to increase community access to hospital environments
Role separation	Inclusion of friends in the rehabilitation process Facilitation of sporting/leisure involvement Modifications and equipment to enhance valued activities that involved friendships

Identity separation	Individual counseling for person with SCI, friends and family Goal setting focused on friendship Coping effectiveness training
Interactional separation	Flexibility in visiting hours for friends Inclusion of friends in the rehabilitation process Offering multiple methods of communication Finding private space for friends
Immediate need	Inclusion of friends in the rehabilitation process while monitoring the balance of perceived role change Early attention to raising awareness about spinal cord injury, hospitals and rehabilitation and friendships within those context to people with SCI and their friends Education about the importance of friendships and strategies for facilitating friendships to staff and families Time management to build in friendship time
Vulnerability to new world	Inclusion of friends in the rehabilitation process Awareness raising
Facing the unknown	Inclusion of friends in the rehabilitation process Awareness raising
Reality shifting over time	Inclusion of friends in the rehabilitation process Goal setting
Breaking the ice	Flexibility in visiting hours for friends Inclusion of friends in the rehabilitation process Multiple methods of communication Finding private space for friends
Negotiating roles and responsibilities	Inclusion of friends in the rehabilitation process Individual and dyadic counseling Coping effectiveness training
Moulding the environment	Inclusion of friends in the rehabilitation process Flexibility in ability to leave hospital
Recruiting staff and peer helpers	Peer support including both informal individual peer support and formal programmatic peer support Staff education regarding friendship, its importance and facilitation Inclusion of friends in the peer support process while monitoring the balance of perceived role change
Redefining friendship	Peer support including both informal individual peer support and formal programmatic peer support Individual counseling Goal setting Coping Effectiveness Training
Priority setting	Inclusion of friends in the rehabilitation process Individual counseling Goal setting Awareness raising

Taken collectively, these suggestions offer a raft of possible strategies for use by individuals with SCI, friends, families and rehabilitation professionals. These strategies are theoretically grounded in the framework developed from this study. It is unlikely that all strategies will work for every friendship. Selection of strategies should be individualised, based on an assessment of the ways in which life paths have diverged and the ways in which the individuals involved are already utilising strategies of working and redefining. Further, selection of strategies should consider the contextual constraints that may make implementation of strategies difficult as well as the personal wishes of the friends for assistance in this area. For instance, friends should not be included in the rehabilitation process without first obtaining the consent of the person with SCI.

The solution to the implementation of effective friendship support may lie in the development of a friendship planning process to be initiated early in the admission. The aim of this process would be to enable people with SCI to manage their friendships in terms of intensity, timing, content and activity, thereby making each aspect of the friendship overt. This could occur through agreements with friends, family and the person with SCI. This solution may also be preventative rather than reactive in the sense that rather than allowing covert processes to dictate divergence, divergence of life paths becomes a deliberate part of the process, managed by the parties themselves with no subsequent need to break the ice.

This may be the most effective way to address the challenge of how to value friends and their role, but at the same time balance the privacy issues and the demands of the rehabilitation process. By putting the process in the hands of the person in developing a joint agreement that is overtly discussed, all stakeholders, including staff

become part of the agreement and therefore have a mandate to act in certain ways in relation to friends.

Systemic challenges exist for the implementation of these strategies, including the use of friendship management plans, to facilitate friendships following injury. These challenges lie within the constraints of the hospital and community environments, the education of health professionals, the empowerment of individuals within a system and the lack of resources to support such interventions. However, many of the suggested strategies are easily implemented at little or no cost to the injured person and without significant time commitments on the part of rehabilitation staff. The challenge lies in facilitating education and understanding of the theoretical frameworks underlying such strategies and recognition that the friendship role is an important one. The current study was developed with the intention of not only identifying a theoretical framework to guide clinical practice, but also developing an agenda for dissemination of that information within the local clinical environment. The final outcome of this work to be completed lies in the development and dissemination (through in-service training and workshops) of clinical guidelines to assist rehabilitation professionals and, in turn, families, friends and people with SCI to positively contribute to the maintenance of healthy friendships following injury.

Implications for future research

The current theory highlights the benefits of including multiple informants in the research process. The inclusion of both people with SCI and their friends represents a significant advancement over existing literature and helped to elucidate dyadic processes that would otherwise have remained uncovered. For instance, the processes of interactional separation would have been much less clearly articulated if

only people with SCI had been included. Thus, the inclusion of both members of the dyad is essential for future research. However, the recruitment of friends was problematic, suggesting the need to find alternative means by which to recruit larger numbers of friends. Further, the study would have benefited from direct observations of the interactions between friends. This is clearly a limitation of the current study as it only uses data collected through the self-report of each member of the dyad.

The inclusion of family members was not part of the original research plan, but emerged as a result of the data collection and analysis. Future research should aim to explicate the involvement of family members in friendship processes more clearly as the current findings were limited to the data provided by only three family members. Greater exploration of the ways in which family members can hinder or facilitate friendships is required, especially during the acute stages of hospitalisation, a period during which family data was not collected in the current study.

In this study, data was only collected within the first six months following discharge from hospital. The current theory suggests, however, that the processes of diverging and reconnecting life paths are episodic in nature and therefore would continue to change over time. The current study only begins to capture the reality shifting that may emerge for friends following injury. Therefore, it was possible that friendships appeared to be reconnecting at this early point in time may experience continued periods of divergence that compromised the friendship. It is clear from the current theory that friendship is not a linear process, but is represented by interacting periods of divergence and reconnection as different contextual factors are encountered. However, the theory also suggests that processes such as reality shifting are likely to continue over time, perhaps giving rise to different forms of reconnection

or inability to reconnect. Further research is needed to appreciate this interaction over time, particularly as new friendship challenges emerge.

The degree to which the possible dissolution of friendships impacts on the physical and psychological health of people with SCI also requires further exploration. The current study, while articulating the interactive friendship processes following injury, fails to adequately explain the exact ways in which enforced separation and priority drift compromise physical and psychological health. Although the concepts of identity and role separation suggest that diverging life paths have psychological and social consequences, the outcomes for individuals with SCI were not specifically explored. Similarly, the findings suggested that loneliness may be a consequence of interactional separation. However, feelings of loneliness were not evident to any great extent in the data, suggesting that the actual causal link may be less clear. The staff and peer support network may have hidden this link, at least during this short period of time, particularly given the fact that staff interactions were often redefined as friendship interactions. Nevertheless, the long term implications of difficulties in this area remain to be explored.

One major implication that emerged from the current study was the inability of the rehabilitation environment to measure friendship. Although rehabilitation professionals do not typically assess friendships, it becomes clear that existing measures of friendships would be inadequate within the rehabilitation context. Formalised friendship measures that have been developed within the child and adolescent literature tend to focus on friendships only in those developmental contexts. Most measures would fail to adequately capture enforced separation and priority drift. In the current study, staff were often unable to appreciate friendships or see how their actions could facilitate or hinder a friendship. Thus, there is a need to

develop appropriate assessments of friendship following injury that can easily be implemented within the clinical setting by rehabilitation professionals. Such measures should assist staff to monitor the perceived divergence (i.e., separation and drift) experienced by both parties over time to sensitise them to any episodic changes that could signal the need to initiate reconnecting strategies.

However, it is important that friendship divergence is not 'pathologised' within the acute treatment context. The current study has shown that if both parties accept that their friendship has become a lower priority, then this adjustment could be a positive step in the friendship. Indeed, SCI may trigger a deliberate reassessment of friendships. For instance, individuals in the current study who had been injured as a result of the risk-taking culture of their friendship network often re-evaluated these friendships and focused on new priorities in their life.

Limitations of the theory

The limitations of the theory lie in its containment to the substantive level. The categories and concepts contained within the theory and the relationships between these categories are abstracted sufficiently to allow comparison to other clinical populations and other contexts (e.g., institutions), thereby enhancing the modifiability of the theory. However, the fact remains that the theory was grounded in data from the substantive field of friendships in SCI rehabilitation. The degree to which the theoretical propositions contained within are applicable at a more formal level, requires exploration through the inclusion of data collected from outside of the substantive area. In addition, the theory is not a 'proven' set of hypotheses, but an integrated set of hypotheses, systematically grounded in the data (Glaser, 1978). As such, these categories and relationships exist in the data collected, as analysed within

a constructivist framework (Charmaz, 1995) but do not represent absolute and objective reality. Indeed, constructivist approaches to research propose that there is no one objective reality (Charmaz, 2006).

Further to its containment to the substantive area of spinal cord injury rehabilitation, it is noted that this theory does not, and indeed does not intend to, explain all likely processes relevant to the substantive topic of friendship following spinal cord injury. As espoused by the grounded theory method, the current theory developed accounted for the variation seen within the data collected. The field of friendship research following acquired disability is in its infancy and indeed, was the justification for the current research. As such, it is likely that there is greater variation, not captured in the current data that can add to our understanding of friendship processes following spinal cord injury. There is a wealth of opportunity for other researchers to build on the work conducted here and indeed, this is something that I encourage.

Summary

The theoretical framework offered within the current study for understanding friendship processes following SCI has proposed a series of integrated categories, concepts and hypotheses that delineate not only the main challenges faced by friendships but also the means by which friends address these challenges. The complexity of the resulting framework would not have been recognised had this research been conducted using more traditional research methods.

The findings are significant because they offer a theoretical model of friendship that has no known parallel in the disability field. The theory confirms,

extends and integrates constructs that have already been identified in the SCI and friendship literature. However, the theory accounts for variation across personal and environmental factors, offering an explanatory framework that could be applied to all friendships. Most importantly, the theory incorporates the perspectives of multiple stakeholders and offers a template upon which clinical interventions can be developed.

The theory is capable of accounting for discrepancies in the existing literature, particularly those related to inconsistencies in the definition of support and friendship following injury. The framework transcends differences in context, demographic and injured-related factors, but also and accounts for the temporal nature of change. When evaluated according to criteria of fit, relevance, functionality and modifiability, the theory emerges as a quality theory.

Perhaps the most important contribution of the theoretical framework lies in its ability to inform both clinical practice and future research. The current study was identified primarily within the context of a clinical setting, conducted using multiple groups of individuals from within that setting. Thus, the theory can offer suggestions for enhancing clinical practice to ensure that it can facilitate friendships following injury.

The current study has made a significant contribution to the literature by developing a clinically useful theory that illustrates the significance of the friendship bond within the rehabilitation context. The findings tell us that loss of friendships is an important issue for people with SCI, and one that may cause individuals significant distress. As such, rehabilitation professionals clearly have a role to play in facilitating friendships as part of the rehabilitation process. It is with relative ease that practitioners in the rehabilitation context can address the friendship process,

particularly given that they are an important aspect of the environment. It is only once we, as healthcare practitioners, begin to take heed of those aspects of life that are most important to our clients, that we will lose our rose-coloured glasses and truly become rehabilitation professionals.

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Appendix A

Reflexivity: A Personal Journey

In constructivist inquiry, interaction is central to the research process and it is impossible to separate the researcher from the researched (Guba & Lincoln, 1994; Mallory, 2001). Hutchinson (1993) highlighted the unique place of Grounded Theory because the emphasis of the approach lies in the analysis of interpersonal interaction. As such, the researcher is inevitably a central aspect of the data (Lincoln & Guba, 1985). Thus, there is a need for the researcher to describe his or her previous knowledge and experience and discuss how it has affected the theory development (Cutcliffe, 2000).

In describing reflexivity, Carpenter and Hammell (2000) stated that we need to expose not only our personal and social position, but also our chosen political and philosophical position that influences the relationships we have with our study participants. My main objective in conducting this research lies in informing practice, changing rehabilitation philosophy and culture. I believe this objective will be achieved by empowering people with disabilities, their families and friends to ask more of our healthcare system, to expect that friendships will be valued. These roles, that are so integral to people prior to their injury, need to be facilitated following injury. However, it is only with an understanding of this area, a theoretical framework from which to work, and specific clinical guidelines, that the rehabilitation profession can move forward in respecting and improving friendship outcomes. This is my purpose and it is clearly stated in all documentation related to this project. I have made this motive transparent to all people who will read, participate in, and utilise this research.

Throughout my thesis, I used methods and strategies to ensure that reflexivity was inherently woven into the fabric of every decision and action I took throughout the research. The most valuable tool has been my journal. Strauss and Corbin (1998) suggested using a journal to record thinking and the effects of researcher thinking on analysis. I used memoing also as a reflective tool to record my thinking about the data. I also used consciousness-raising questions to explore my reflexivity, provoking thought about power differentials that might exist. Asking questions such as 'How is this person like me or not like me?', 'How are these similarities and differences being played out in interactions?' and 'How is that interaction affecting the research?'

The constructivist approach recognises that the researcher is a social being who creates and recreates social processes and therefore the previous experiences of the researcher are also data. Some researchers (Chenitz & Swanson, 1986; Smith & Biley, 1997) have suggested that previous knowledge should be used when the researcher compares his/her theory to previous theories, later in the analysis process. I felt that it was not possible to bracket my existing knowledge so it was woven into all aspects of the study. The following story describes how my personal, social, philosophical and political backgrounds have directed and influenced the decision to undertake this research.

Losing My Rose-Coloured Glasses

Through rose-colored glasses

With an unduly cheerful, optimistic, or favourable view of things:
see the world through rose-colored glasses.

(Answers.com, n.d) <http://www.answers.com/topic/rose-colored>

What causes us to follow certain paths in life? Life presents us with so many intersections, each with so many roads leading in an endless possibility of directions. However, at each intersection, we select a road to follow, sometimes intentionally with a clear purpose and goal in mind and sometimes unintentionally in a haphazard and chance way. At other times, we are channelled down certain roads by the environmental forces that surround us. In pondering these decisions, what emerges as key is that these roads that we choose or are forced to choose lead us on a journey that is unique. Nobody else will follow these same roads and there is no definitive map which tells us what lies ahead. Sometimes our choices prepare us for what lies ahead and sometimes nothing can prepare us.

The Professional in the Making

It is with this thought that I wonder why I chose, so clearly in my mind, at the age of 15 years to study psychology, the study of cognition and behaviour, the study of the human mind, that vast array of neural connections and gray matter that remain as mystical today as they were at the beginning of time. I still vividly recall sitting in this poky little room at the back of the common area at Penleigh and Essendon Grammar School, a school I hold dear for fostering the work ethic I now have. At the time I was in Year 9 and in this little room was a career counsellor, one of my senior teachers, my parents and myself. It was our collective task to plan my future

vocational path as I had to choose electives for the coming years and these would determine what I could continue on to do at university. So here I was pondering the variety of vocational options available to me and time after time, I returned to psychology as a career choice, drawn to the mystic of it as well as the promise of having a life role that 'meant something'.

Did I even truly understand at this time what psychology was or what a psychologist does? Probably not and although I don't recall with clarity, I suspect that in my naïve teenage mind, I thought that, by studying psychology, I would learn all the answers. I would know why people behave the way they do, I would know why people think the way they do, I would know why people feel the way they do, I would know exactly 'what controls what' within the human brain and most of all, I would know how to 'fix' it. I would be able to help anybody that had some disturbance in thought or behaviour or emotion. I would understand how people act in groups, how children develop and how we learn. From this early point in my life, I had put on my rose-coloured glasses and, in my naivety, adopted a professional stance, namely the stance of the all-knowing and all-conquering professional.

And I didn't waver, not once in the next three years after I chose this life path did I veer off course. I completed Year 12, achieved the marks required to enter a Bachelor of Science degree at the University of Melbourne and nominated my major in psychology (with a minor in genetics thrown in for good measure), all with the intention of becoming the professional that I had decided to be. I had done very well at school so university should be a breeze. I had it all planned, my life was settled, I would be successful, I would have purpose and direction and I would be able to help others.

With my mother being a nurse, it is perhaps not surprising that I chose to

follow a path in the helping professions and yet as I write this doctoral thesis in my 37th year of life, I find that I am nowhere near where I had envisaged. I don't really understand human cognition, behaviour or emotion in the all-knowing way that I expected. I can't predict how people will behave in groups or how people learn and I can't 'fix' people. Indeed, my current world-view is that this is a task that can not be achieved in the way that I had anticipated or hoped. What appears realistic for me now is to understand some minute aspects of thought, behaviour and emotion within the chosen substantive area that I have selected for the completion of this research. And so this is my endeavour.

How I reached this conclusion is as much a journey of discovery as the one I aim to achieve through my research but one which defines who I am and how I came to be at this point. What I will tell you of next is historical. It tells of this journey, from the naïve teenager to the assuming professional with rose coloured glasses. And it tells of how I lost those rose-coloured glasses, was left in the dark, blind and fumbling to understand the simplest of things. It tells the story of how I had to find my way back, to be able to see clearly again, but no longer through rose-coloured glasses, but in the bright light of reality, human suffering and human experience.

Wandering Aimlessly

So I completed my Bachelor of Science with a major in psychology and a minor in genetics, followed by a Graduate Diploma of Applied Science, Professional Psychology at Ballarat University College. And make no mistake; these years were tough for me. I found that it didn't come quite as easily to me as I thought it would have. I had to work hard and I thank my school for providing me with the skills to persist. However, after all this study, hard work and commitment, I felt perplexed that

it had not offered me the personal or vocational satisfaction I had anticipated. After all this study, I didn't feel like a psychologist and in fact, by this time, had no real desire to pursue this career path. Indeed, at this point I was rather disillusioned with psychology as it didn't offer me the concrete answers that I still believed existed 'somewhere out there'. Surely I must have another calling. Despite being so sure back in Year 9, I must have been wrong. And so I drifted for many years, working in roles peripheral to psychology such as youth work and others completely removed such as those in the hospitality industry. I remained unsettled however. I had sacrificed so much of my post-school years, trying really hard to secure those plaques that sit proudly on my wall, yet felt that in terms of fulfilling an important vocational role, this clearly amounted to very little.

So after moving to Queensland in 1993, I decided to return to university and complete a Masters degree in Human Services, with a focus on rehabilitation counselling, still hoping and believing that a clinical role would be my life direction. Completing this degree in 1996, I felt much more assured that I was closer to my calling. Rehabilitation offered a more 'hands-on' and applied opportunity to help people and through this degree I realised that what I failed to gain from the study of psychology was a philosophy that recognised the systems within which we live and the way in which these systems shape who we are and what we do. I felt much closer to the core values I held than I had throughout my entire educational life. However, my opportunity to pursue a vocation in this area was cut short when I fell pregnant with my first child towards the completion of my Masters. So I graduated from my degree and had another lovely plaque to place on my wall yet still hadn't found my vocation. Well maybe not completely true. I felt like I had, I felt like the all-knowing professional I had always wanted to be. It was just a matter of getting out there and

doing it but that would have to wait. For financial reasons I continued, as I had throughout this period of study, working in a completely different role in insurance until my first child was born in June 1997. At this point, I was vocationally at a standstill. I couldn't work and be a first time mum at the same time so I had some time off. I felt comfortable with this however, after having worked and studied since leaving school. I had earned a rest and my career could wait a little longer.

The Worst Day of my Life

A phone call from my mother at 6.45pm on Friday September 12, 1997, less than 3 months after my daughter was born changed my life forever and became the catalyst for not only my ongoing career path but also the context within which this doctoral research emerged. My brother had been hit by a car crossing the road and his injuries were numerous. These included a badly broken leg (near hip), a bruised and damaged left lung, dislocated left shoulder and deep scars in his right hand. But this wasn't all. The one injury, given my educational background that I dreaded to hear emerged shakily through my mother's voice. 'He has head injuries, is unconscious and his condition is critical'. I was at an intersection, but this time I had no choices. The road that I would follow had been thrust upon me by fate.

Although I knew that this meant my own life and the life of others around me had forever changed, the coming years would challenge all that I thought I knew about injury and disability and rehabilitation. No longer would my experience of disability and my notions of rehabilitation be filtered through a textbook. No longer would I be able to reduce the concepts of autonomy, self-determination, social support and human worth to that which was advocated by rehabilitation professionals. The fact is that working with injury and disability through the rose-coloured glasses and

espoused values of the rehabilitation profession and living it were two different things. And the void was larger than anyone who has not been personally touched by this experience could understand.

My previous life experiences and education held opposing functions, both good and bad. On the one hand, they helped me to understand the continuous terminology, jargon and hidden messages that the medical and allied health professions conveyed and assisted me to become the conduit through which my parents could understand the enormity of the situation. They helped me to call on networks and colleagues and resources that the layman couldn't possibly hope to have in situations where comprehension failed me. They helped me to rationalise, objectify and distance myself in some instances where the pain was too much. But they failed me miserably in trying to plan and prepare for what lay ahead. The simple fact is, the void was too big between the ideal (as I knew it) and the actual (as I lived it). What should happen (according to rehabilitation philosophy and espoused practice) doesn't. Not all rehabilitation professionals truly value the 'whole' person, not all rehabilitation professionals understand the social construction of disability or believe in social justice and not all rehabilitation professionals have the capacity for empathy that I believed they did. What happened? Had I been lied to for all this time or were these rehabilitation professionals still looking through the same rose-coloured glasses that I had now lost. This I will probably never really know because I cannot return to the 'all-knowing professional' paradigm within which I previously existed. I now had two hats, one professional and the other personal, but without the capacity to ever truly remove one hat and wear the other. These roles were merged and it was my challenge to make them complement rather than oppose each other. Not an easy task.

The situation required me to call on all my resources, both internal and

external, to help guide me through that dark tunnel within which my brother nearly died, but from which he survived a traumatic brain injury and emerged changed but triumphant. But a brain injury doesn't just happen to the person that is injured. As Lezak (1988) put it, an acquired brain injury (ABI) is a family affair. The family is forever changed, not just by the injury itself, or by the remaining impairments to 'body structure or function', or by the 'activity and participation restrictions' for the injured individual, but also by the rehabilitation environment and the way in which each family member's life interacts with and is changed by the rehabilitation experience.

The despair of the intensive care unit, the uncertainty regarding life or death and the machines that constantly beep and instigate a mini tornado of anxiety each time can never be forgotten. There is the agitation of your family member in their unconscious state paralleled by the hope that (despite knowing different) alights each time they open their eyes, or take an independent breath, or squeeze your hand, and the hope that is crushed each time that progress is not noted. These are pervasive aspects of the family's every living minute during these early few weeks or months and for some, years. And in hindsight, after speaking with my brother many years later, are experiences that belong with the family. The injured person is usually blissfully unaware (or at least this was so in our situation). Thank god for small mercies.

Nothing can prepare you for this. Although the intensive care unit and hospital experience was something that was not so familiar to me, it was something that was familiar to my mother. As a professional, you may have seen this happen to someone else and their family a million times and, with your professional hat on, maintained a 'safe' distance. But when it is your mother, father, sibling, or child that you see lying helpless hooked up to a multitude of machines, the intensity of this experience is often

all-encompassing. There is no escape and avoidance is not an option. My mother still tells me stories now of times when she is called to the intensive care unit at the hospital where she works and how she feels sick to the stomach each time, how the flood of memories comes rushing back in torrents of anxiety. As I said, this lives with you forever and changes who you are but you would do it all over again if the need arose and you would cope, because you have no choice.

Friendships

Up to now, I have spoken of what this means to the family, as I experienced it as a sibling. However, even from this early stage, through my own grief, I had moments of awareness of the importance of friends. The importance of their presence for the injured person and the importance of their presence for the family to 'share the load' was something that I recognised very early following my brother's injury. For a single male in their mid-twenties, their friends are a larger part of their life than you are as a family member and this is reflected in your ignorance of what occurs in their life on a day-to-day basis. I didn't know what he was doing when that car hit him and I wasn't with him. But one of his friends was. I didn't have to see him lying unconscious on the road, but his friend did. I didn't have to see the passing doctor and then the ambos [paramedics] fight to stabilise him right there on the bitumen. But his friend did. And even before the accident, I didn't know where he was the night before. He was with his friends, the same people he lived with and played sport with and went out with. These people were the most important people in his life at that point in time. And I was acutely aware of this in the early days. They helped to fill in the gaps in my knowledge.

What slowly emerged during these early days following my brother's injury

was also an awareness of not only the importance of friends, but also their relative exclusion from the rehabilitation setting. They were never included, apart from being at the end of a Chinese whispers chain that started with the medicos, passed through nurses, the family and onto them. And to be honest, although aware of it, as a family member, you hold these notions of mutual exclusivity, almost as if at this point you felt like they had no right to be there. So, although aware of their exclusion and to some degree supportive of their exclusion at the time, I can reflect now on the possible impact that this may have had for these people. No one really considered how this affected them, despite the fact that their friend as they knew them was lying unconscious in a hospital bed. How did they observe and assimilate the image of their friend through the indignity of restraints or the gut-wrenching sound of the nasogastric tube being reinserted after it had been pulled out for the tenth time that day? Nobody stopped to consider how traumatic this must have been for them. No-one explained to them that the person, who would emerge, after all the rehabilitation and recovery, would probably not be the same person they knew before. No-one offered them counselling, or included them in physiotherapy sessions, or invited them to take their friend out for the day. And most of all, nobody explained that the injured person would need them, as friends, more than ever during their period of recovery.

And yet early on, they came in numbers, waiting patiently outside the intensive care unit for their 'turn of two' to come. They tried to help and would often sit there talking to my brother, telling about all the 'days of our lives' dramas that permeated their 'pre-injury' conversations, with my brother being a passive recipient. Other times they would apprehensively ask questions of the staff. At other times they would just sit there, the concerned looks on their faces betraying some signs of their inner fears. But as time passed, these moments became fewer. As my brother slowly

but surely emerged from unconsciousness, the visits became less. There wasn't a time where I could say this changed, perhaps because of my own oblivion or perhaps because it happened so gradually as to escape notice. But in the end, they just seemed to fade away, pursuing their own lives and allowing family the exclusive right to fill the days.

These fleeting early thoughts on the importance of friends were encapsulated in time by the need to live the experience of recovery with my brother. They didn't engender daily thought; they just occurred as momentary glimpses of reality. So day after day, for three months, I drove the 30 plus kilometres with a baby in tow, to watch my brother give the fight of his life. From the intensive care unit of the Royal Brisbane Hospital, to the high dependency unit across the hall and from there to the Brain Injury Rehabilitation Unit at the Princess Alexandra Hospital, this experience alone could fill a book. Indeed, I kept a diary of this time that may, one day in the future, provide the basis for sharing this experience. For the moment, suffice to say, this was an extremely difficult and trying time, filled with tears, anger, frustration, anxiety, sadness and loss. And it heralded the fact that my rose-coloured glasses existed no more, I was not the all-knowing professional, I was just a little boat in a big sea, drifting aimlessly in the vast expanse of this thing we call 'rehabilitation'.

However, periodically, my thoughts on friendship would resurface, prefaced by some incident that had occurred, typically perceived to be negative either by my parents, my brother or myself. Indeed, there were times where my own feelings towards my brother's friends were overrun by anger and hurt and these remain clear memories, signalled by the intensity of the emotion that accompanied them. I recall the female friend, who spent so much time in the early days just talking and touching my brother, trying desperately to uncover memories and awareness. And I remember

when she stopped coming to see him after realising that recovery in many respects followed its own timeline. I remember the time, while my brother was in the Brain Injury Rehabilitation Unit, when the friends he shared a house with prior to his injury, decided to move out, leaving the house in a state of disrepair and mess, and simultaneously leaving my brother with the massive bond debt, which of course my parents covered. I remember the times following his discharge from hospital when his friends excluded him from involvement in recreational activities because they didn't think they would be able to help him if he got into trouble. And I remember the raw emotional pain that was obvious each time he was disappointed, or forgotten, or deliberately excluded.

In these early days, my sisterly protectiveness was fierce and I blamed those friends. Why couldn't they just support him? Why was their friendship no longer a part of their everyday lives? How could they go on with their lives while he struggled to regain some semblance of normality to his own? The immediacy of this situation left me with an overwhelming sense of the unfairness of life. As if he hadn't been through enough already.

Friendships in Hindsight

Hindsight is a wonderful thing however and it was not until many years later that reflection enabled me to let go of these feelings of anger. In more recent years, since commencing this doctoral research, curiosity and contemplation has replaced anger and frustration. What has emerged is an awareness of the fact that friendships are a process unto themselves. Despite what we may see as a family member or as a rehabilitation professional, friendships follow an independent process, a process of maintenance or dissolution in the wake of trauma and injury. However, nobody truly

understands this process and I would even go as far to say that nobody has really recognised that this process even exists. It is only at the times that this friendship process intersects with the 'family process' or the 'rehabilitation process' that we become aware of it. However, these intersections are so brief, that we fail to understand that friendship is a process rather than a collection of static moments in time. As family members or rehabilitation professionals, we are outsiders in this process, mere spectators. Sometimes, we may throw rubbish on the field that interrupts the game, but in the end, the outcome of the game rests with the major players, namely the injured person and their friends. Their experiences of injury and friendship are their own, independent of the family experience and maybe at times, independent of each other.

What are the motives for their friendship behaviours? How do they feel about friendship? What do they think about friendship? What level of reciprocity exists in maintaining that friendship? What level of awareness do they have of their friendship and the direction that it follows? What is the rehabilitation experience for the friends, as outsiders, as people who stand in the sidelines, but don't receive any cues or props to assist them? Would these friendships have stood the test of time without the injury or did we just attribute a natural course of events to the injury? The simple answer is we don't know and there is probably no rehabilitation professional or family member who could come close to answering these questions given our current state of knowledge. These are questions for now, to be asked of the major players. The importance of friendships has not been recognised, not by the rehabilitation professionals, not by the families and even in some instances, not by the injured individual themselves, until it was too late. It was with growing realisation of this fact that I returned to work...

A Career Returned

My return to work following my brother's injury and the birth of my first child took the form of some casual research work with the university and from this emerged a decision to do my Masters by Research, which then developed into a doctoral thesis. From this, emerged a position as Research and Development Officer with the Transitional Rehabilitation Program, a state health funded transitional rehabilitation service for people with Spinal Cord Injury (SCI). As so my professional career and my 'life path' as I see it now emerged, not as a clinician but as a researcher. And at last, I felt I had found what I had been looking for. Indeed, it became clear to me at this point in time, that I could no longer fulfil the role of the 'clinician', my personal hat covered too much of my head. However, my desire to exist in the 'real world' of the clinical setting, rather than in academia was realised within this position. I wasn't sitting in the ivory tower of academia, but in the real world, with real people who had real injuries, real families and real losses. So I witnessed on a daily basis, whether through personal contact, or involvement with a clinical team, the struggle that injured people and families had trying to negotiate the rehabilitation system. Sometimes that system worked extremely well, usually for certain types of people, those whose physical impairment itself represented the major personal aspect of their injury. In other instances, the system failed dismally, for those who didn't fit the norm, for those whose psychological or social needs were of overarching relevance, for those whose cultural backgrounds were different, for those who experienced cognitive impairments as a result of their injury and for those who were just that little bit 'rebellious'. Research offered for me the opportunity to see these personal losses and triumphs, sometimes vicariously and other times personally. It allowed me the space to examine

the systems in rehabilitation without being one of the key stakeholders in the process. It allowed me objectivity while still allowing compassion. And it allowed me to realise that our system often fails to provide the support that people need. I could develop research agendas that would not only give me publications as a professional, but would provide direction for practice, to make real changes that would enhance the lives of people who have been injured and their families. I had found my calling and to this day, believe that this is where I can make the largest difference.

Of course, the life stories I see and hear in SCI rehabilitation offer me a different perspective to those in ABI rehabilitation, each with their positives and negatives, each with their own idiosyncrasies and philosophies. For people with SCI, there was an overwhelming focus on the physical, often leaving large gaps in providing adequate psychosocial support. On the other hand, in SCI rehabilitation, there was greater autonomy provided to the injured person because at least they had 'insight', something that is often a mark against the reputation of and struggle for autonomy for people with brain injury. For people with ABI, the psychosocial was often foremost, but in many instances attributed merely to the nature of the injury itself, and therefore perceived as 'untreatable'. Each rehabilitation system had parallel challenges. Both systems struggled against the dominance of the medical model, the focus on the individual, the failure to consider the whole person and the entirety of their social circumstances, the inadequacy of the system to facilitate a return to valued social and vocational roles and in both, an overwhelming failure of the system to recognise and value the role of friends. In SCI rehabilitation, I have experienced this within my 'professional' role alone. In ABI rehabilitation, I had experienced this on a personal level but would later experience this as a researcher when I took a part time position in a Research and Development role with the Acquired Brain Injury Outreach

Service (ABIOS), a community rehabilitation service for people with ABI.

As I prepare this thesis, I continue to hold both these research roles in SCI and ABI rehabilitation. I remain entrenched within the rehabilitation setting, although never truly removing the personal experience that set me on this life path. And therefore I write this thesis from a position of inclusion in the clinical rehabilitation arena. It is not just a thesis to ensure that I complete a doctorate. In fact, I place very little importance on the 'glory' of the completed task. This thesis is, however, of critical relevance to me, both as a professional and as a person. It is true that the roads that we follow lead us in unique directions and I am sure that had it not been for my brother's injury I would not be where I am today.

Does my personal position and history impact on how I see my work and how I continue with this thesis. It surely does and I would be disappointed if it didn't. And yet it is a point from which I may be and have been criticised or questioned, particularly in the professional arena. I have been asked whether I could maintain objectivity, whether I show too much empathy for clients, whether I act like an advocate rather than a professional. If these are my greatest sins as a professional, then I gladly accept them, because I don't ever want to lose the ability to hear the stories of clients and to fight to improve the way in which we help them return to their lives. I don't ever want to be detached from their realities and I don't ever want to hear myself calling a client 'the T4 paraplegic'. This person is not defined by their injury, but by who they are as a person. Through this thesis, I hope that I can do justice to the experiences of people who have SCI or ABI as well as doing justice to the experiences of their friends, the forgotten majority. The truth is I don't ever want to wear those rose-coloured glasses again, reality becomes too blurry.

INFORMATION SHEET

SOCIAL SUPPORT FOLLOWING SPINAL CORD INJURY: A QUALITATIVE EXAMINATION OF FRIENDSHIPS

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This research project is being conducted to fulfil the requirements for a doctoral degree by Ms Melissa Kendall. Dr Elizabeth Kendall is the supervisor and chief investigator of the study.

Project Aims

This research project aims to find out about the friendships and social support that friends provide to people with spinal cord injury. To do this, the research will involve talking to people who have recently sustained a spinal cord injury and a close friend that is nominated by the injured person. Specifically, the project aims to:

- ❖ Find out about the social support that is needed and provided between friends during the first six months following injury
- ❖ Find out about the benefits that friendships provide and the difficulties that friendships experience following injury

Why is this study important?

Recent research suggests that, although friendships can be a particularly important source of social support to people who have sustained injuries, there are often difficulties experienced that mean those friendships break down and people lose contact. Currently, rehabilitation providers have very little information about these difficulties as perceived by the injured person and their friends. This means that rehabilitation providers often don't know how best to help people maintain their friendships following injury. It is expected that this study will assist rehabilitation providers to identify better ways to assist people with spinal cord injury and their friends to provide support to each other.

What does the study involve?

If you agree to be involved in this research, you will participate in three interviews. One interview will take place although you are still in hospital or just after discharge and the other two interviews will take place at one month and 4-6 months following your discharge from hospital. These interviews will be about one hour long and will be conducted at a place that you nominate. Attached to this sheet is a list of the types of questions that will be asked of you in the interviews. You will also be asked to nominate a close friend to be involved in the study. They will complete interviews at similar times.

The information that you provide in these interviews will be confidential and only available to the researchers. In other words, your friend will not have access to the information that you provide in your interviews and you will not have access to the information that they provide in their interviews. The interviews will be audio taped. The information that is taped during the interview will be typed out and the tape itself will be destroyed. The typed copy of the interview will have your name and any identifying details removed so that your confidentiality is maintained.

If you are agreeable, we would also like to access your hospital records to understand more fully the injuries that you have sustained.

What are my rights and how will they be protected?

Your participation in this study is completely voluntary and you can withdraw from the study at any time without providing reasons for your withdrawal. Your withdrawal will not affect the care or treatment that you receive in any way. You have the option to have a friend or relative present with you when this study is explained to you.

It is not anticipated that the research study will involve any risks or costs to yourself or your nominated friend. It is important that you read the interview questions through prior to signing the attached consent form and that you feel comfortable in answering those questions however. Should you feel discomfort at any stage during the interviews, the researchers involved in this study are qualified counselors and will be able to assist you.

The information that you provide will be used in this study only and your name will not be made available to any other party. You have the right to ask questions at any time and the researchers can be contacted on the numbers listed at the top of this information sheet. Furthermore, the University requires that all participants be informed that if they have any complaints concerning the manner in which a research project is conducted, it may be given to the researcher, or, or if an independent person is preferred either

The University's Research Ethics Officer
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OR The Pro Vice-Chancellor
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Ph: (07) 3875 7343

The study has been approved by the Princess Alexandra Hospital Research Ethics Committee. The secretary can be contacted on 3240 5856.

At the completion of the study, you will receive feedback that will outline what the researchers found and how that information will be used to further improve services offered to people with spinal cord injury and their significant others.

Thank you for your assistance with this research project.

Appendix C

Consent Form

**SOCIAL SUPPORT FOLLOWING SPINAL CORD INJURY: A
QUALITATIVE EXAMINATION OF FRIENDSHIPS**

**Ms Melissa Kendall and Dr Elizabeth Kendall
Centre for Human Services, Griffith University**

The project aims to find out about the social support that people receive from friends following spinal cord injury. To do this, the project will involve talking to people who have experienced injury and their friends. The information you provide will be used to improve the assistance available to people with injuries and their friends in the future.

If you agree to be involved in this research, you will be asked to complete three (3) interviews to discuss the types of social support that you need and receive from your friends. These interviews will take about **1 hour** each to complete and will be audio taped. One interview will be conducted while you are still in hospital or just after discharge. The other two interviews will occur at one month and six months after you have been discharged from hospital. You will be asked to nominate a close friend who, if agreeable, will also be involved in interviews at similar times. The information that you provide will not be available to your friend and the information that they provide will not be available to yourself.

If you are in agreement, we would also like to access the medical information that is available about your accident and your injuries so we can fully understand what you have been coping with.

Please read the following and indicate your decision below.

- **My participation is voluntary and I can withdraw from the project at any time without affecting my care or treatment.**
- **Any information I provide will remain confidential and my name, or any identifying information, will not appear on that information.**
- **Information obtained will only be used for this study and my name will not be given to any other researcher**
- **I have been given the option of having a relative or friend present when the study was explained to me and I have been provided a copy of the questions that will be asked of me during the interviews**
- **I will receive feedback about the findings of the study and can contact the researchers at anytime (Telephone: (07) 3406 2307)**

ID NO:.....

I have read the information sheet and the consent form. I agree to participate in the 'Social Support following Spinal Cord Injury' project and give my consent freely. I understand that the project/study will be carried out as described in the information statement, a copy of which I have retained. I realise that whether or not I decide to participate is my decision and will not affect my care and treatment. I also realise that I can withdraw from the study at any time and that I do not have to give any reasons for withdrawing. I have had all questions answered to my satisfaction.

Signed: Date:/...../.....
Participant

Signed: Date:...../...../.....
Investigator

Signed: Date:...../...../.....
Witness

INFORMATION SHEET (FRIEND)

SOCIAL SUPPORT FOLLOWING SPINAL CORD INJURY: A QUALITATIVE EXAMINATION OF FRIENDSHIPS

Researchers

Ms Melissa Kendall
(B.Sc, Grad.Dip.Psych. MHumSrv)
School of Human Services
Griffith University
Ph: (07) 3406 2307

Dr Elizabeth Kendall
(B.A., Grad.Dip.Psych, PhD)
School of Human Services
Griffith University
Ph: (07) 3382 1202

This research project is being conducted to fulfil the requirements for a doctoral degree by Ms Melissa Kendall. Dr Elizabeth Kendall is the supervisor and chief investigator of the study.

Project Aims

This research project aims to find out about the friendships and social support that friends provide to people with spinal cord injury. To do this, the research will involve talking to people who have recently sustained a spinal cord injury and a close friend that is nominated by the injured person. Specifically, the project aims to:

- ❖ Find out about the social support that is needed and provided between friends during the first six months following injury
- ❖ Find out about the benefits that friendships provide and the difficulties that friendships experience following injury

Why is this study important?

Recent research suggests that, although friendships can be a particularly important source of social support to people who have sustained injuries, there are often a difficulty experienced that means those friendships break down and people lose contact. Currently, rehabilitation providers have very little information about these difficulties as perceived by the injured person and their friends. This means that rehabilitation providers often don't know how best to help people maintain their friendships following injury. It is expected that this study will assist rehabilitation providers to identify better ways to assist people with spinal cord injury and their friends to provide support to each other and maximise the benefits that friendships can offer.

What does the study involve?

Your friend has nominated you as someone who is a close friend to them. Your participation in this study is your decision however and you do not have to participate just because your friend nominated you. If you agree to be involved in this research, you will participate in three interviews. One interview will take place while your friend is still in hospital or just after their discharge and the other two interviews will take place at one month and 6 months following their discharge from hospital. These interviews will be about one hour long and will be conducted at a place that you

nominate. Attached to this sheet is a list of the questions that will be asked of you in the interviews.

The information that you provide in these interviews will be confidential and only available to the researchers. In other words, your friend will not have access to the information that you provide in your interviews and you will not have access to the information that they provide in their interviews. The interviews will be audio taped. The information that is taped during the interview will be typed out and the tape itself will be destroyed. The typed copy of the interview will have your name and any identifying details removed so that your confidentiality is maintained.

What are my rights and how will they be protected?

Your participation in this study is completely voluntary and you can withdraw from the study at any time without providing reasons for your withdrawal. Your withdrawal will not affect the care or treatment that your friend receives or the services that are offered to you in any way.

It is not anticipated that the research study will involve any risks or costs to yourself or your friend. It is important that you read the interview questions through prior to signing the attached consent form and that you feel comfortable in answering those questions however. Should you feel discomfort at any stage during the interviews, the researchers involved in this study are qualified counsellors and will be able to assist you.

The information that you provide will be used in this study only and your name will not be made available to any other party. You have the right to ask questions at any time and the researchers can be contacted on the numbers listed at the top of this information sheet. Furthermore, the University requires that all participants be informed that if they have any complaints concerning the manner in which a research project is conducted, it may be given to the researcher, or, or if an independent person is preferred either

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The study has been approved by the Princess Alexandra Hospital Research Ethics Committee. The secretary can be contacted on 3240 5856.

At the completion of the study, you will receive feedback that will outline what the researchers found and how that information will be used to further improve services offered to people with spinal cord injury and their significant others.

Thank you for your assistance with this research project.

Appendix E

Consent Form- Friend

**SOCIAL SUPPORT FOLLOWING SPINAL CORD INJURY: A
QUALITATIVE EXAMINATION OF FRIENDSHIPS**

**Ms Melissa Kendall and Dr Elizabeth Kendall
Centre for Human Services, Griffith University**

The project aims to find out about the social support that friendships can provide to people following injury. To do this, the project will involve talking to people who have experienced spinal cord injury and their friends. Your friend has nominated you as a close source of support to them. The information you provide will be used to improve the assistance available to people with injuries and their friends in the future.

If you agree to be involved in this research, you will be asked to complete three (3) personal interviews to discuss the types of social support you believe your friend needs and the types of social support that you provide to your friend. These interviews will take about **1 hour** each to complete and will be audio taped. Your first interview will occur although your friend is still in hospital or just after their discharge. You will then have interviews at one month and six months after they have been discharged from hospital. Your friend will be involved in interviews at similar times. Any information that you provide during these interviews will not be available to your friend and the information that they provide will not be available to yourself.

Please read the following and indicate your decision below.

- **My participation is voluntary and I can withdraw from the project at any time without affecting the care my friend is given or the services offered to me.**
- **Any information I provide will remain confidential and my name, or any identifying information, will not appear on that information.**
- **Information obtained will only be used for this study and my name will not be given to any other researcher**
- **I have been provided a copy of the questions that will be asked of me during the interviews**
- **I will receive feedback about the findings of the study and can contact the researchers at anytime (Telephone: (07) 3406 2307)**

_____ **ID NO:.....**

I have read the information sheet and the consent form. I agree to participate in the 'Social Support following Spinal Cord Injury' project and give my consent freely. I understand that the project/study will be carried out as described in the information statement, a copy of which I have retained. I realise that whether or not I decide to participate is my decision and will not affect my access to services or those provided to my friend. I also realise that I can withdraw from the study at any time and that I do not have to give any reasons for withdrawing. I have had all questions answered to my satisfaction.

Signed: Date:/...../.....
Participant

Signed: Date:...../...../.....
Investigator

Signed: Date:...../...../.....
Witness

Appendix F

Friendships following spinal cord injury

Dear

Thank you for your continued involvement in this important research that we are conducting within the Queensland Spinal Cord Injury Service. By sharing your experiences with us, this has helped us to better understand the benefits and challenges that friendships face following injury. We are writing to you today for two reasons.

1. To give you an update on what we have found so far from the study
2. To ask for your help in identifying family members to also participate in the study

What have we found?

Friendships can take many different directions after people sustain a spinal cord injury. One of the initial things that we discovered is that there is often a delay before friends find out about the injury and often the news is communicated through family members. As such, family members can be the first point of contact with friends after injury, especially when friends live a long way away from Brisbane. Another interesting finding is that many people use their mobile phone for keeping in touch with friends while still in hospital. This is very important for people whose friends cannot get into the hospital to see them.

What more do we need to know?

Because many people have told us that family members can be an early point of contact with friends, we thought that it would be a good idea to speak to some family members about this. Therefore, we are hoping to identify up to ten family members to also participate in the study. The family members that we want to talk to are the ones who have had the most contact with your friends (it is OK if this is not the family member who has helped you the most in other ways). If you have a family member who would be important for us to talk to, you can let us know their details by calling Melissa Kendall on 3406 2307.

Alternatively, we may telephone you in the near future to ask you whether there is anyone that you have identified. It would also be a good idea to have a talk with this person first just to make sure that they feel OK about being asked to participate in the study.

Melissa Kendall
Principal Investigator

Ronita Neal
Senior Research Assistant

PARTICIPANT INFORMATION SHEET: Family

SOCIAL SUPPORT FOLLOWING SPINAL CORD INJURY: A QUALITATIVE EXAMINATION OF FRIENDSHIPS

Researchers

Ms Melissa Kendall
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Ph: (07) 3406 2307

Dr Elizabeth Kendall
(B.A., Grad.Dip.Psych, PhD)
School of Human Services
Griffith University
Ph: (07) 3382 1202

This research project is being conducted to fulfil the requirements for a doctoral degree by Ms Melissa Kendall. Dr Elizabeth Kendall is the supervisor and chief investigator of the study.

Project Aims

This research project aims to find out about the friendships and social support that friends provide to people with spinal cord injury. To do this, the research will involve talking to people who have recently sustained a spinal cord injury, their close friends, family members and rehabilitation staff. Specifically, the project aims to:

- ❖ Find out about the social support that is needed and provided between friends during the first six months following injury
- ❖ Find out about the benefits that friendships provide and the difficulties that friendships experience following injury

Why is this study important?

Recent research suggests that, although friendships can be a particularly important source of social support to people who have sustained injuries, there are often difficulties experienced causing those friendships to break down. Currently, rehabilitation providers have very little information about these difficulties as perceived by the injured person, their friends and family members. This means that rehabilitation providers often don't know how best to help people maintain their friendships following injury. It is expected that this study will assist rehabilitation providers to identify better ways to assist people with spinal cord injury and their friends to provide support to each other and maximize the benefits that friendships can offer.

What does the study involve?

If you agree to be involved in this research, you will participate in one interview. This interview will take place at approximately one month following the discharge from hospital of your family member. This interview will be about one hour long and will be conducted at a place that you nominate. Attached to this sheet is a list of the types of questions that will be asked of you in the interview.

The information that you provide in these interviews will be confidential and only available to the researchers. In other words, your family member will not have access

to the information that you provide in your interviews and you will not have access to the information that they provide in their interviews. The interviews will be audio taped. The information that is taped during the interview will be typed out and the tape itself will be destroyed. The typed copy of the interview will have your name and any identifying details removed so that your confidentiality is maintained.

What are my rights and how will they be protected?

Your participation in this study is completely voluntary and you can withdraw from the study at any time without providing reasons for your withdrawal. Your withdrawal will not affect the care or treatment that you or your family member receives in any way. You have the option to have a friend or relative present with you when this study is explained to you.

It is not anticipated that the research study will involve any risks or costs to yourself or your family member. It is important that you read the interview questions through prior to signing the attached consent form and that you feel comfortable in answering those questions however. Should you feel discomfort at any stage during the interviews, the researchers will organise assistance for you with your consent.

The information that you provide will be used in this study only and your name will not be made available to any other party. You have the right to ask questions at any time and the researchers can be contacted on the numbers listed at the top of this information sheet. Furthermore, the University requires that all participants be informed that if they have any complaints concerning the manner in which a research project is conducted, it may be given to the researcher, or, or if an independent person is preferred either

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The study has been approved by the Princess Alexandra Hospital Research Ethics Committee. The ethics manager can be contacted on 3240 5856.

At the completion of the study, you will receive feedback that will outline what the researchers found and how that information will be used to further improve services offered to people following injury and their significant others.

Thank you for your assistance with this research project.

Appendix H

Consent Form: Family

**SOCIAL SUPPORT FOLLOWING SPINAL CORD INJURY: A
QUALITATIVE EXAMINATION OF FRIENDSHIPS**

**Ms Melissa Kendall and Dr Elizabeth Kendall
School of Human Services, Griffith University**

The project aims to find out about the social support that people receive from friends following spinal cord injury. To do this, the project will involve talking to people who have experienced injury, their friends, family members and rehabilitation staff. The information you provide will be used to improve the assistance available to people with injuries and their friends and family in the future.

If you agree to be involved in this research, you will be asked to complete one interview to discuss your perspectives of friendship following injury. This interview will take about **1 hour** each to complete and will be audio taped. This interview will be conducted approximately one month after your family member is discharged from hospital. The information that you provide will not be available to your family member and the information that they provide will not be available to yourself.

Please read the following and indicate your decision below.

- **My participation is voluntary and I can withdraw from the project at any time without affecting the care or treatment my family member or myself receive.**
 - **Any information I provide will remain confidential and my name, or any identifying information, will not appear on that information.**
 - **Information obtained will only be used for this study and my name will not be given to any other researcher**
 - **I have been given the option of having a relative or friend present when the study was explained to me and I have been provided a copy of the questions that will be asked of me during the interviews**
 - **I will receive feedback about the findings of the study and can contact the researchers at anytime (Telephone: (07) 3406 2307)**
-

ID NO:.....

I have read the information sheet and the consent form. I agree to participate in the 'Social Support following Spinal Cord Injury' project and give my consent freely. I understand that the project/study will be carried out as described in the information statement, a copy of which I have retained. I realise that whether or not I decide to participate is my decision and will not affect my care and treatment. I also realise that I can withdraw from the study at any time and that I do not have to give any reasons for withdrawing. I have had all questions answered to my satisfaction.

Signed: Date:/...../.....
Participant

Signed: Date:...../...../.....
Investigator

Signed: Date:...../...../.....
Witness

Participant Information Sheet for Staff

SOCIAL SUPPORT FOLLOWING SPINAL CORD INJURY: A QUALITATIVE EXAMINATION OF FRIENDSHIPS

Researchers

Ms Melissa Kendall
(B.Sc, Grad.Dip.Psych. MHumSrv)
School of Human Services
Griffith University
Ph: (07) 3406 2307

Dr Elizabeth Kendall
(B.A., Grad.Dip.Psych, PhD)
School of Human Services
Griffith University
Ph: (07) 3382 1202

This research project is being conducted to fulfil the requirements for a doctoral degree by Ms Melissa Kendall. Dr Elizabeth Kendall is the supervisor of the study.

Project Aims

This research project aims to find out about friendships following spinal cord injury. To do this, the research will involve talking to a range of people who have knowledge of friendship during this time, including people who have sustained an ABI or SCI, their friends and rehabilitation staff. Specifically, the project aims to:

- ❖ Find out about the nature of friendships and interactions between friends following injury
- ❖ Find out about the benefits that friendships provide and the difficulties that friendships experience following injury
- ❖ Find out about how personal and environmental factors currently affect friendship during rehabilitation
- ❖ Find out how rehabilitation services may be enhanced to facilitate friendship maintenance and the development of new friendships following injury

Why is this study important?

Recent research suggests that, although friendships can be a particularly important source of social support to people who have sustained traumatic injuries, there are personal and environmental factors that impact on friendships and that means those friendships break down and people lose contact. Currently, there is very little research information about how these difficulties are perceived by the injured person, their friends and their rehabilitation providers. This means that rehabilitation providers often don't know how best to help people maintain their friendships following injury. It is expected that this study will assist rehabilitation providers to identify better ways to assist people with traumatic injury and their friends to provide support to each other and maximise the benefits that friendships can offer.

What does the study involve?

If you agree to be involved in this research, you will participate in one interview. This interview can be as long or as short as you want.

The information that you provide in these interviews will be confidential and only available to the researchers. The interviews will be audio taped. The information that is taped during the interview will be transcribed within one month of the interview and the tape itself will be destroyed. The transcribed copy of the interview will have your name and any identifying details removed so that your confidentiality is maintained.

Participation, risks and complaints

Your participation in this study is completely voluntary and you can withdraw from the study at any time without providing reasons for your withdrawal. Your withdrawal will not affect you or your work environment in any way.

It is not anticipated that the research study will involve any risks or costs to yourself as all information gathered will be of a clinical rather than a personal nature. As such, you will not be required to sign a written consent form. By agreeing to participate in the interview, you will have provided your consent.

The information that you provide will be used in this study only and your name will not be made available to any other party. You have the right to ask questions at any time and the researchers can be contacted on the numbers listed at the top of this information sheet. Furthermore, the University requires that all participants be informed that if they have any complaints concerning the manner in which a research project is conducted, it may be given to the researcher, or if an independent person is preferred either

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The Pro Vice-Chancellor
Administration
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Nathan QLD 4111
Ph: (07) 3875 7343

This study has been also been approved by the Princess Alexandra Hospital Research Ethics Committee. Any complaints can be directed to the Ethics Manager, Anne Walsh, who can be contacted on 3240 5856.

At the completion of the study, you will receive feedback that will outline what the researchers found and how that information can be used to further improve services offered to people with spinal cord injury and their significant others.

Thank you for your assistance with this research project.

Appendix J

Example Interview Questions

The following questions are examples of what I may ask during each interview. You are not obligated to answer any question you do not wish to and you are not restricted to only answering these questions. If you have further details or information that you wish to share, you can expand on this list. If you are not clear on any of the following questions, please feel free to ask me to explain them to you.

1. Describe for me a little about your injury and your experiences in hospital since the time of your injury
e.g., How did your injury occur? What is your understanding of your injury? How long have you been in hospital? What has it been like in hospital?
2. Describe for me a little about yourself prior to your injury
e.g. What were you like as a person? What were your interests and hobbies? What was important to you?
3. Describe for me a little about yourself at the moment
e.g., What are you like as a person now? What are your current interests and hobbies? What is important to you now? How have you changed as a person?
4. Describe for me a little about your friendship with (*your nominated friend*) and what it was like prior to your injury
e.g., How often did you see each other? How close was your friendship? What types of things did you do together? Who initiated contact and outings? What types of support did you want from your friend? What types of support did your friend provide? How did the friendship make you feel? What were the benefits or positives of the friendship? What were the difficulties or negatives of the friendship? What was the happiest time that you had with your friend prior to your injury? What was the most difficult time that you had with your friend prior to your injury?
5. Describe for me a little about your friendship with (*your nominated friend*) and what it has been like since your injury
e.g., How often do you see each other? How close is your friendship now? What types of things did you currently do together? Who initiates contact and outings? What types of support do you currently want from your friend? What types of support does your friend currently provide? How does the friendship make you feel currently? What do you perceive as the current benefits or positives of the friendship? What are the current difficulties or negatives of the friendship? What is the happiest time that you have had with your friend since your injury? What is the most difficult time that you have had with your friend since your injury?

6. Describe for me the ways in which you think your injury has affected your friend
e.g., How have they changed as a person since your injury? How have their interests and hobbies changed since your injury? How do you think their thoughts and feelings towards your friendship have changed since your injury?
7. Do you feel that there has been a change in your friendship since your injury? If so....
 - a) What do you think has changed?
 - b) What do you think has caused this change?
8. What factors have helped your friendship with (*your nominated friend*) since your injury? (e.g. things you have done, things your friend has done, things staff or family have done, aspects of your surroundings, finances, resources, etc)
9. What factors have hindered your friendship with (*your nominated friend*) since your injury? (e.g. things you have done, things your friend has done, things staff or family have done, aspects of your surroundings, finances, resources, etc)

Appendix K

Example Interview Questions- Friends

The following questions are examples of what I may ask during each interview. You are not obligated to answer any question you do not wish to and you are not restricted to only answering these questions. If you have further details or information that you wish to share, you can expand on this list. If you are not clear on any of the following questions, please feel free to ask me to explain them to you.

1. Describe for me your understanding of your friend's injury and their experiences in hospital
e.g., How did their injury occur? How long have they been in hospital? What is your understanding of their injury? What has it been like in hospital for them? How has their injury impacted on them physically and mentally? What are the short and long term implications of the injury that they have sustained?
2. Describe for me a little about how your friend's injury has impacted on you personally?
e.g., How do you feel about it? How has it changed you as a person? How has it changed what is important to you? How has it changed your interests or hobbies?
3. Describe for me a little about your friendship with (*your friend*) and what it was like prior to their injury
e.g., How often did you see each other? How close was your friendship? What types of things did you do together? Who initiated contact and outings? What types of support did you want from your friend? What types of support did your friend provide? How did the friendship make you feel? What were the benefits or positives of the friendship? What were the difficulties or negatives of the friendship? What was the happiest time that you had with your friend prior to their injury? What was the most difficult time that you had with your friend prior to their injury?
4. Describe for me a little about your friendship with (*your friend*) and what it has been like since their injury
e.g., How often do you see each other? How close is your friendship now? What types of things did you currently do together? Who initiates contact and outings? What types of support do you currently want from your friend? What types of support does your friend currently provide? How does the friendship make you feel currently? What do you perceive as the current benefits or positives of the friendship? What are the current difficulties or negatives of the friendship? What is the happiest time that you have had with your friend since their injury? What is the most difficult time that you have had with your friend since their injury?

5. Describe for me the ways in which you think your friend's injury has affected them
e.g., How have they changed as a person since their injury? How have their interests and hobbies changed? How do you think their thoughts and feelings towards your friendship have changed?
6. Do you feel that there has been a change in your friendship since their injury? If so....
 - c) What do you think has changed?
 - d) What do you think has caused this change?
7. What factors have helped your friendship with (*your nominated friend*) since their injury? (e.g. things you have done, things your friend has done, things staff or family have done, aspects of their surroundings, finances, resources, etc)
8. What factors have hindered your friendship with (*your nominated friend*) since their injury? (e.g. things you have done, things your friend has done, things staff or family have done, aspects of their surroundings, finances, resources, etc)

Appendix L

Example Interview Questions- Family

The following questions are examples of what I may ask during each interview. You are not obligated to answer any question you do not wish to and you are not restricted to only answering these questions. If you have further details or information that you wish to share, you can expand on this list. If you are not clear on any of the following questions, please feel free to ask me to explain them to you.

1. Describe for me a little about your experiences since your family member had their injury
e.g., How did the injury occur? What is your understanding of the injury? What has it been like with your family member in hospital?
2. Describe for me a little about yourself
e.g., What are you like as a person? What are your current interests and hobbies? What is important to you? How has the injury of your family member impacted on you?
3. Describe for me a little about the friendships of (*the injured person*) and what they were like prior to their injury
e.g., How often did they see their friends? How close were their friendships? What types of things did they do together? What types of support did they provide each other? What were the benefits or positives of their friendships? What were the difficulties or negatives of their friendships? How was your relationship with their friends before their injury? What role, if any, did you play in their friendships?
4. Describe for me a little about the friendships of (*the injured person*) and what they have been like since their injury
e.g., How often do you see their friends? How close are their friendships now? What types of things do they currently do together? What types of support do they currently provide each other? What do you perceive as the current benefits or positives of their friendships? What are the current difficulties or negatives of their friendships? How is your relationship with their friends now? What role, if any, do you play in their friendships now?
5. Describe for me the ways in which you think your family members injury has affected their friends
e.g., How have they changed as a person? How have their interests and hobbies changed? How do you think their thoughts and feelings towards their friendship with your family member have changed?
6. What factors have helped your family member's friendships since their injury? (e.g. things your family member has done, things their friends have done, things staff or family have done, aspects of your surroundings, finances, resources, etc)

7. What factors have hindered their friendships since their injury? (e.g. things your family member has done, things their friends have done, things staff or family have done, aspects of your surroundings, finances, resources, etc)

Appendix M

Example Interview Questions- Staff

1. In the rehabilitation context, how frequently do clients discuss the issue of friendships? (either between themselves or with staff?)
2. What are the ways in which friends help people following SCI? (benefits of friendship)
3. What are the challenges that people with SCI face in maintaining pre injury friendships?
4. What factors do you think might contribute to whether friendships are maintained through this period?
 - a) personal (client)
 - b) familial (family)
 - c) unit (rehabilitation setting)
 - d) systemic (societal issues)
5. To what degree do you perceive gender to play a role in friendships of people with SCI?
6. To what degree do you perceive age to play a role in friendships of people with SCI?
7. How does informal support from fellow patients differ from pre-existing friendships?
8. How does formal support offered through peer support differ from more informal supports?
9. From your observations, how do the interactions between friends and the injured person differ from those you might observe between friends in typical circumstances?
10. What difference does it make to friendships if the client also has cognitive impairments?
11. From your experience, how does a person's injury on their close friends?
12. What supports do you perceive exist for the friends of the injured person?
13. To what degree are friends made aware of these supports?
14. To what degree are these supports used?

15. How does the hospital and community environment differ in facilitating friendships?
16. To what degree do you think that friends play a role in the rehabilitation of people with SCI?
- a) as a visitor
 - b) as an active participant in the rehabilitation process
 - c) how does this change over the course of the persons hospitalisation or rehabilitation?
17. To what degree do you think that friends should play a role in the rehabilitation of people with SCI?
- a) as a visitor
 - b) as an active participant in the rehabilitation process
 - c) how should this change over the course of the persons hospitalisation or rehabilitation?
- 18 How could we, as healthcare professionals, facilitate the maintenance of friendships for people with SCI?

Appendix N

Example interview questions- Second interview

Being at home

1. Tell me a little about what has happened since you were discharged from hospital/since last we spoke?
2. What have been the benefits of being at home?
3. What have been the challenges of being at home?
4. What is the happiest time you have had since being home?
5. What is the most difficult time you have had since being home?

Friendship with nominated friend

6. How frequently have you seen *your nominated friend* since coming home?
7. How is contact initiated with *your nominated friend*?
8. What sort of things have you done with *your nominated friend*?
9. How has *your nominated friend* helped you since you have been home?
10. What challenges have you faced in your friendship with *your nominated friend* since coming home?
11. What factors have helped your friendships with *your nominated friend* since coming home?
12. How would you describe your friendship with *your nominated friend* now?
13. How does this compare to your friendship with *your nominated friend* prior to your injury?
14. How would you like your friendship with *your nominated friend* to be now?
15. What factors do you think have contributed to any change in your friendship with *your nominated friend*?

Friendship with other friends

16. How frequently have you seen any of your other friends since coming home?
17. How is contact initiated with these friends?
18. What sort of things have you done with these friends?
19. How have these friends helped you since you have been home?
20. What challenges have you faced with these friendships since coming home?
21. What factors have helped these friendships since coming home?
22. How would you describe these friendships now?
23. How does this compare to how these friendships were prior to your injury?
24. How would you like these friendships to be now?
25. What do you think are the factors that have contributed to any change in these friendships?

Friendship with other people from hospital

26. To what extent have you maintained contact with friends you made in hospital?
27. What do those friends offer that is different to your existing friends?
28. How would you like these friendships to be now?

Helping friendships

29. What should hospital staff do to help people maintain their friendships following injury?

Appendix O

Example Interview Questions- Third Interview

Reintegrating

1. Tell me a little about what has happened since last we spoke?
2. What have been the benefits of being at home since we last spoke?
3. What have been the challenges of being at home since we last spoke?
4. What is the happiest time you have had since we last spoke?
5. What is the most difficult time you have had since we last spoke?
6. What are the priorities in your life now?
7. How have these priorities changed over time since your injury?
8. In what ways have you changed the way you think about yourself and others since your injury?

Friendship with nominated friend

9. What contact have you had with *your nominated friend* since we last spoke?
10. How has *your nominated friend* helped you since you have been home?
11. What challenges have you faced in your friendship with *your nominated friend* since we last spoke?
12. What factors have helped your friendships with *your nominated friend* since we last spoke?
13. How have your family been involved in your friendship with *your nominated friend* since your injury?
14. In what ways have you changed the way you think about your friendship with *your nominated friend* since your injury?
15. How would you like your friendship with *your nominated friend* to be now?
16. What factors do you think have contributed to any change in your friendship with *your nominated friend*?

Friendship with other friends

17. What contact have you had with any of your other friends since we last spoke?
18. How have these friends helped you since we last spoke?
19. What challenges have you faced with these friendships since we last spoke?
20. What factors have helped these friendships since we last spoke?
21. How have your family been involved in your friendships generally since your injury?
22. In what ways have you changed the way you think about your friendships generally since your injury?
23. How would you like these friendships to be now?
24. What do you think are the factors that have contributed to any change in these friendships?

Friendship with other people from hospital

25. To what extent have you maintained contact with friends you made in hospital?
26. What do those friends offer that is different to your existing friends?
27. How would you like these friendships to be now?

Appendix P

Field note recording sheet

ID Number _____ Participant or friend _____ Interview No: ____

Interview date	
Start/end time	
Pre interview goals	
Location of interview	
Description of environment	
People present & interactions	
Content of interview (key words, topics, focus, what stood out)	
Non-verbal behaviour (voice, posture, eyes, gestures)	
Researcher impressions (discomfort/emotional responses)	
Technological problems	
Impact of researcher positioning (did participant connect)	
Analysis (questions, hunches, familiar themes, data trends or patterns)	

Appendix Q

Excerpts from personal journal: reflections on the research process

Aspect of project	Excerpt from journal	Date of entry/entries
Selecting sample	Have limited sample to those from spinal unit. Doesn't seem ideal...all one context. But I suppose that everyone will see that context different. Is this really maximum variation sampling though...how can one unit be maximum variation. Other options limited. Can't go to other states- not enough money, too many ethics, not practical. Have to accept limitations of this.	14 th February, 2004
Recruiting sample	Frustrated at difficulty in recruitment, particularly in relation to friends. How do I get access to them? Stayed til 7pm didn't turn up. Participant says contacted but not their type of thing. Very anxious to ensure that friends have a 'voice' in the data. What does this tell me? Does this just reflect why friends aren't involved in rehabilitation? Did the participant even ask them....are they afraid of what friend will say?	30 th April, 2005
Recruiting sample	<p>I know this is a rehabilitation unit, but why do therapies take up so much of the day. Staff sometimes have a little trouble accepted that research might be important too. Some staff being obstructive....maybe that is too strong a word. No, probably more dismissive. Don't reckon they are going out of their way to help let's put it that way. Feels like a power struggle sometimes. Then again, sometimes the participant doesn't either. Trying to put myself in their position. Suppose therapy would be more important to me too.</p> <p>Re entry 22nd feb. Perhaps being too critical. I think people are trying to facilitate the process where possible. Think relates to my exceeded frustration. Should be going quicker than this. Need to get finished. Not long on ethics. Deep breath. Context important....this is the context isn't it. What would this be like for a friend?</p>	<p>22nd February, 2005</p> <p>16th March, 2005</p>
Ethical conduct	Team meeting at work. Oh hell. [Staff] making a lot of assumptions with [client]. Wonder if they have asked him those questions.Does he just not want to say anything maybe?... Can't say anything myself....don't think they are going to get best results here. Anything to do. Probably not. Have to let it go.	1 st April, 2005
Power in data collection	Reading something written by Seed (1995) today....makes an interesting point in terms of power differentials in interviewing and found that although traditionally power would be seen to lie with the researcher as compared to the participants, she felt it was	11 th October, 2006

	often the participants who held the power to accept or reject the researcher and their research. How true. Don't feel like I have the power here...clients in a position to say no. 3 so far. Reasons varied- no time, overwhelmed or topic was too confronting. Also treating clients by sharing power...they have info that I want, they are experts .	
Power in data collection	Get the feeling some participants not being completely honest. How do I know. Not recorded in charts. No information in charts that I need. No light. But does this tell me something about their current state of mind. Focus on ways to strengthen rapport. Re entry 19 th September 2006. multiple interviews...helps get to truth. Participants trust more 2 nd interview. Like the fact that you remember things from 1 st interview. Feel better about this now. But how to analyse initial data in light of new info????????????	19 th September, 2006 28 th October, 2006
Keeping a personal journal	This is such a good place to put thoughts not directly contributing to theory. Well not really thoughts...more the way I feel. Better place to be pissed off than on data notes. stress, fatigue, despair, uncertainty. Don't have control here. HELP. Analysis is sooo hard.	18 th December, 2006
Study design	Who can understand grounded theory....so confused. Need different perspective. Seems like babble. Am I really constructivist. Method slurring might be the way to go- can't be pure. Bits and pieces help. Is this OK?	11 th January, 2003
Open coding	my initial readings of the analysis techniques proposed by all Grounded Theorists had almost convinced me to change my thesis topic- enormity and uncertainty of the task appear overwhelming. Eaves a saviour. Makes more sense. Probably still can't say that it is 'easy' or 'clear' smaller steps have helped me to recognise at least some of the important milestones along the way. Press on.	30 th November, 2004
Theoretical coding	Still open coding. Got tentative core category...at least basic problem. Scared of missing something. Not sure on core category. What if I'm wrong. Glaser says if confused and unsure, read the data again and again, and continue coding even if unsure. Writing down some thoughts. Need to talk to someone else.	22 nd August, 2007
Selective coding	Made decision. Core categories good. Diverging life paths reconnecting life paths. Much easier. Bit of a relief. Still finding stuff but fits in cores. Looking for relationships- mini theories. See how we go.	3 rd October, 2007
Memoing	Damn, damn damn. Don't know how many times have had great thought for memo only to lose it like half a second later. Too many ideas come too quickly then I lose them and nothing at all comes. Got to work out other plan- maybe tape recorder. Sick of sitting in traffic and losing thought.	14 th May, 2007

Appendix R

Writing Theory

Where do you start in writing Grounded Theory? A difficult question this is for research that does not fit clearly into the 'Introduction, Method, Results, Discussion' format of research within the positivist realm. Sorting is the precursor to writing and works effectively where coding produces highly sortable and flexible memos. Conceptual sorting is something the analyst needs to do themselves (Glaser, 1978) and the initial sorts are virtually the first draft of the manuscript. Although constantly feeling the need to have an outline of where I was going with writing, Glaser (1978) suggested that the analyst should not have an outline for what they will write because this should emerge from the sorting process rather than being pre-empted. Translation of the theory into writing involved moving back and forth between memos and a potential outline, forcing me to write at a conceptual level rather than at the level of the data. Sorting proceeded as memos related to the core variables. This ensured that any categories that were not related to the core categories were left out of the theory. Diagramming using linear models worked well not only to structure my theoretical coding but also for setting the scene for sorting memos and writing.

Conceptual ordering of sorting occurred at two levels, namely chapters and sections. Although sorting for chapters was easiest as it related to the core variables, sorting for sections was inherently more difficult but proceeded in line with the temporal ordering of categories within the theoretical model. Sorting should have commenced much earlier than it did for this study, as this may have helped to ensure saturation much earlier. As it happened, when sorting in the latter stages of theory development, a need was identified to return to data collection where empty areas

appeared. Sorting could only stop when there were no more memos and where theoretical saturation of the core variable and most sub core variables had occurred. Although I also felt the need to saturate all categories completely, this was something that was not necessary and resulted in a more protracted process. The use of qualitative software helped greatly in this process, where memos were more easily sorted than through manual means. Links could be easily made to pass notes on memos to be carried forward in the development of theoretical codes (Glaser, 1978)

Writing the grounded theory

Once the sorting process was complete, the writing process had in essence already commenced. Diagramming helped to always write at the conceptual level rather than the descriptive level through the derivation of theoretical statements about the relationships between categories. Writing was about categories and their relationships rather than about people (Glaser, 1978). Although consciously aiming to write as I talk, rather than standard prose, I found this difficult to achieve and often found myself slipping back into more positivist frameworks and language.

Glaser and Strauss (1967) suggested that the results section of a report should start by presenting the discovered grounded theory and the categories. The problem was how to disengage from the data to write theory and unfortunately I experienced this as a very lonely process. Outsiders cannot evaluate the interpretation made by the researcher, particularly when using a constructivist approach where meaning is the co-creation of the parties involved. As such, I have had to own the write-up presented and I, as coconstructivist have attempted to include my own voice where necessary (Mills et al., 2006).

The researcher in writing can quote directly from interviews or conversations, include dramatic segments of case studies, describe events and acts, provide background descriptions of places and spaces, offer accounts of personal experience to show how events impinged on him and unroll a narrative (Glaser & Strauss, 1967). To some degree, I have used each of these techniques in various places to illustrate the theory. A cardinal rule however for researchers is that whenever one feels dubious about an important interpretation or foresees that readers may well be dubious, you should state explicitly upon what kinds of data interpretations rests (Glaser & Strauss, 1967). Again, I have attempted to integrate these descriptions throughout.

Furthermore, in writing, it is important for the researcher to acknowledge that the choice to present certain words and not others reflects the choices and priorities of the researcher and this should be made explicit (Hammell, 2006). Quotations are important for 'revealing how meanings are expressed in the respondents own words rather than the words of the researcher (Baxter & Eyles, 1997) but data are only used in the writeup to show how a theory was constructed and that it was indeed constructed from this data. In the current write-up however, I never lost sight of the fact that participants might view things differently from the researchers and yet with equal validity.

APPENDIX S

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Perceived hassles for staff

Cultural displacement

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Role
separation
Change of roles
Emotional connection
Activity orientation
Communication
Interest

Codes underlying environmental, role, identity and interactional separation

Peer group acceptance
Functions and roles of family
Impact on and costs to family
Respite for family
Protective role of family
Fifal obligation
Family involvement
Impact on adjustment

On the sidelines
Participation
Leisure
Vocational Independence
Personal career
Career vs friend

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Perceptions

Developmental stage

Developing an identity

Individual reactions

Life experiences

Personality

Self esteem

Body image

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Same person
Perceptions of sameness in friendship
Indefinable aspects
Size of support network
Similarity
Closeness
Level of friendship

Definitions of friendship
Length of friendship
History of friendship
Somehow different
Knowledge of the other person
Understanding the person
Perceptions of the other person
Equality, inclusion and discrimination
Public awareness
Public understanding

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Changing interactions
Conversation
Increased attention
Perceived over-involvement
Need for timeout
Disclosure
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Internet access
Email
Justifications
Inappropriate
Privacy
Withdrawal
Displacement from friends
Somehow different
Type of support
Consistency of support

Waning support
Use of jargon
Activity orientation
Emotion orientation
Closeness
Loneliness
Social isolation
Guilt

APPENDIX T

Codes underlying immediate need, vulnerability to new world, facing the unknown and reality shifting over time

Medical emergency
Im Stress
me Anxiety
dia Suddenness
te Relief
Nee Back from the dead
d Lucky to be alive
Recovery and rehabilitation
Ability of the family to cope
Ability of the friend to cope
Focus on physical
Focus of rehabilitation
Involvement in rehabilitation
Self absorption
Privacy
Sadness
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Ability of the injured person to cope with
friend's grief
Hierarchy of need
Decreased urgency
Time limitations
Treading water waiting
Varying needs for support
Wait and see
Readiness
Reduced capacity to cope
Over-stimulation
Overwhelmed
Over-involvement
Need for timeout
Moral obligation
Increased attention
Level of care
Economic rationalism

Vul Inherent emotionality
ner Familiarity with environment
abil Healthcare professionals
ity Expectations of hospital
to Medications
ne Harsh realities
w Confronting mortality and
wo morbidity
rld Realise their vulnerability
Face or flee
Fragility
Uncertainty
Anger
Frustration
Disappointment
Identifying potential losses
Stress
Anxiety
Uncomfortable feelings
Control
Rule breaking
Risk taking behaviour
Busy just existing day to day
Crises

Abuse
Peer pressure

Suddenness
Fac Uniqueness
ing Novelty
the Lack of explanation
un Other injuries in life
kno Previous life experiences
wn Previous experience of disability
New experience
Individual differences in expectations of friendship
Expectations of recovery
Assumptions of need
Overcompensation
Previous expectations of friends
Preconceptions of injury
Living in the past
Safety of hospital environment
Friend knowledge of hospital
experience
Un
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Lacking insight
Confused
Knowledge of friend's experience
Rose coloured glasses
Staff and family knowledge of

friend experience
 Staff recognition of friendship role
 Just a blur
 Fear of the injured person
 Fear of burden
 Denial
 Apprehension
 Anxiety
 Pity
 Ambivalence
 Empathy and regret
 Unpredictable/ambivalent outcomes
 Legal aspects
 Wishful thinking
 Test of the friendship

Reality shifting over time	Gradual Ongoing cyclical process Time since injury Awareness of reality Waning support Busy just existing day to day Intentions Behaviours Absence of friends Changing realities
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APPENDIX U

**Codes underlying breaking the ice, negotiating new and old
 roles and responsibilities, moulding the environment and
 recruiting staff and peer helpers**

Breaking the ice	<ul style="list-style-type: none"> Critical task Fostering communication Relieving boredom Alleviate barriers Engagement in actual interaction Family conduit for information Family debrief Denial Facades 	<ul style="list-style-type: none"> Open communication Disclosure Humour Role modelling Honesty Groups Different individual approaches Nature of friendship
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Negotiating new and old roles and responsibilities	<ul style="list-style-type: none"> Participation Geographic and temporal context Time to be realised Visiting Initiator of contact Frequency of contact Reciprocity Beyond the call of duty Motivators Realists Confidantes Normalising Empathy Persistence 	<ul style="list-style-type: none"> Equality of roles Control Joint definition Previous caring experience Maintain separateness Proximity Sharing load Function of support Active role Seeking support Friends buffer low periods Keeping the peace Making new friends Substitute friendship roles
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Moulding the environment	Broader environmental changes	Looking for direction, information and resources
	Temporal context	Social environment
	Rules and infrastructure	Protecting friends
	Control	Services
	Flexibility and choice	Financial support
	Think creatively	Ad hoc interventions
	Using resources	Flexibility around hospital guidelines
	Seeking information	Linkages in networks
	Social action	
	Public awareness and education	
	Asking specific questions	

Recruiting staff and peer helpers	Duration	Maintaining hope for the future
	Depth	Reassurance
	Intensity	Relief of boredom
	Function	Ongoing source of support
	Valence	Staff recognition of peer role
	Emotional importance	External agencies
	Perceived need	Friendships with staff
	Specific purpose	Professional boundaries
	Environmentally defined	
	Time limited	
	Hopes and dreams	

APPENDIX V

Codes underlying redefining friendship and priority setting

Redefining friendship	<ul style="list-style-type: none"> Redefining self Redefining others Importance of disability Self esteem Self efficacy Comparison to others Facilitating adjustment Values Hope Motivation Pride Responsibility Spirituality Mentally active Learning new things Personal growth through adversity Continuum Developmental stage Previous life experiences New perspective Sounding board 	<ul style="list-style-type: none"> Reference point Sacrificing Dependability Reassurance Trust Tolerance of difference Pre injury Post injury Realignment of friendship terms Commitments True meaning of a friend Different types of friendship Temporal context Environmental context Shared activities Common bond Abstract Abandon friends Reassess nature of friendship Rationalising
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Priority setting	<ul style="list-style-type: none"> Context Living status Location Organising own environment Setting new priorities Cyclical Valued Attention Balancing competing demands Compromise Hierarchy of needs Trigger 	<ul style="list-style-type: none"> Achievement oriented Allocated time Goals for the future Forward planning Making decisions Sacrifice Getting on with it Individual readiness Looking into the future Finding a place for friendship Finding positives Fostering hope
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