TITLE

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JOURNAL

The Sport Psychologist

DEPOSITED IN ORE

13 February 2015

This version available at

http://hdl.handle.net/10871/16349

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The Influence of Social Support on the Lived Experiences of Spinal Cord Injured Sportsmen

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Abstract

This study draws upon life history data to investigate the influence of social support on the lives of 6 men who had acquired a spinal cord injury and become disabled through playing sport. Interviews were analyzed using categorical-content analysis (Lieblich, Tuval-Mashiach, & Zilber, 1998). The participants experienced emotional, esteem, informational and tangible support (Rees & Hardy, 2000) from various sources. Alongside the positive influence of social support, examples are shown of inappropriate or negatively-experienced support and where participants considered support to be lacking. The spinal cord injured person is encouraged to be proactive in resourcing social support, but providers might also be taught to recognize the impact, either positively or negatively, that their giving support can have.

The Influence of Social Support on the Lived Experiences of Spinal Cord Injured Sportsmen

In mainstream social psychology, social support has been the most frequently studied psychosocial resource, and has been noted alongside stress and coping as one of the three most important constructs in mental health research (for reviews, see, e.g., Cohen, Underwood, & Gottlieb, 2000; B. R. Sarason, Sarason & Pierce, 1990; Thoits, 1995; Veiel & Baumann, 1992). Relationships have been observed with physiological processes (Uchino, Cacioppo, & Kiecolt-Glaser, 1996), and physical disease and mortality (Cohen, 1988). Social support has also been linked to spinal cord injury and disability. In relation to spinal cord injury (SCI), social support is an integral part of quality of life (Manns & Chad, 2001) and is one of the most frequently used strategies for coping with such a traumatic event (Kennedy, Marsh, Lowe, Grey, Short, & Rogers, 2000). Social support is a predictor of disability status (Wilcox, Kasl, & Berkman, 1994), and it buffers people with disabilities from stress (Pescosolido, Wright, & Sullivan, 1995). Furthermore, with good social support, disabled people report a high quality of life, even though to externals they appear to lead an undesirable existence; this is known as the disability paradox (Albrecht & Devlieger, 1999).

In sport, there has been active encouragement for athletes to harness social support as a useful resource (e.g., Gould, Jackson, & Finch, 1993; Hardy & Crace, 1991; Richman, Hardy, Rosenfeld, & Callanan, 1989), and there is an emergent research literature focusing on the important role social support may play in relation to sport injury. This includes the study of social support and injury vulnerability, etiology of injury, recovery from injury, and subsequent return to fully competitive sport (for reviews, see, e.g., Bianco & Eklund, 2001; Brewer, 2001; Hardy, Burke, & Crace, 1999; Udry, 1996; Williams, 2001). Social support is considered important, since it works in a global way to enhance the well being of the individual, and helps to prevent isolation. It also functions to protect the individual from the deleterious effect of stress; this is referred to as the stress-buffering hypothesis, by which it is

meant that "support 'buffers' (protects) persons from the potentially pathogenic influence of stressful events" (Cohen, 1988, p. 278).

Despite this literature in relation to sport injury, there has been an absence of research into the impact of social support on people who have acquired a SCI that has disabled them through playing sport. One might consider this an oversight, since each year in the United Kingdom 20% of all SCIs are attributed to sports accidents (220 persons), whilst in the United States the figure is 8% (624 persons) (Glass, 1999). Generally, 80% of all SCIs occur to men. There may be commonalities between the provision of social support to injured sportspepople and SCI sportspeople. However, the experience of injury (perhaps lasting for one month) on the one hand, and SCI, disability, and impairment on the other is quite different (Oliver, 1996). For example, in this study, as a result of the sport injury, the participants moved from being able-bodied to being disabled. In view of this major difference, it would be inappropriate to assume that the literature on sport injury should necessarily apply directly to those who have become disabled. As Glass (1999) notes:

> Spinal cord injury, both intrinsically and in the case of each person, is a unique form of trauma; in no other area of injury or illness does there tend to remain, throughout the rest of the life, complete cognitive control with the inability to control the body. (p. 32)

In considering the impact that social support may play on the lives of men who have acquired a SCI through sport, one is faced with a key issue relating to the model of social support to be used. Research has generated a plethora of different models of social support, leading to difficulty in creating a synthesis of findings (Vaux, 1992). If one were to use the current sport injury literature as a starting point, one would probably consider using the multidimensional model of social support of Richman, Rosenfeld and Hardy (1993). This model is generating increasing attention in relation to sport injuries, the typology of eight

social support dimensions used either implicitly or explicitly in various papers and reviews

(e.g., Bianco, 2001; Bianco & Eklund, 2001; Brewer, 2001; Evans, Hardy, & Fleming, 2000;

Hardy et al., 1999; Johnston & Carroll, 1998; Robbins & Rosenfeld, 2001; Udry, 1996).

However, we would urge caution in using this model without careful consideration. Richman

et al. based their measurement instrument, the Social Support Survey (SSS) on this model of

social support. Examination of the validity of the SSS using confirmatory factor analysis led

to issues being raised regarding the content and structural validity of the SSS (see Rees,

Hardy, Ingledew, & Evans, 2000). The conclusion here was that there was insufficient

evidence to support the existence of this eight-factor model in a sport setting.

An alternative multidimensional model of social support is that of Rees and Hardy

(2000). Rees and Hardy generated a four-dimensional model of social support through

interviews with high-level sportspeople. The four dimensions are emotional, esteem,

informational, and tangible. To explain the meaning of each type of social support, Rees and

Hardy drew upon the conceptualizations of social support noted by Cutrona and Russell

(1990) to cover all aspects of social support. As such, their definition of emotional support

was: "the ability to turn to others for comfort and security during times of stress, leading the

person to feel that he or she is cared for by others" (Cutrona & Russell, p. 322). Esteem

support was defined as:

> The bolstering of a person's sense of competence or self-esteem by other people.
>
> Giving an individual positive feedback on his or her skills and abilities or expressing a
>
> belief that the person is capable of coping with a stressful event are examples of this
>
> type of support. (Cutrona & Russell, p.322)

Informational support was defined as "providing the individual with advice or

guidance concerning possible solutions to a problem" (Cutrona & Russell, p. 322). Tangible

support was defined as "concrete instrumental assistance, in which a person in a stressful

situation is given the necessary resources (e.g., financial assistance, physical help with tasks) to cope with the stressful event" (Cutrona & Russell, p. 322).

In the present study, this four-dimensional model was used as a framework to examine the social support experiences of 6 men who acquired a SCI through playing rugby football union. These men were selected from a larger on-going project that focuses on men, sport, SCI and the reconstruction of body-self relationships over time. For a complete explication of the rationale and the methodology underpinning the larger project, please refer to Sparkes (1998a), Smith and Sparkes (2002), and Sparkes and Smith (1999; 2002). The present study differs from the larger project, in that in the larger project, the life history data were subjected to various forms of narrative analysis, in order to explore how the participants reconstruct a sense of self following a traumatic biographical disruption.

Method

Participants

The participants in this study (see Table 1) were 6 Caucasian men, with ages ranging from 25 to 51. They had all been heavily involved in rugby football union and had experienced a SCI through playing this contact sport. They all now use wheelchairs and define themselves as disabled. All received financial compensation from the English Rugby Football Union (RFU), and claim disability benefit. None is currently involved in sport. To ensure the confidentiality of the men, pseudonyms are used throughout this paper, with any subsequent quotes identified by the pseudonym. Immediately following the injury, the men lost all movement from the neck downwards. With time they have been able to regain some, limited upper body movement. However, with the exception of Paul, all lower body feeling and movement is lost.

Phil was born in 1950. He read law at university, and then studied chartered accountancy, before starting a job with an accountancy firm. He enjoyed sport, particularly

the related social life. Whilst playing rugby on a cold December afternoon, Phil "went head first into somebody, rather than . . . side ways". He was 33 when he broke his neck. At the time of interviewing, Phil was working part-time as an accountant. He remains unmarried.

David was born in 1974. As a child, he was always at the local rugby club, his father being the chairman of the club. David became a talented all-round sportsman and enjoyed participating, competing, and watching a number of physically demanding sports, including rugby, association football, cycling, and skiing. In 1990, at the age of 15, and whilst still at school, he acquired a SCI following the collapse of a scrum. David later studied at his local university, initially earning a first degree in Leisure Management, and later a teaching qualification. David now works in a school, and lives with his long-term girlfriend.

Harry was born in 1963. As a child, he lived in a rural community, and became somewhat introverted. However, he was a physically active person, enjoying a variety of sports. Leaving school, he worked full-time on his parents' farm. Generally, his days were occupied with farm life and rugby. In 1994, he missed his nephew's christening, in order to play a rugby match, in which the scrum twisted, and he broke his neck. During his time in hospital, he experienced four episodes of post-traumatic-stress-disorder. Nine months later, he left the spinal injury centre and moved back to the countryside. He still lives in the countryside with his wife whom he met in 1987. He is currently unemployed.

Dan was born in 1974. He lived in Canada between the ages of 4 and 9, before returning to England. He became quite independent, since while growing up he saw his parents only infrequently at weekends and for holidays. He played a lot of sports, such as association football, rugby, and cricket, and was also involved in other activities, such as playing violin and piano. He attended boarding school in Canterbury, aged 12. In his third year there, he acquired his SCI playing rugby in London against Epsom. A collapsed scrum precipitated the injury occurrence. He now lives with his parents.

Paul was born in 1975, and has lived in London, England all his life. Sport was compulsory at secondary school, and he played association football mainly, as well as cricket and field hockey. He had a very competitive relationship with his best friend, and the two of them developed an interest in rugby. At the age of 16, he was playing in a match against this friend. His friend received the ball and was running for a try. Paul felt he had to stop him, else he would "never live this down, if he scores a try past me." Making contact with his friend, in order to tackle him, he remembered: "As soon as I hit him, it was like a feeling of falling, but you can't stop yourself from falling . . . then I couldn't see anything . . . then I couldn't hear anything." He had broken his neck and immediately suffered a cardiac arrest. He has actually regained a limited ability to walk and at the time of the interviews was working as a check-in agent for an airline company. He lives with his parents and has a one-year relationship with a girlfriend.

Richard was born in 1959. Growing up, he was a good swimmer as well as a good rugby player. He had become heavily involved in rugby on entering sixth form college, and then on leaving college had played in a successful and serious team, such that almost everything centered around rugby during the season. However, he was also very interested in theatre and was involved in charity fund-raising work. He was 23 when he acquired his SCI. As he put it, "I went from helping others to needing help." Since the injury occurrence, he has acted as secretary for his local rugby club across a 7-year period and been the first chairperson. He still attends meetings, but resents the fact that he cannot still play rugby. He took a social work degree prior to the injury occurrence, and now lives alone.

Contact was made initially with the participants via the RFU support network for injured players. In accordance with ethical procedures we did not seek or desire to know the identity of any members of this group. To ensure confidentiality, and following negotiations with the Sports Injuries Administrator for this organization, it was agreed that an open letter

from ourselves explaining the project, along with a brief questionnaire seeking demographic details, would be distributed in one of the series of newsletters circulated by the support network to the injured players. The questionnaire ended by asking respondents to indicate if they would agree to being interviewed about their experiences, and if so to provide names and addresses in a stamped addressed envelope that was also supplied.

Following the spinal cord injury, all participants were initially taken to the emergency room at their local hospital for immediate care of this life-threatening condition. Later, to begin the process of stabilization of their physical condition and formal rehabilitation practices, they were transferred to appropriate spinal injury units. Each person spent, not unusually (Seymour, 1998), approximately nine months in the spinal injury institution.

Procedure

All participants were involved in confidential, thematic, informal, life history interviews conducted in their homes by the second author. All interviews were tape-recorded using digital recording equipment and were transcribed verbatim. Whilst the interviews were informal in nature, they were structured around a number of core themes, with a view to eliciting the life stories of the participants in a supportive and trusting atmosphere. As such, participants were encouraged to tell their stories in their words and take the interview in directions that they felt were appropriate. Apart from these interviews, communication took place in informal settings for meals, breaks, and follow-ups with telephone and e-mail. For the 6 participants focused on in this paper, each was interviewed at least twice, with interviews lasting from 2 to 6 hours and a total formal interview time of 77 hours. Following the first interviews, and with the permission of the participants, the first author of this paper was allowed access to the verbatim transcripts. Based upon these data, suggestions were then made to the second author for follow up questions in subsequent interviews.

Analysis. All transcripts from the interviews were subjected to a categorical-content analysis (Lieblich, Tuval-Mashiach, & Zilber, 1998), with a view to developing general knowledge about the core themes that made up the content of the stories collected in the interview context (Sparkes, 1999), with specific reference to social support. This approach focuses on the content of narratives as manifested in separate parts of the story, irrespective of the context of the complete story. It is intended to examine the thematic similarities and differences between the narratives provided. The process moves from stories to common elements, which can be accomplished in two ways (Sparkes, 1999). One approach allows themes to emerge and concepts to develop from stories in an inductive manner. In contrast, concepts derived from theory or other logical possibilities can be applied to the data in order to determine the concepts or outcomes. This paper draws on the latter strategy with the multidimensional model of social support of Rees and Hardy (2000) used to examine the core themes.

A number of actions were taken to address the issue of indwelling, as described by Maykut and Morehouse (1994). The transcripts were read through by the first author numerous times, in order to immerse himself thoroughly in the data and to understand the point of view of the participant from an empathetic rather than a sympathetic position (Sparkes, 1998a). The transcripts were read through with a view to identifying narrative segments and categories within them. Analytical memos were written as preliminary and tentative connections were made to various theoretical concepts that were considered to be related to specific issues emerging from the participant's interview data; analytical memos along with the coding helped shape the questions and themes that were raised at the subsequent interviews as part of a cyclic process. As the study progressed, the data generated were continually reflected upon; that is, analysis was ongoing throughout the study, with questions related to issues raised in early interviews used to expand on those issues in

subsequent interviews. Preliminary engagement with the transcripts involved investigation of evidence of the four dimensions of emotional, esteem, informational, and tangible social support in the data, as well as evidence of general help and support. During this process, other important themes related to social support, but not directly related to the categorising of social support dimensions, were noted. Regular discussion took place between all three authors, and all three authors checked the quotes against the generated themes and social support dimensions, in order to check that quotes had been correctly assigned. Where possible the interpretation of the authors was also taken back to the participants for discussion.

Goodness criteria. With regard to the issue of goodness criteria, as discussed by Strean (1998) and Sparkes (1998b; 2000; 2002), a number of features of the current study may be considered to enhance its goodness. For example, both the process of conducting multiple in-depth interviews and actively listening to the participants' stories were deemed important for building rapport and trusting relationships, and for contextualizing events and meanings over time. It was also deemed important that the subjectivity of the researcher conducting the interviews be monitored in order to be aware of how this might shape the study. To this end, a reflexive journal was kept and regular discussions took place between the second author and the third author, who acted as a critical friend (Faulkner & Sparkes, 1999; Holt & Sparkes, 2001; Maykut & Morehouse, 1994). This monitoring process aided critical reflection on the dilemmas and tensions associated with the authors being able-bodied and with the different ways in which both the participants and authors might be represented. It also allowed concepts and categories to emerge in situ as the study developed. These were then integrated with relevant theory to provide explanations with regard to social support.

As an ethical principle, member checks were deemed important (Sparkes, 1998b). These generated the opportunity to check with the participants the accuracy of what was said,

that the reality portrayed was recognizable to them, and that they felt they were being

represented fairly. As with Holt and Sparkes (2001), this approach was considered a useful

process for exploring the reactions of the participants to researcher interpretations of their

world and the role social support played within it. These reactions created a further

opportunity for reflexive elaboration, and formed another valuable source of data and insight

regarding the themes under study.

In the sections that follow, the authors have attempted to provide a sufficient range of

quotations from the participants, so that their perspectives and voices are represented in a

balanced manner. It is hoped that the selected quotations will enable the reader to develop a

better understanding of the experiences of these six men and how social support operates in

their world on a daily basis.

Results and Discussion

The analysis was arranged so that note was made of the specific behaviors performed

by supportive others and the functions those supportive behaviors served. This may have

been a general helping support or may have involved the buffering of a stressor. It may also

have elucidated a potential mechanism by which the supportive behavior was operating.

Within each of the four social support types, quotes denote themes, wherein commonalities in

the data between participants' stories were observed. In each of these sections, either a series

of quotes or exemplar quotes are used to highlight the theme. Different types of social

support were salient at specific times in the history of the SCI for the participants, and quotes

are generally contextualized by a discussion of the time-line of the injury.

Emotional support

The findings of our study reflect aspects of this type of support, in terms of

demonstrating how others were there for comfort and security, leading the men to feel loved

and cared for. It also reflected the concept of generalized emotional support highlighted by I.

G. Sarason, Sarason, and Pierce (1990) as "Knowing that one is loved and cared for may be the essence of social support" (I. G. Sarason et al., 1990, p. 119). The following quotes relate to general support in dealing with the experience of disability, and support in dealing with concerns and frustrations.

In dealing with the experience of disability, the concept of others "just being there" that was noted by Rees and Hardy (2000) was noted by all participants in this study. For example, David highlighted the importance to him of his mother in the immediacy of his injury. She drove a four-hour round-trip journey to the hospital from the family home every night through seven months across the winter period. David stated: "it was knowing that every night I was going to see my mum. Just her being there." David also discussed and espoused the tremendous support he had experienced from his friends, many of them from the rugby team in which he had played, and whose presence in and out of hospital never dwindled. His mother had set up a rota system to bring David's friends to see him in turn on the daily trips she made to the hospital. From these friends, there was no doom and gloom:

> The emotional support they gave me was just being there and coming to see me, asking how things were, showing a genuine interest. They wanted to do anything to help. It was the fact that they showed up, stood or sat at the bed, that they were physically there.

This all gave David "the incentive to adopt more of a positive role of how to deal with my injury." Much of this is similar to the work of Sarason and colleagues (e.g., I. G. Sarason et al., 1990), David further commenting: "Knowing that people can help you and knowing there are people there that you can turn to when you are in a vulnerable situation, which I am in." This highlights the importance of the perception that support is available, should it be required. It is this perception of support that has often been suggested as more important than the actual receipt of support, in terms of protecting people from the harmful effects of stress

(e.g., see Cohen, 1988; Cohen et al., 2000; B. R. Sarason et al., 1990; Veiel & Baumann, 1992). Just having people there is considered important, even if those people do very little explicitly.

Phil highlighted the importance to him of having people there for him, now that he is at home. Without this help and support, he would have had to rely solely on a carer, who would arrive in the morning some time between 9am and 11am to get him out of bed. Later, with all the care work finished, he might be put to bed again at 6pm, leaving him little of a daily experience. If people are simply there for him, Phil has people to talk to and be with, instead of living a dull, isolated life:

> Just the fact that friends are around, and people are there having a good time. That's support in itself. I don't think you always have to discuss exactly how you're feeling or what you're doing to get emotional support, do you?

In dealing with concerns and frustrations, David discussed his talking to a nurse within the first four weeks of bed rest, following his injury. Here, he hinted at aspects of emotional support that are similar to Richman et al.'s (1993) concept of listening support, in terms of the fact that someone is listening without judging.

> I had quite a few nights just pouring my heart out to her, blubbing like a baby, which helped, because I got it all out. . . . Because it helps you to sift out all the crap from your mind, because you've got so much flying around in there, you have to get perspective on what's happening; where you are, what the situation is, and what your feelings are. Just by talking, you're actually getting that from the inside out. It's like, someone's sitting there nodding their head; they may not be listening, it's just the psychological thing of getting the weight off your shoulders. . . . It just helps sifting the stuff out, because you're airing your views rather than keeping them stored inside. When you store things inside, I think they become a bit twisted and start to go stale

after a bit. If you get them out there, and then while you're thinking, you might say

something, and when you've said it, think, well, that's not necessarily true.

In hospital, Paul was helped to deal with frustrations associated with the feeling that he was

making little progress with his rehabilitation. He experienced this sort of support from his

physiotherapist and his parents:

My physio became more like a great friend. Um, so I mean I could always talk to her,

um, about basically anything. I could talk to my parents about anything as well,

especially my mum . . . so, I mean, I had the support around me. . . . I used to just sort

of get it off my chest when my friends came to see me. I'd tell them what I was

feeling and stuff like that, and, I mean, but not really that, it was just how I was doing,

so I was lucky that I had the support around me.

Humor was noted by Harry as an important aspect, whilst he was in hospital in the first year

of his injury: "The one thing with the nurses and the carers is they are very good at bringing

some humor into it. . . . It takes your mind off it, it gives you something else." Albrecht

(1999) suggested that in some instances laughing at oneself or with others redefines the

disability experience. He noted that disability humor may convey group solidarity, articulate

inherent value structures, put experiences in context and ease the difficulties experienced in

everyday life (cf. Corker, 1999; Shakespeare, 1999).

Esteem support

The following quotes relate to this type of support, demonstrating how others

bolstered the men's sense of competence and/or self-esteem, and expressed the belief that

they had the capability to overcome some of the obstacles in their paths. The following

quotes relate to help in regaining motor movements, and help setting up for the future.

Whilst in hospital, all participants were helped in rehabilitation to regain control over

basic motor movements. Relatively soon after his injury, Paul was transferred to a relatively

small spinal unit to begin his rehabilitation. He was determined that he would walk again, but progress had been very slow. However, he was greatly encouraged by the input from his mother:

> Trying to do it and you can't. It's so frustrating. Um, but then I sort of saw a flick here, and my mum was like, "well you know, it could be a spasm." And she went, "did you try and move your arm then or your hand?" I was like, "I was thinking about moving my finger," and she went, "try it again," and then it sort of did it again, and she went, "you just moved your finger," and I was like, "Oh, oh okay."

Paul had also been doing various rehabilitation exercises with the help of his physiotherapist, including gym work, stretches and hydrotherapy. He was not entirely sure where all these exercises would lead, but he was then inspired by the confidence that his physiotherapist had in him:

> She was obviously confident that I could do it and it just seemed so out of the blue, though, that I mean, now looking back all these exercises were geared up to do that and she obviously realized, or she thought I could do it from the, from the word go, or whatever. She obviously knew, but she was putting me through all these exercises, just so I could get there.

> David related a time in hospital, when his father greatly encouraged him to be positive about his future. Despite the SCI, his father led him to believe that he would still be able to do all the things he had planned to do, such as attend university:

> Basically, my dad instilled in me the attitude that nothing was changed; you were still going to do your education, you're still going to do the things you wanted to do. . . . He instilled in me the attitude that I could go on and do anything still. . . . I was encouraged to do positive things, which encouraged a more positive attitude in myself.

Whilst he was in hospital, in the immediacy of the injury, David also appreciated the strength he drew from the interest of the people in the surrounding neighborhood, since there had been newspaper reports on him, and charity events had been organized to raise funds for him. Furthermore, whilst he acknowledged the help of his parents, his parents were in turn bolstered by their friends and the response from the local community: "It all gave us that impetus to think, you know, that we can make some good out of this, and we felt encouraged. You can't give up when people are so supportive." David also commented as follows: "Other people pushed me when I got out, pushed me and wanted me to do more."

Informational support

The following quotes relate examples of this type of social support, demonstrating how others provided the men with advice and guidance. The following quotes relate to help in dealing with feelings of upset and anger, and advice about dealing with feeling fed up with some of the more problematic issues related to SCI.

Whilst in hospital, and relatively soon after his injury, Paul commented on the advice and guidance he was given by the nurses. This mirrors the finding of a study on bone marrow transplant long-term survivors, who found that the support of a nurse greatly aided psychosocial adjustment, increasing quality of life (Molassitois, van den Akker, & Boughton, 1997). Here, Paul felt this support helped him deal with his feelings of upset and anger:

> There was a couple of really good nurses; they were superb. They were like, you
>
> know, all this energy, all this negative, all this upset you're feeling at the moment,
>
> you know, you've just got to channel that into getting better. Focus it in the right
>
> direction and, um, you know, just put your mind to getting yourself better and fit.

Richard related an account of a trip organized by the RFU "a couple of years back," to use his words. Richard had already been injured many years and suggested that this sort of trip would probably be most beneficial to more recently injured players. However, he nonetheless

related how he gained strength and support by discussing issues with another person who had

acquired a similar injury. He noted that between the two of them, they could discuss issues

and give each other advice. This is similar to the peer support highlighted by the SCI

participants in a study by Manns and Chad (2001), the informational support highlighted by

the cancer patients in a study by Dakof and Taylor (1990), and the informational support

suggested in Richman et al.'s (1993) concept of shared social reality support:

> I mean someone you could talk about the most basic and awful aspects of spinal
>
> injury with, someone who knew what you were talking about . . . a lot of the rest of us
>
> actually liked that sort of support. You could talk to people about it, give them advice.
>
> You could get advice, you know just for very basic advice, like bowel management;
>
> what they'd experienced, what they'd tried. . . . You knew what they'd been through,
>
> and you'd have been bloody surprised if they hadn't had a lot of the same feelings. I
>
> have had a bit more of a friendship with one of them. . . . I have spoken in depth with
>
> him. Um, but just generally how pissed off you are with the whole thing. . . . The
>
> support's there in the fact that if you get really cheesed off or whatever you can phone
>
> someone who has got an idea about what it's like. You know, however much you
>
> shouldn't do it, one does feel better if someone has had the same problem or similar
>
> problems.

Tangible support

The following quotes relate to this type of social support, demonstrating examples of

concrete instrumental assistance to aid the coping process, and physical help with tasks. The

following quotes relate to help dealing with the loss of physical functioning, help in regaining

basic motor movements, help to get about outside hospital, and help setting up for future.

All participants discussed the need for fundamental help and support in dealing with

the loss of physical functioning. The following examples highlight similar problems faced by

Albert Robillard (1999) who described the support he had from his research assistants in dealing with motor neuron disease. For example, they helped with: "suctioning my mouth . . . wiping my nose" (p.153). As such, these examples are almost the forgotten fundamental issues facing people with SCIs. Phil commented on the initial problems one is shocked to be faced with, following the injury. Initially, Phil was flat on his back, with neck in stabilization: "So you needed help with physical things, feeding you, shaving, washing, turning." Harry commented on the help given by the nurses in the hospital: "The physical, washing, toilet, things like that, of course, which needs to be done." David commented on the change experienced, on finally leaving the hospital and restarting one's life at home, without twenty four hour nurse attention: "Like, you know, I didn't feed, couldn't drink. You know, I couldn't feed myself when I left; I didn't have the strength in my arms. I had to do everything by straws. I do still have stuff by straws . . . I had to have people feed me." Harry noted the help he received from the nurse on duty: "Whenever she's on duty, she's the one who washes you, feeds you, does everything for you."

Following the initial period after the injury, Paul was taken off his ventilator and his breathing had started improving. At this point, the doctors informed him that he would never walk again. In what he described as his stubbornness, he claimed he would indeed walk again. After six weeks, he was transferred by helicopter to a new, smaller, but more intimate hospital for rehabilitation. Here, he received one-on-one attention from the senior physiotherapist, who saw him as a challenge. Initially, Paul could not even move a finger, and he started to believe that he would never walk again. However, Paul animatedly described the actual physical help and support received from the physiotherapist and the sense of achievement he felt whilst trying to recover some physical motor movements:

I mean obviously her doing physio and stretching, things like that. Um, the first sort of movement I got back was in my right hand, I think, just a couple of fingers

twitching and moving. And it was just the sense of so much achievement, really, you know. . . . I mean, I think I took a step or transferred my weight and sort of tried to drag it and someone helped me, another physio helped me to do it, but I mean it was like, from doing nothing to one step, and it was like, what an achievement.

Dan described the benefits of having someone around who could provide actual physical help to get him about, once he was outside of the hospital setting and living at home. For example, it was great to have someone to drive him places and enable him to get out and about. In particular, having gone on to university, he found the university environment excellent socially, and he was helped by a friend who lived just opposite him:

The guy would drive me places. Basically, he was strong, he could lift me in and out of other cars. That was a great, that was a really big part of me getting out and being involved with people again; it was the fact that there was someone like that.

Dan also had similar help and support from his parents and brother: "And my parents, and my brother was quite a strong guy so far as like, you know, overcoming barriers and stuff like that."

Similarly, Dan also described the physical help he has had from a girlfriend:

The other day I went to a concert in London with a girl I knew . . . she was like a little girl. She just popped me in the car, clamped me down, put the ramps in, drove me in my big van, parked me up, helped me up the step.

The following examples are about others doing tasks that will help the participants cope better with the disability, and aid in setting up for the future. Richard commented on his father's help following the injury occurrence: "My father . . . did what he did best, which was try and find out every little bit of information he could on disability. My father was the kind of person, if he bought a boat, he'd go out and read a book on it." David commented: "My

dad, he did a lot of administrative things, paper work, he set up a trust fund for me, so all the

money that was raised . . . was there for me for the rest of my life." David continued:

He realized, not only from his own digging, but by talking to doctors and other people

who had witnessed similar tragedies, there needed to be some kind of base for the

future. That's what he decided to do; he set that up because that was his duty as

father.

The preceding examples have demonstrated how it has been possible to use the four-

dimensional model of social support of Rees and Hardy (1990) as a framework to highlight

the multidimensional nature of the social support received by the men in this study. Beyond

these examples, there was also frequent mention of how the participants had come to realize

that social support is crucial to their being able to overcome problems that they are faced

with. Phil commented: "You have to sort your life out, there are limitations, you tend to have

to rely on people more, you can't dress yourself or think, 'I think I'll get up now and have a

bath. I'll do this, I'll do that.'"

In general all the participants suggested that social support was very important to

them. Phil commented: "I've had a lot of help from other people, which is a lot better.

Without that, it's quite tricky, really. If you're all on your own, with no support there, I think

it is difficult." This shows similarities with the comments of the tennis player in the Rees and

Hardy (2000) study, who had felt that to make it in world tennis would be very difficult

without having good social support. Phil also commented on the enabling influence of social

support: "The support is a way of . . . enabling you to do things really isn't it, without . . . if

you were on your own and just relied purely on what social services had to offer, which

would be someone coming very briefly." Phil also made the following comment:

Friends and family . . . I need their physical help at times, but more complicated,

because the body, I can't control it, which is a huge problem. They help in that sense,

helping to get some control, I suppose. If I needed to talk, they would listen, but it's more just being there again. Putting me to bed at night. With a carer I had to go at specific times. I suppose having people around gives me more opportunities, opens up spaces. Without them, I'm sure life would be a lot worse.

Paul commented: "I mean, definitely, friends and family around me, that was a huge thing. I mean, without them, I don't know if I could have coped so well." David commented:

Without their help I would be nothing; I wouldn't be nothing, but I wouldn't be where I am. . . . The reason why I took the path to getting on with things and accepting what's happened, making the most of my life was, I mean, as I always say, until the day I die, it's due to the people that supported me. . . . People look at me and say you know, well, you've done marvelously. Yes, I suppose if I looked from the outside in, perhaps I might think that, but I put that down to other people. If it wasn't for them then I wouldn't be where I am today.

Richard commented that these issues are still prevalent for him today: "Sometimes you forget how much you need doing for yourself. First time you want to get a paper and you can't reach, there's no-one about, it brings it all back." David commented:

It showed the importance of people to me and people power . . . To me, people are much more important than money or anything in the world. If I had been given there and then two million pounds and had no support from anybody, I wouldn't be as happy as I am now."

However, there is a contrast to this in the comment made by Dan:

Financially, you know, I've had support and from friends and family. I wish there was more, because there'd be more adaptations I'd make, make life a lot more comfortable for me and for getting round and doing things.

In applying the Rees and Hardy (2000) model to the data, it became clear that a number of other characteristics of the social support experience were raised. For example, not all forms of informational support were regarded as beneficial. In the following examples, it is shown how, in the immediate period following the injury, being given the "worst-case scenario" feedback from the hospital doctor was a huge shock for the participants. Harry's comment was this:

> The worst thing is . . . they come out and they tell you, based on the worst-case scenario all the time. That is a shock. When I was there I'd got no use of my arms or anything. I was totally dead from my shoulders down. They turned around and said, well, this is probably how you're going to be for the rest of your life. So that is one hell of a shock.

In the following example, Paul is describing what the doctor said to him:

> 'No, I don't think you'll ever walk again. . . . I have to tell you, you are a worst case,' and la di da, 'you're going to be like this for the rest of your life'. . . . It was obviously the worst feeling you could ever have.

Phil described the somewhat distant manner of the doctor, and how the doctor's opinion had influenced his/her medical judgement: "Well, you can't have been any good at rugby, because if you had been, you wouldn't have broken your neck."

Paul would have liked more informational support. In the rehabilitation period in the hospital, in the relatively immediate period following the injury, he would have liked to have had more explained to him about why he was doing certain rehabilitation exercises:

> I mean, you see it as, say, increase the hours in the chair, go to the gym and sort of increase stretching, all these things with these big plastic balls, which I thought was completely pointless. Um, it was like, why? I mean, obviously you realize now, but it's just like, okay, you're doing stretches, but I couldn't see how doing stretches and

stuff like that and moving this could actually get me to what I wanted, which was [to]

walk. Because I mean, no one had ever said, ever since I asked the doctor if I was

going to walk again.

In a similar fashion to these experiences with informational support, not all forms of

tangible support were regarded as beneficial. Phil described a time when a physiotherapist

attempted to get him sitting up:

When I was at the physio's, [the physiotherapist] decided to . . . sit me up in a

wheelchair. It must have been about eight weeks after my injury. [Hospital Name]

would have had a fit about it, and that was absolutely horrendous, I must admit . . .

you know, because you see this, body sitting there in pyjamas, and it was like,

"bloody hell!" It was probably one of the nastiest moments. That was where it really

did hit you. You couldn't feel what the hell was happening to your body at all.

David described his frustration in hospital, when he felt that useful tangible support was

missing. Early on in his rehabilitation, he lamented the lack of time that the nurses could

devote to helping him, instead of which he was often treated with drugs, when he feels this

was not the best method for treating him:

Since then I can now feed myself, I can now drink, I can make myself a cup of tea. I

couldn't do that at all. You know, if I was worked on with those things then, with the

smaller things, then you know I may be doing a lot more now. I don't know, I could

be completely wrong, but if I've done that five years down the line when I had very

little strength, why didn't they work on it then? So, you know, I do believe that the

drugs didn't help. I was on Valium, 10 mg of Valium three times a day, which made

me feel like I didn't want to do anything. . . . For spasm, but to be honest I think it

was just to shut me up. Um, and make me feel, you take these things because you

think it's good for you, think it's helping the situation, but it's not. It was making me

feel worse. And, unfortunately, I feel they shove this stuff down your throat and it has an adverse effect on people's mental state. I think, you know, that can be quite a manipulative, the health service at times . . . when I talk about the health service, it was good, I mean it was very good at the time, but I do think sometimes, at times, because they haven't got the funds, they look at the more things, the people who can do more rather than the person who can't.

The participants mentioned clear differences between their experiences in hospital, where their needs were catered for in a great way, and their initial reaction on getting home, where there appeared to be far less provision for them. Harry mentioned something that might be taken for granted when in hospital; the issue of physical access in and out of buildings:

Because the real hit, the one that fucks you, is the first time you go out. You are faced with, well just everything is new. You are starting again. Building to get access to, if you want access to them, people stare at you. . . . When you're inside, everyone is in the same boat and it's a big shock when you come out, because the hospital's all ramped and everything. Everything is geared for you. All of a sudden you come out and nothing is geared for you. That's a big shock.

Harry also mentioned the issue of leaving hospital and being at home, in a situation wherein he no longer had lots of other patients or hospital staff around him that he could talk to:

All of a sudden there was no one to talk to. I think that's the first time it really sort of like, "well, what the hell do I do now?" I want someone to talk to; there's no one to talk to. That's the first time it hits you as "I can't do anything," sort of thing. . . . It hits you. When you're in hospital, there's always someone there. You can have a laugh and a joke with somebody . . . on the ward, always someone to go to and find to talk to.

It was noted that the role of parents was very important, but that the role of each parent was invariably different, for example, with the mothers prevalent in providing emotional support in terms of giving general help and support, and the fathers providing tangible support in helping setting up for the future. Phil commented on the fact that there were differences in his parents' support in the immediate period following the injury:

> Yeah, he [father] was also a big help, much like mum, but, well, mum is mum. She understood my needs better, I suppose. . . . Don't get me wrong, dad was very supportive. It was, I don't know, you have a different relationship with your father than with your mother. For instance, if I needed moving, then my father just seemed the person to ask. Just different.

Conclusions

This study has demonstrated the multidimensional nature of social support of men who have acquired a SCI and become disabled through playing rugby football union, utilizing the work of Rees and Hardy (2000) as a framework. Each of the four types of social support (emotional, esteem, informational, and tangible) were highlighted by the participants, demonstrating the functions served by this social support. Through the supportive behaviors it has been demonstrated how different functional forms of social support are used to help in dealing with the SCI. Despite the important distinction between the experience of injury on the one hand, and SCI, disability and impairment on the other, comparisons can be made between the present study and the work on social support and sports injury noted in the introduction to this paper (Bianco, 2001; Bianco & Eklund, 2001; Brewer, 2001; Evans et al., 2000; Hardy et al., 1999; Johnston & Carroll, 1998; Robbins & Rosenfeld, 2001; Udry, 1996). In particular, social support is generally regarded as an important resource. Also, various types of social support are considered useful in helping the recovery and rehabilitation process. Amongst other behaviors, participants received emotional support in

terms of others simply being there for them, esteem support in terms of encouragement and reassurance, informational support in terms of help dealing with feelings of upset and anger, and tangible support in terms of physiotherapy treatment. The results also hint at the notions of social support working in a global way, as well as a stress-buffering way. Of course, whilst there are some similarities between the provision of social support in this study and previous work on sport injury, participants' responses were framed by a four-dimensional model of social support as opposed to a model with more dimensions.

Despite the comparisons with sport injury, probably a major difference is that, in the the context of the lives of the disabled men in this study, who had experienced a major, life-changing event, the need for social support issues had become intensified. And whilst the beneficial nature of social support for the men in this study supports the literature on coping, SCI, and disability (Albrecht & Devlieger, 1999; Kennedy et al., 2000; Manns & Chad, 2001; Pescosolido et al., 1995), it also sheds light on some of the complexities within the social support experience. The participants generally regarded social support as very important to them, and a critical part of their being able to increase their quality of life. However, they noted discrepancies between the provision of support in and out of hospital. This implies that whilst they espoused the help and support from <u>all</u> those around them, they did still experience feelings of isolation once outside of the hospital setting, where all their needs had been catered for. The different role of each parent was noted, implying that the process of discussing the support of "parents" (e.g., Hardy et al., 1999) may mask the unique contribution of mothers and fathers. We do not mean here to dwell on who provides what types of support, since the quality and functional effectiveness of the support may well be the most important aspect. Indeed, our results would concur with those of Bianco (2001) that various network members engaged in the provision of various types of social support. However, in a similar fashion to the observations of Johnston and Carroll (1998), we did find

that informational support, whether beneficial or negatively received, was generally provided by medical personnel or others with a similar SCI. Within informational and tangible support, the men also mentioned some experiences where they were disappointed at the lack of provision, as well as examples of inappropriate or negatively experienced social support. This touches upon issues related to nonsupport (e.g., Rook, 1992; Harris, 1992) and the discrepancies observed between the perceptions of supporters and supported on what is seen as useful. Examples of this have been demonstrated with students taking exams (Coriell & Cohen, 1995), cancer sufferers (Dakof & Taylor, 1990), the bereaved (Lehman, Ellard, & Wortman, 1986), and headache and irritable bowel syndrome sufferers (Martin, Davis, Baron, Suls, & Blanchard, 1994). Udry Gould, Bridges and Tuffey (1997) demonstrated in a sport injury setting how athletes tended to view their social support interactions as more negative than positive. In particular, they noted examples of inappropriate or insufficient rehabilitation guidance, a lack of sensitivity to the injury, and a lack of concern, with others being somewhat distant. In the Dakof and Taylor (1990) study, the results of interviews with 55 cancer patients showed similar results to the present study, with unhelpful actions by physicians listed as: expressed little concern, empathy or affection; provided insufficient information; and provided technically incompetent medical care.

Whilst generalizing from our sample to others is limited in terms of the inherently small sample of this qualitative research, the quotes from the interviews may well be salient to other people who have received a similar injury, or to those who care for and support such people. Ultimately, as is expressed by Paul: "In the end, if someone can use my story, then that would be great." There are important implications for men with a SCI and all those involved with them. It needs to be recognized that important others can play a crucial role in the life of these men, and that the consequences of isolation from support and the provision of inappropriate support can be damaging. However, in relation to the provision of social

support to injured skiers, Bianco (2001) noted that it is "important that well meaning network members recognize their support may or may not always be necessary or welcome" (p.384). In fact, in this study, the participants also mentioned that they preferred on many occasions not to be "fussed" around, but instead preferred to be free to be proactive in seeking help and support, when they needed it (cf. Richman et al., 1989). Phil said: "I just want to be left alone, or for people just to be there." Dan made the following point: "I don't want people to fuss around me . . . I like to do things my own way . . . I'll shout if I need any help." The men essentially wanted to be proactive in seeking social support, but also frequently just wanted to know that the support was there should they need it.

This is important, since the results of the present study might lead important others to the conclusion that they should actively give support. Clearly, the person with a SCI does need much social support. However, herein lies a problematic issue, in that un-skilled others are often poor providers of support, basing their understanding of what the individual needs solely on intuition. Lehman, Ellard, and Wortman (1986) noted that others can provide unhelpful support by trying, among other things, to minimize the importance of an event, avoid open communication about the event, criticize attempts at coping, encourage quicker coping, and give inappropriate advice. How these people behave towards us can have a tremendous impact upon our thoughts, feelings and behaviors following an event (e.g., Gilbert, Fiske, & Lindzey, 1998), and even expressing empathy can have a huge impact on a person's thoughts and the consequences of those thoughts (Cutrona & Cole, 2000). Interventions might, therefore, focus upon providers to improve the quality and aptness of the support they provide. However, interventions might also focus upon helping these men to fully understand how they can maximize the support that is available in their network of supportive others, and learn the skills necessary to be proactive in using this resource. As applied practitioners, sport psychologists could provide a context for empowering individuals

to recognize their needs, to understand that specific problems and stressors require specific types of support to help deal with them, and to seek out appropriate supportive exchanges to help deal with those needs (Richman et al., 1989). This is akin to the concept of matching social support with stressors (Cutrona & Russell, 1990).

Future research might consider the use of different forms of analysis and representation (Sparkes, 2002); it might explore further the issues of inappropriate or negatively received support, the manner this is received/interpreted, and the consequences of this interaction; it might look at the impact that supportive interactions have on the providers of social support; it might consider how social support shapes and is shaped by the different types of bodies and narratives that are available to people in the various cultures and sub-cultures that they inhabit. Finally, future research might critically explore the gendered character of social support. This study has provided an initial insight into the supportive experiences of these men, and has shed some light on some of the complexities of the social support process. We hope it will generate future research into social support and sportspeople who have acquired a SCI through playing sport.

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Table 1: Characteristics of participants (at time of last interview)

Name	Age at interview	Age acquired SCI	Level of SCI	Living arrangements	Occupational status	Number of times interviewed	Formal hours interviewed	Informal hours interviewed	Total time interviewed
Phil	51	33	C6	Alone	Self-employed	2	11	2	13
Richard	42	23	C4/5	Alone	Unemployed	5	14	4	18
Harry	38	31	C6	With wife	Unemployed	2	11	2	13
Paul	26	16	C2	With parents	Employed	3	11	2	13
David	26	15	C4/5	With girlfriend	Employed	4	19	4	23
Dan	25	15	C5/6	With parents	Unemployed	3	11	2	13

Note. SCI denotes the exact level of damage to the spinal cord. Here, C denotes cervical vertebrae. This is also expressed as the neurological level of damage, below which power and/or sensation have been affected.

Author Note