# SECTION B

## PREFACE

### Resilience-Promoting Processes to be Included in an Intervention for Spinal Cord Injured Persons' Partners: A Qualitative Research Synthesis

This manuscript forms part of a larger, more encompassing intervention research study, which consists of six phases (de Vos & Strydom, 2011). Phase 1 (Problem analysis and project planning) was reported in section A. This manuscript that follows, reports on phase 2 (Information gathering and synthesis), and consists of a qualitative research synthesis.

Two secondary research questions were driving this part of the study, namely:

(1) What is already known about the processes that promote resilience in SCIPPs?

(2) What resilience-promoting processes can be organized and synthesized, from previous research, in order to be included in a group resilience-promoting programme for spinal cord injured persons' partners?

**MANUSCRIPT 1**

# Resilience-Promoting Processes to be Included in an Intervention for Spinal Cord Injured Persons' Partners: A Qualitative Research Synthesis

*Prepared for submission to*

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**NOTE TO EXAMINER:**

**This manuscript has not been submitted to the mentioned journal yet, but will be done so after examination. Therefore, for the purpose of the examination process the length of the manuscript might exceed the word-limit of the journal, but will be adjusted before submission.**

## ABSTRACT

This manuscript reports on phase two of a six-phase intervention research study that aimed at designing, developing and evaluating a group resilience promotion programme for spinal cord injured persons' partners. The aim of this manuscript was to organize and synthesize previous research on resilience-promoting processes, in order to inform the design and development of a group resilience-promoting programme (GRPP) for spinal cord injured persons' partners (SCIPPs). Two research questions directed this manuscript, namely (1) What is already known about the processes that promotes resilience in SCIPPs? and (2) What resilience-promoting processes can be organized and synthesized from previous research in order to be included in a group resilience-promoting programme for SCIPPs? A qualitative research synthesis was employed and consisted of a systematic review of literature. Inclusion and exclusion criteria were applied to select applicable papers. A total of 163 papers were reviewed and 21 studies were included in this research synthesis after a quality appraisal had been done. Eight categories were extracted that could be included in a process-focused intervention approach for SCIPPS, namely information; thinking/problem solving; spirituality; support; on-going relationships; stress management; coping and acceptance. These eight categories were aligned with resilience theory, embedded in six protective processes, and emerged in formulating an outline for such a programme which consists of the outcomes and content that could be included in an intervention programme. Conclusions and recommendations highlight that the formulated outline of the GRPP for SCIPPs needs to be further developed into an intervention that could be implemented with SCIPPs. Hence further development of the programme is needed.

**Keywords**: Spinal cord, spinal cord injury (SCI), intervention research, social group-work, process-focused approach, a resilience-based framework, six resilience protective processes, qualitative research synthesis, resilience.

## OPSOMMING

Die doel van hierdie studie was om vorige navorsing aangaande veerkrag-bevorderingsprosesse te organiseer en te sintetiseer ten einde 'n veerkrag-bevorderingsprogram vir spinalekoord-beseerde persone se eggenote (SKBPE'e) (Spinal Cord Injured Persons' Partners [SCIPPs]), te ontwerp en te ontwikkel. Twee navorsingsvrae het die studie gelei, naamlik (1) Wat is reeds bekend aangaande die prosesse wat veerkrag by SKBPE'e bevorder? en (2) Watter veerkrag-bevordingsprosesse kan georganiseer en gesintetiseer word, ook uit vorige navorsing, om ingesluit te kan word by veerkragbevorderingsprogram vir SKBPE'e? In die konteks van toegepaste navorsing, is 'n intervensie-navorsingsmodel, bestaande uit ses fases, geïmplementeer. Met inagneming van bogenoemde word daar op fase 2 van die intervensie-navorsingsmodel gefokus, naamlik die insamel van inligting asook kwalitatiewe navorsingsintese. As gevolg daarvan is insluitings- en uitsluitingskriteria aangelê om toepaslike studies te selekteer, waarna 163 beoordeel is en 21 studies na kwaliteitsbeoordeling by die navorsingsintese ingesluit is. Uit hierdie studies is agt kategorieë/strategieë geïdentifiseer wat in 'n proses-gefokusde intervensiebenadering vir SKBPE'e gebruik kan word, naamlik, inligting; probleemoplossing; spiritualiteit; ondersteuning; volhoubare verhoudings; hantering van stres; behartiging (*coping*), en aanvaarding. Hierdie agt kategorieë/strategieë hou verband met die veerkragteorie, geïntegreer met ses beskermingsprosesse, en het aanleiding gegee tot die formulering van 'n uiteensetting vir so 'n program bestaande uit uitkomste en inhoud wat by 'n intervensieprogram ingesluit kan word. Gevolgtrekkings en aanbevelings dui aan dat die geformuleerde uiteensetting van die SKBPE vir SKBPMs verder ontwikkel moet word in 'n intervensie wat met SKBPMs geimplimenteer kan word. Dus is verdere ontwikkeling van die program nodig.

**Sleutelwoorde**: Spinale koord, spinal koord besering (SKB), intervensie navorsing, maatskaplike groepwerk, 'n proses-gefokusde benadering, a veerkrag-gebaseerde raamwerk, ses veerkrag-beskermende prosesse, kwalitatiewe navorsings sintese, veerkragtigheid.

**Resilience-Promoting processes to be Included in an Intervention for Spinal Cord Injured Persons' Partners: A Qualitative Research Synthesis**

## 1 PROBLEM STATEMENT

Spinal cord injury (SCI) is an acquired physical disability through traumatic injuries such as car accidents and shooting incidents, and non-traumatic injury such as a tumour on the spinal cord, amongst others. The medical dictionary (2012) defines a spinal cord injury as damage or trauma to the spinal cord that results in a loss of function and mobility or impaired function and reduced mobility. Unlike other parts of the body, the spinal cord does not have the ability to repair itself if it is damaged. Consequently, a person who has acquired an SCI will have a physical disability and will be either a paraplegic – paralysis of the lower part of the body, including the legs, or a quadriplegic, which is paralysis of all four limbs (International Spinal Cord Society [ISCoS], 2012). SCI has increased over the last three decades (Dawodu, 2011), leaving thousands of people injured, who are now faced with the reality of being paralysed and consequently have to cope with severe permanent lifestyle changes (Chappell & Wirz, 2003; Keleher, Danny, Dixon, Holliman, & Vodde, 2008; Ross & Deverell, 2010; van Zyl, 2008; Young & Keck, 2003).

Several studies found that the spinal cord injured person's partner (SCIPP) is seen to be the most important source of social support (Isaksson, Josephsson, Lexell, & Skär, 2008; Steyn, 2008; Young & Keck, 2003). As such, the acquirement of an SCI might put the romantic relationship at risk, since the original relationship changes (Isaksson et al., 2008; Ross & Deverell, 2010; Steyn, 2008; Young & Keck, 2003); which is specifically the case with pre-injury marriages (Crewe, Athelstan, & Krumberger, 1979; Crewe & Krause, 1988). Consequently, the SCIPP now has to physically care for his/her partner,

face the possibility that his/her partner may struggle for several years to accept the reality of being paralysed (Migliorini & Tonge, 2009) and, as a result, has to deal not only with the partner's psychological reactions, but also has to accept the reality that their entire life as a couple has changed (ISCoS: 2012; Marias et al., 2006). In addition, the SCIPP has to take over responsibilities that were executed by the injured person before the injury, but also has to deal with their own frustrations, fears, feelings of helplessness, uncertainty and sadness (Steyn, 2008; Young & Keck, 2003). It is thus not only the injured person who has to adapt to permanent lifestyle changes, but also his/her partner, especially in cases of pre-injured marriages whereby the marriage or romantic relationship had taken place before one of the partners had acquired an SCI.

The literature is unequivocal that, in the presence of such risk, potential negative outcomes are expected to follow (Masten & Wright, 2010; Simpson & Jones, 2012). Therefore there is a high rate of divorce after SCI, and commonly, it occurs within three years of injury (Arango-Lasprilla et al., 2009; Karana-Zebari, De Leon, & Kalpakjin, 2011; Keleher et al. 2008; Phelps, Albo, Dunn, & Joseph, 2001; Priebe et al., 2007; Steyn, 2008). Bonanno and Giudice (2009) and Bonanno, Westphal and Mancini (2011) argue that not all adversities such as trauma and loss will result in negative outcomes for the individual and significant others. When trauma and loss do not lead to negative outcomes, resilience processes are considered fundamental to such positive adjustment as occasionally unexpected pathways to resilience do occur (Masten, 2011). When couples where one partner has acquired an SCI, cope positively with the adversities inherent in such a trauma, they function resiliently (Dickson et al., 2011; Dunn, Uswatte, & Elliott, 2009; Fronek, Kendall, Booth, Eugarde, & Geraghty, 2011; Gilad, Lavee, & Innes-Kerig, 2009; Steyn, 2008). Thus, in order to adapt effectively to the prolonged risks, couples need

to be resilient (if both the injured person and the partner have resilience skills, their potential to reconstruct a meaningful life would be encouraging).

Bonanno et al. (2011) argue that some people have the natural ability to resile in adverse circumstances, but Masten (2001) and Schoon and Bynner (2003), on the other hand, stated that some people might need resilience-promoting assistance. Some SCIPPs thus might need to be equipped with the needed knowledge and skills shortly after the acquired physical disability on, among others, self-regulation and negotiating actions to make positive adaptation more successful in order to adjust positively during the continuous hardships that they might experience.

A qualitative study by Steyn (2008) with five pre-injury married South African couples, where one had acquired an SCI, found that couples have a need for improved skill interventions that could provide them with truthful information regarding the physical; psychological; psychosocial and socio-economical adaptation after an SCI in order to assist them in adapting positively to the negative outcomes. Steyn (2008) also found that little is done during the rehabilitation period of the SCI partner to promote the positive adaptation of the SCIPPs, as the treatment-intervention is mostly focused on the SCI person. This was confirmed during informal feedback from Therapy Services Co-ordinators at two rehabilitation centres in South Africa (M van Niekerk, personal communication, August 15, 2011 & July 16, 2012; M van Vuuren, personal communication, February 2, 2013). This appears to be an international trend as little has been documented on interventions specifically developed and evaluated for SCIPPs (Elliot, Brossart, Berry, & Fine, 2008; Maddick & Stud, 2011; Steyn, 2008).

Furthermore, culture defines a community's interpersonal relationships, as found in a South African study by Hassim and Wagner (2013); therefore the latter as well as the unique trauma of the acquired SCI stresses that mere resilience-promoting programmes for adults who experience trauma (de Villiers & van den Berg, 2012; Dodding, Nasel, Murphy, & Howell, 2008; Liossis, Shochet, Millear, & Biggs, 2009; Lopinzi et al., 2011; Olivier, 2009) can't be used as such: hence a specific programme needs to be tailor-made to address the challenges of being a SCIPP, and more specifically for pre-injury relationships (Steyn, 2008). A strong argument was also presented by the afore-mentioned practitioners employed at rehabilitation centres, that a group programme could be more effective as the value of peer support and exposure to other SCIPPs should not be underestimated.

To address this practice need, the researcher planned and executed an intervention research project, which aimed to design and develop a group resilience-promoting programme for SCIPPs, tailor-made for the South African context. The first phase of intervention research, namely problem analysis and project planning (de Vos, Strydom, Fouché, & Delport, 2011) was covered in section A. Phase two, namely information gathering and synthesis is reported in this manuscript. A qualitative research synthesis was employed, which aimed at bringing together for discussion the findings and conclusions of previous research. The qualitative research synthesis entailed a systematic review of literature of relevant studies on resilience processes and documented resilience promotion programmes. An inclusion and exclusion criterion guided the systematic reviewing of literature. Next, studies were critically appraised and qualitative data analysis methods were employed to organize and synthesize content and themes that could be covered in a resilience-promoting programme for SCIPPs. The themes extracted were then triangulated

with the researcher's experience as well as with resilience literature (Masten & Wright, 2010), and literature on the negative outcomes of SCI in order to formulate a group resilience-promoting programme (GRPP) for SCIPPs. Hereafter it was further developed and refined by an advisory panel and a pilot study in 2014 (phases 3 & 4) (manuscript 2). Finally it was subjected to an evaluability assessment by experts (social workers and psychologists) (phase 5) in 2015 (manuscript 3). It will be formally evaluated in the future.

Next, the prevalence and impact of SCI will be discussed in more detail, following a review of resilience literature, the research methodology findings and discussion.

## 2 OVERVIEW OF LITERATURE

### 2.1 Prevalence and negative outcomes of SCI

The International Spinal Cord Society (ISCoS: 2012) reveals that approximately 250 00, 00 – 500 00, 00 people acquire SCI annually (Kalke, 2014). An estimated 12 000 Americans acquire a spinal cord injury each year (ISCoS, 2012), and German SCI Centres report to have 2 200 admissions with SCI annually (Kalke, 2014). Limited published statistics on the prevalence of acquired disabilities such as SCI in South Africa exist but the available statistics obtained from two rehabilitation centres in Johannesburg and Pretoria reported that they had treated approximately 350 SCI patients during 2009 to 2011 (M. van Niekerk, personal communication, August 15, 2011 & July 16, 2012; M. van Vuuren, personal communication, February 2, 2013). Furthermore an eleven-year descriptive study (from April 2003 – April 2014) at a Rehabilitation Hospital in the Western Cape indicated that a total of 2 042 patients were treated for SCI, 84% male and 16% female, with an average admission of 185 new patients per year, and 15 new patients per month (Sothmann, Stander, & Dunn, 2014).

Resilience-Promoting Activities for Spinal Cord Injured Persons' Partners

As mentioned earlier, the acquirement of a disability such as SCI places both the injured person and his/her partner at risk for potential negative outcomes. These negative outcomes could be categorised on physical, psychological, psychosocial, and socio-economical level (Chappell & Wirz, 2003; Keleher et al., 2008; O'Connor, Young, & Saul, 2004; van Zyl, 2008; Young & Keck, 2003), and will be briefly discussed.

Firstly, on a physical level, injured people with SCI have enormous changes regarding their activities of daily life (hereafter referred to as daily activities), such as getting dressed and taking a bath (O'Connor et al., 2004), amongst others, constant pain (Mayo Clinic, 2012) and pressure sores (South African Spine Society, 2012), which subsequently have an influence on their physical functioning (Keleher et al., 2008). This might put strain on the relationship between the injured person and his or her partner, since the SCIPP has to assist his/her partner with daily activities and in many cases has to take over some of his/her partners duties (e.g. household duties such as mowing the lawn) especially in the case of pre-injury marriages. This was also highlighted in two earlier but seminal studies, done nine years apart, which did a comparison between pre-injury and post-injury SCI marriages (Crewe, et al., 1979; Crewe & Krause, 1988). These authors found a number of differences between the marriages that took place after the onset of disability and those that had occurred earlier. Those married after injury reported greater over-all life satisfaction than pre-injured couples (Crewe & Krause, 1988).

Several authors reported negative outcomes on a psychological level, namely persons with SCI may be challenged with the reality of being disabled (Cohen & Napolitano, 2007; Ross & Deverell, 2010) and labelled as such, with little hope of recovery (Lee & Green, 2002; Saulino & Keenan, 2012). Subsequently, there is a high sense of loss of control for both the SCI person and the SCIPP, resulting in feelings of

powerlessness and leaving some patients (20%) at their departure from the rehabilitation facility, clinically depressed (Mayo Clinic, 2012; Young & Keck, 2003), which might have a ripple effect on the SCIPP who now has to be emotionally strong for their partners' sake although having difficulty regulating their own emotional feelings and reactions (Young & Keck, 2003).

Regarding the socio-economic functioning of the mentioned disability, a devastating statistic indicates that approximately 25% of paralysed people live in poverty due to the fact that they can no longer work, or their partners have to quit their jobs to become their caregivers, with resulting financial consequences (Reeve & Reeve, 2012). Furthermore Lee and Green (2002) and Priebe et al. (2007) concluded that SCI is expensive and that significant costs are incurred throughout the life of a person with SCI, including initial hospitalisation, acute rehabilitation, home and vehicle modifications, recurring costs for durable medical equipment, supplies, medications, and personal assistance.

Lastly, a body of research points to negative outcomes on a psychosocial level following an SCI of one of the partners, namely vast frustrations which might result in divorce (Chan, Lee, & Lieh-Mak, 2000; Crewe et al., 1979; Crewe & Krause, 1988; Dickson et al., 2011; North, 1999). Thus, the couple is constantly busy adapting to the prolonged risk of having an SCI in their midst, and consequently resilience processes such as emotional regulation and creative problem-solving skills, amongst others, need to be present or promoted in such couples in order for them to adapt positively .

## 2.2 Resilience Defined

Until recently, resilience was thought of as an individually focused construct, and a combination of individual capacities and environmental support was associated in an individual's success when facing risks (Bonanno, 2004). However, Ungar (2011) defines resilience from a social-ecological framework as the capacity of the community to be provided with what is meaningful to them, in ways that they can use whatever was provided to them, apart from the statement that resilience is also our individual capacity to overcome adversity.

Masten (2001) defines resilience as that there are two core elements that need to be present, namely (1) the presence of risk; significantly enough that it threatens to disrupt normal development, and (2) the ability to adjust well to experiencing significant risk. Masten and Wright (2010) have also classified six protective processes which they argue are universally prevalent among resilient individuals. The influential role protective factors play in helping individuals and families to overcome risks, stress and adversity was also found in the course of the same decade, in studies by Vasquez (2000) and Patterson (2002). Although these protective processes are mostly aimed at resilience in children at risk, it was included in interventions with adults such as the development of a US Army Master Resilience Training course (Robertson, Cooper, Sarkar, & Curran, 2014).

As such, for the purpose of this study the researcher will use these six universal protective processes as resilience-based framework. Masten and Wright (2010) argue that resilience-promoting-person-context interactions are embedded in six protective processes over the lifespan, namely "attachment relationships" (Masten & Wright, 2010); secondly, there is "agency and the mastery motivation system" (Masten & Wright, 2010). The third reported protective process is "intelligence" (Masten & Wright, 2010), involving

intelligent behaviour such as problem solving, which develops over time, in accordance with socially supported learning opportunities. In the fourth place, "self-regulation" is needed (Masten & Wright, 2010) and fifthly "making meaning" (Masten & Wright, 2010). The last protective process is "cultural tradition and religion" and refers to beliefs and practices that enable people to deal with hardship (Masten & Wright, 2010; Pargament & Cummings, 2010).

## 2.3 Resilience-promoting intervention approaches

Given the complexity of resilience, promoting resilience should be well-planned within a suitable intervention approach. Three approaches, regarding the promotion of resilience, are identified by Masten, Cutuli, Herbers and Reed (2009) and include a risk-reduction approach (focuses on reducing risk and aims at reducing exposure to adversity), an approach attentive to assets (this approach is interested in increasing the number and quality of resources) and a process-orientated approach (involves influencing processes that will encourage positive adjustment for the person at risk's life, instead of merely limiting exposure to risks or increasing the number of resources (Masten et al., 2009). Although these approaches are aimed particularly at fostering resilience in children who are at risk, the principles may be applied to others at risk, such as SCIPPs. The process-focused approach was chosen as a reference for SCIPPs' resilience promotion since it is very unlikely that exposure to risks in SCIPPs would be reduced. Such a process-focused approach could be implemented during the rehabilitation period of the injured person.

Bearing this intervention approach in mind, existing resilience-promoting programmes were searched and quite a few were found regarding promoting resilience (in groups and individuals) of children (De Villiers & van den Berg, 2012; Graham, 2004;

Morgan, 2009; Olivier, 2009; Pillay, Dunbar-Krige, & Mostert, 2013; van der Westhuizen, 2011) and adults with breast cancer (Lopinzi et al., 2011); woman with substance abuse problems (Hernandez & Mendoza, 2011); hospital workers and patients (Allielo et al., 2011) etc., but none was found that promotes resilience processes in SCIPPs; therefore it is evident that there is a dearth of resilience-promoting programmes regarding SCIPPs nationally and internationally (Elliot et al., 2008; Steyn, 2008). It was therefore imperative to conduct a research synthesis of literature in order to determine what has been done on this topic, but also what could be learned from what has been done in order to develop a GRPP for SCIPPs.

## 2.4 Group versus Individual

Bearing in mind that resilience theory is the resilience-based framework that directs this research study (Masten & Wright, 2010; Ungar, 2011), and that resilience can no longer be seen as an individual characteristic/trait, but rather navigation between the person and the social-ecology in an effort to negotiate support (Masten, 2001; Masten & Wright, 2010; Ungar, 2011), the researcher aimed at adopting group work as a social work method that will be best suited to fit the aims and objectives of this study.

Toseland and Rivas (2014, p. 2) define Social group-work as: "Goal-directed activity with small treatment and task groups aimed at meeting socio-emotional needs and accomplishing tasks. The activity is directed to individual members of a group and to the group as a whole within a system of service delivery". Bearing in mind that SCIPPs' resilience promotion is the main aim of this study, and that resilience is seen from a social-ecological perspective (Masten & Wright, 2010; Ungar, 2011), this seems to fit Toseland and Rivas' (2014) explanation of a "treatment group" with specific emphasis on two of the

six primary purposes of treatment groups, namely *education* and *support.* As such the main purpose of the GRPP for SCIPPs is to assist members in gaining new information and skills (Toseland & Rivas, 2014), and supporting group members so that they will be able to effectively adapt to and cope with future stressful life events (Maddick & Stud, 2011; Toseland & Rivas, 2014).

Although Social group-work also has limitations, for example that some people might have personality traits that could result in negative rather than positive interactions which may lead to the failure of others to continue with the group (Toseland & Rivas, 2014), the researcher still decided on adopting the Social group-work method for this study, as this method's advantages seem to be a well-fitted match for the social-ecological view of resilience (Ungar, 2011).

## 3 THE REVIEW

### 3.1 Aim of the Study

The aim of this study was to organize and synthesize previous research done on resilience- promoting processes in order to inform the design and development of a group resilience-promoting programme for SCIPPs to conceptualise protective processes that nurture resilience in SCIPPs.

Two research questions were driving this study, namely (1) What is already known about the processes that promotes resilience in SCIPPs? (2) What resilience-promoting processes can be organized and synthesized, from previous research, in order to be included in a group resilience-promoting programme for spinal cord injured persons' partners?

## 3.2 Design

A research synthesis differs from a literature review in that it aims to investigate what is known from what has been done, and not on what has been done alone (Coast, 2015). There are many types of research syntheses and no consistency pertaining to the naming of the different research synthesis (Kastner et al., 2012). As such, various terms, amongst other, are used, namely systematic synthesis (Saini & Shlonsky, 2012), meta-synthesis (Cooper, Hedges, & Valentine, 2009; Saini & Shlonsky, 2012); narrative synthesis (Leamy, Bird, Le Boutillier, Williams, & Slade, 2011), thematic synthesis (Thomas & Harden, 2008), meta-interpretation (Weed, 2008); qualitative interpretive meta-synthesis (Aguirre & Bolton, 2013); qualitative systematic review (Major & Savin-Baden, 2010) and a qualitative research synthesis (Flemming, 2009; Suri, 2011). The main difference between variety of types is which study designs they include and analyse, and the way in which they analyse the data that was extracted (Kastner et al., 2012). One type of research synthesis, namely qualitative research synthesis, includes qualitative-; quantitative-; and mixed method studies, and uses qualitative methods to analyse data (Flemming, 2009; Suri, 2011).

The strengths of a qualitative research synthesis are that it is a unique type of systematic review and it is descriptive, informative, evaluative and connective (Mays, Pope, & Popay, 2005). Suri (2011) further argues that a synthesis enhances the practical value of qualitative research as it enhances practice on a broader level. A possible disadvantage of a research synthesis is that many qualitative researchers believe that the viability of holistically synthesizing a large number of reports might be questionable and that an in-depth synthesis of purposefully selected studies is more desirable, a synthesis might also be too time consuming and expensive (Suri, 2011). Davis, Drey and Gould

(2009) state the inconsistencies in the interpretation of the synthesis as a possible limitation which required the need for a protocol (Suri, 2011).

In the process of reviewing literature and assessing which studies to include or exclude from the QRS, the researcher wanted to ensure trustworthiness so that only high-quality studies that relate to the aim of the study were selected (Dawson, Jackson, & Nyamati, 2012). Therefore the researcher developed a protocol with the intention of guiding the time slot for studies to be included in the QRS, relevant search methods were described; databases; inclusion and exclusion criteria; quality appraisal; extraction of data and iterative data analysis of extracted data; plotting of patterns and relationships across the first level and second level codes (Suri, 2011), and linking the latter with the six resilience-protective processes of Masten and Wright (2010).

Next, the researcher will elaborate on the different search methods used; how the quality appraisal was done and how data extraction and synthesis took place, where after the results will be discussed and a relevant conclusion will be conveyed.

### 3.3 Search methods

A systematic search of literature was done between August 2013 and March 2014, searching electronic archives of publications (between 2003 and 2014), in accredited journals, from the following search engines: Google Scholar, EBSCOhost, Scopus, One Search, Web of Science, Crossref, Emerald, SAePublications and LexisNexis, to determine whether a similar study had not perhaps been done. In each search archive, consistent keywords were used to ensure accuracy of findings. In this case none could be found. The researcher adapted the protocol through-out the process, as needed (see addendum 1).

Resilience-Promoting Activities for Spinal Cord Injured Persons' Partners

Hereafter the researcher then searched further to report on what is already known about the process that promotes resilience in SCIPPs. The following inclusion criteria (key words) were used to guide the search: Afrikaans and English studies; the following key words: spinal cord injured persons' partners' resilience, spinal cord injury, marriage and resilience; caregiver and resilience; physical disability and resilience; persons and their partners; spinal cord injury and spinal cord injured persons' partners' rehabilitation. Exclusion criteria pertaining to research question 1: studies older than eleven years and grey literature. Grey literature, such as technical reports and unpublished studies were not included because the quality of the information is unknown and this study relies on the rigorous standards peer-reviewed journals employ (Cooper et al., 2009; Norris & Ortega, 2000). The researcher found 53 studies relating to the first question of this synthesis.

The researcher furthermore searched for studies that can answer the second question of the synthesis, namely: How can resilience-promoting processes documented in research literature be represented in a group resilience-promoting programme (GRPP) for SCIPPs? The researcher finds it necessary to mention that resilience is not bounded by the type of adversity; the dynamic is in the person; the social-ecology and context (Ungar, 2011). Thus programmes for different kinds of adversities were searched, guided by the following inclusion criteria (key words): Afrikaans and English studies; Intervention programmes and resilience; caregiver and programmes; resilience and adults; adult attachment and resilience; mental health and resilience, resilience and SCI and programmes; SCI, resilience and depression; SCI, resilience and anxiety; group programmes and resilience; group programmes for adults; enhancing resilience in adults; enhancing resilience in caregivers; resilience processes in adults; social work resilience programmes; skills and resilience; adaptive coping and resilience. Exclusion criteria that

was employed: studies older than 11 years and marital enrichment programmes. As a marital therapist herself, the researcher became aware that a mere marital therapeutic programme, addressing, among others, issues such as conflict, communication challenges, and different sexual needs, was not sufficient for couples and specifically the partner of the person who acquired an SCI. Over and above the abovementioned issues, the partner of the person with an SCI needed to learn and develop skills promoted resilience and were grounded in the enhancement of protective processes in order to build on existing strengths and learn how to adjust positively to the prolonged risk as a result of the partner's injury. The researcher then found 47 studies but was not satisfied that the obtained studies answered both of the research questions sufficiently. Therefore, after consulting with an expert on resilience, from Trinity College in Ireland (R. Gilligan, personal communication, December 4, 2013), the search was expanded by including more terms, namely programmes with children and resilience; group resilience-promoting programmes and children; parenting programmes and resilience; occupational therapist with SCI and resilience; Caretaker morale in chronic conditions affecting spouse/partner, where after another 55 studies were extracted.

The researcher thus found 155 papers and reviewed 8 cited papers in these retrieved articles (therefore a total of 163 papers were reviewed) where after the abstracts and titles were assessed for relevance in order to select the 74 full-text versions of potentially suitable papers, to be quality appraised. Quality appraisal was done with these studies before 21 studies were included in this research synthesis. The quality appraisal process will now be discussed.

### 3.4 Quality Appraisal

There are different ways of doing quality appraisals, but what is important, however, is to appraise the quality of the published studies before synthesizing it, in order to avoid the reviewers to be biased (Shanenyfelt, 2015) and to ensure that these studies could be reproducible and that the reader can moreover be assured that they can follow the reviewers' recommendations (Canadian Partnership Against Cancer, 2015; Shanenyfelt, 2015). The researcher has used an example of a quality appraisal template (Flemming, 2009; Roberts & Bailey, 2011) and adapted this for the specific needs of this study. Higgins and Green (2008) also convey that a decision concerning the last-mentioned is among the most influential decisions in a review process which consequently involves decent judgment.

The adapted quality appraisal checklist (see addendum 2) consists of 13 questions, each of which has four sub-categories (Hawker, Payne, Kerr, Hardy, & Powel, 2002). A summed score of methodological quality is calculated, ranging from 52 (good) to 13 (very poor). The descriptors propose the possibility to produce a clear and open scoring of each study (Flemming, 2009) in order to assist the research with evident reasons for inclusion for data extraction (Dixon-Woods et al., 2007). Each paper was assessed for quality by the researcher and a cross-section of the papers was second-checked by an independent reviewer, no disagreement emerged (Flemming, 2009). Most papers were of reasonable methodological quality, with scores ranging from 31 – 44. Following this quality appraisal, 21 studies were prepared for data extraction which will be explained hereafter.

### 3.5 Data extraction and synthesis

The 21 selected qualitative, quantitative and mixed studies (Flemming, 2009; Suri, 2011), as well as literature reviews (which also answered the research questions, although it did not include specific participants), were included to be subjected to data extraction. Data were extracted only from the findings/results and discussion sections of primary quantitative, qualitative and mixed method research reports. The researcher acknowledges that qualitative and quantitative findings are presented differently. Quantitative findings mostly refer to numbers presented in text, tables and figures in a section labelled 'results', with a researcher's interpretation in a 'discussion' section (Sadelowski, Leeman, Knafl & Crandell, 2012). Qualitative findings are generally not linked to numbers, but presented in narrative form, organized thematically (Schurink, Fouché, & De Vos, 2011). The findings of quantitative studies were thus not meta-analysed, but reviewed for summaries of findings that answered the two research questions (Flemming, 2009).

Considering the fact that this study was guided by a resilience-based framework (Masten & Wright, 2010) a pro-forma or adapted template (Flemming, 2009; Roberts & Bailey, 2001) was created to enable the extraction of a summary of meaningful information on the title of the research, the research approach/design, the sample and participants, the findings (first and second level codes), the format, and how this align with the six resilience processes of Masten & Wright, 2010) (see table 3 and addendum 4).

**Table 3: Extraction of information from synthesized studies**

| Author and date | Title | Research approach/ design | Sample and Participants | First level codes (open codes) | Second level codes: 8 categories identified from synthesis | Alignment with the 6 resilience-protective processes of Masten & Wright (2010) |
|---|---|---|---|---|---|---|
| | | | | | | |

A suitable data analysing framework was chosen to meaningfully analyse the included data named Iterative data analysis, which is a deeply reflective process that promotes insight and develops meaning by visiting and revisiting the data and connecting it with emerging insights to enhance understanding (Srivastava & Hopwood, 2009). Iterative data analysis may be used when a preconceived theory guides the research whereby the researcher alternates between the considered existing theory and research interests on the one hand and emergent qualitative data on the other (Tracy, 2013); therefore this data analysis was guided by three main questions, namely (1) What is the data telling the researcher (engaging with theoretical, subjective, ontological, epistemological and field understandings)?; (2) What is it the researcher wants to know (according to research objectives, questions, and theoretical points of interest)?; and (3) What is the dialectical relationship between what the data is telling the researchers and what they want to know (refining the focus and linking back to research questions)? (Hopwood, 2015; Srivastava & Hopwood, 2009). As such, first-level coding was employed, which means that the researcher inductively coded the data to determine what content and reported resilience processes had emerged from the data (see addendum 3).

Hereafter second-level coding was implemented whereby all the first-level codes were grouped into eight categories. Following this process, the researcher deductively integrated the eight categories with the six universal resilience-protective processes found by Masten and Wright (2010). All eight categories could be contextualised into one or more of the six protective processes. An independent coder also coded the studies and a

consensus discussion took place before patterns and relationships across the emerging categories were strategized in order to answer the two research questions of this QRS, which enabled the formulation of an outline of a GRPP for SCIPPs with extracted categories which will be elaborated on (see addendum 4).

## 4 FINDINGS

With regard to the first research question, findings from the QRS confirm that there are no documented studies that report resilience processes in SCIPPs. Pertaining to the second research question eight categories emerged from synthesizing studies on processes that promote resilience in people exposed to various forms of adversities. The eight categories are: information; thinking/problem solving; spirituality; support; on-going relationships; stress management; coping, and acceptance. Each category will now be discussed and contextualized within the six universal protective processes of Masten and Wright (2010).

### 4.1 Information

The importance of giving participants information and educating them regarding the nature and impact of the specific adversity they're facing, was found in a number of studies, for example studies that focused on resilience training for hospital workers (Aiello et al., 2011); adults returning to work after illness (Kellett, Purdie, Bickerstoffe, Hopper, & Scott, 2013); a group work programme on empowering adolescents for the possible death of their HIV-infected caregivers (Olivier, 2009); a literature framework (Orbke & Smith, 2013); and adolescent orphans in foster care, affected by HIV and AIDS (van der Westhuizen, 2011).

Resilience-Promoting Activities for Spinal Cord Injured Persons' Partners

In the context of SCI, some imperative information should be conveyed to SCIPPs, such as knowledge concerning spinal cord injury (for instance different levels of the spinal cord) (Newsome, 2009), as well as the physical challenges and possible complications and potential negative outcomes thereof for the person with the acquired SCI and his/her caretaker/partner (for instance pressure sores; needed paraphernalia; rehabilitation; caretaking) (Newsome, 2009).

Furthermore, the significance of skills development in order to enhance competency was highlighted in studies focussing on problem-based learning to enhance nursing students' resilience (Chen, 2011); resilience training for survivors of breast cancer (Loprinzi, Prasad, Schroeder, & Sood, 2011); empowering adolescents for the possible death of their HIV-infected caregivers (Olivier, 2009); and to facilitate the learning of key needed concepts for adapting positively to adversity, as in a study in which children faced with culturally and linguistically diverse backgrounds is discussed (Mitchelson et al., 2010). Furthermore, participants should be empowered with skills to decrease their post-injury dependence, and enhance their social competence, as well as decision making- and time management skills, as found during studies covering spinal cord injuries acquired by men (Basson, Walter, & Stuart, 2003), being the caretaker of a family member with SCI (Elliot et al., 2008), and being in a romantic relationship in which a hearing impairment is experienced (Yorgason, Piercy, & Piercy, 2007).

Pertaining to SCI, SCIPPs importantly need to be educated regarding loss and the trauma process (Retief, 2014), as well as acquiring time-management and decision-making skills (Fouché & Williams, 2005; Jude, 2006), as the dynamics of "every-day-life" and the romantic relationship changes tremendously. Moreover, the caretaking role can be taxing (Newsome, 2009; Ross & Deverell, 2010) and might handicap the SCIPP preventing

him/her to resile (Masten & Wright, 2010). Providing SCIPPs with the needed information might thus promote their agency.

### 4.2 Thinking/problem solving

The ability to optimally make use of problem solving skills and utilize own analytical thinking-abilities was a leading strategy that emerged in interventions specifically addressing resilience training for hospital workers in anticipation of an influenza pandemic (Aiello et al., 2011); problem-based learning to develop resilience in nursing students (Chen, 2011); empowering women in treatment for substance abuse (Hernandez & Mendoza, 2011); stress management and resilience training for breast-cancer survivors (Loprinzi et al., 2011). Furthermore, cognitive emotion regulation strategies for patients with depression and/or anxiety disorders (Min, Yu, Lee, & Chae, 2013); evaluation of a resilience intervention to enhance coping strategies and protective factors and decrease symptomatology in students (Steinhardt & Dolbier, 2013); and on empowering adolescents for the possible death of their HIV-infected caregivers (Olivier, 2009). These studies also suggest a link with a self-help approach in managing one's life and practical problems experienced by adults returning to work after illness (Kellet et al., 2013) and might assist in identifying and creating opportunities for growth and future problem-solving in cases of survivors of childhood abuse (Orbke & Smith, 2013); being an adolescent orphan in foster care (affected by HIV and Aids) (van der Westhuizen, 2011); as well as being in a romantic relationship in which a hearing impairment is experienced (Yorgason et al., 2007). The use of cognitive behavioural therapy (CBT) was one of a few helping models/methods that emerged from a number of studies that could add value and might assist with collecting behavioural skills, as seen in a study in which a resiliency programme for children was employed (de Villiers & van den Berg, 2012); also where

group therapy for people experiencing anxiety and/or depression (with a significant other) was performed (Dodding et al., 2008); and an adult resilience programme to promote their effectiveness in the workplace (Liossi et al., 2009).

Furthermore the synthesized studies of Elliot et al. (2008); Graham (2004) and Pillay et al. (2013), recommended that a person's orientation or attitude towards problem-solving, the practicing of critical awareness; understanding and decision- making as well as time management can be of assistance to promote resilience which again correlates with the mentioned CBT models/methods previously mentioned (de Villiers & van den Berg, 2012; Dodding et al., 2008:41-49; Liossis et al., 2009).

In the context of SCI, SCIPPs need problem-solving and decision-making skills regarding physical caretaking of their spinal cord injured partners (Newsome, 2009); skills for taking care of themselves after this adversity (de Kooker, 2005; 2007); assistance with means to cope with their own reactions to the loss (Retief, 2014) and the dual role they will have to fulfil; and consequently to deal with possible relationship changes (Chapman, 2010; de Kooker, 2005; Fouché & Williams, 2005) as the "new" SCI in their midst can be overwhelming and be the spoiler of their dreams (Ross & Deverell, 2010). Therefore, by equipping them with adequate processes to promote their resilience (Masten & Wright, 2010), SCIPPs can learn "to dance in the rain" despite the adversity they're facing.

### 4.3 Spirituality

In their study with breast cancer survivors, Loprinzi et al. (2011) found that forgiveness and higher meaning, as well as a feeling of purpose, enhances hardiness and is in accordance with Olivier's (2009) findings during a group-work programme, whereby adolescents were empowered for the possible death of their caregivers, that spirituality

nurtures resilience. Therefore, in the case of SCI, spirituality can also be a protective factor for SCIPPs as this can, amongst others, assist them in higher meaning-making and purpose-seeking during and after this life-changing experience (Masten et al., 2010). It is thus imperative to include the resilience-protective process of spirituality during intervention. However, one needs to be careful not to enforce specific religious practices on any person, as every SCIPP's culture, religion and freedom of choice should be respected at all times (Patton, 2015).

### 4.4 Support

Comparatively a significant number of studies in the QRS, highlight the importance of fostering resilience competencies regarding the participants' social and emotional functioning and navigation towards support (Masten, 2001; Masten et al., 2010; Ungar, 2011). These studies are focusing on males with spinal cord injuries' experiences of their sexuality (Basson et al., 2003); developing resilience in nursing students (Chen, 2011); the implementation and evaluation of a resiliency programme for children (de Villiers & van den Berg, 2012); people experiencing anxiety and/or depression (and a significant other of their choice) (Dodding et al., 2008); empowering women in treatment for substance abuse (Hernandez & Mendoza, 2011); attachment injuries in couple relationships (Johnson, Makinen, & Millikin, 2001); and a mother-and-child intervention to promote resilience in young children of HIV-infected mothers in South Africa (van der Westhuizen, 2011)

In the context of SCI, a SCIPP needs to be educated on how to navigate towards support in more than one way. Firstly the SCIPP must understand how to 'support" himself/herself, by employing resilience-promoting activities such as visualization;

awareness; introspection and assertiveness (Chapman, 2010; Childre, 1997; de Kooker, 2005; 2007; Fouché & Williams, 2005); secondly they must also acquire information on how to support their partner as the partner has to deal with emotional reactions of their own (Jude, 2006; McFarlane, 2011; Retief, 2006; 2014). Utilizing the protective process of "support" in their lives might assist SCIPPs with the "ability to bounce back" in the context of this adversity (Boerner & Jopp, 2010).

### 4.5 On-going relationships

Knowledge on creating safe connections (or secure base/source of security) that makes exploration for comfort and protection possible, seems to be a noteworthy source of protection for people exposed to adversity, as was detected in a resilience training study with hospital workers (Aiello et al., 2011); a peer-based education programme for children confronted with changes, loss and grief (Graham, 2004); a HIV and AIDS group work programme empowering adolescents for the possible death of their caregivers (Olivier, 2009); enhancing resilience in adult survivors of childhood abuse (Orbke & Smith, 2013); a mother-and-child intervention to promote resilience in young children of HIV-infected mothers in South Africa (Visser et al., 2012); and an exploration of couple resilience processes with older couples where hearing impairments are experienced (Yorgason et al., 2007). Furthermore, Mitchelson et al. (2010) found that a resilience-building programme for children and young people (from culturally and linguistically diverse backgrounds) promoted the participants' resilience, since it, amongst others, offered material that supports creative and interactive group activities to facilitate the learning of key concepts which correlates with the resilience-promoting process, namely "attachment relationships" (Masten & Wright, 2010).

Pertaining to a newly acquired SCI, changes within the romantic relationship and within the family relationships are inevitable, as most stressors are shared by family or friends, directly or indirectly, in the paths to recovery for people in predicament (Zautra, Hall, & Murray, 2010). Therefore information, awareness and sharing regarding the latter can reduce the SCIPPs' uncertainty and help him/her to come to terms with the disability and the promotion of strategies to resile in the midst of the adversity (Chapman, 2010; McFarlane, 2011; Patton, 2015; Ross & Deverell, 2010).

### 4.6 Stress management

Notably information on stress, the reduction thereof, relaxation, and the idea that participants should be sensitized to recognize triggers (that might have a negative influence on their hardiness), is importantly found by studies focusing on people exposed to adversity, as was detected in a resilience training study with hospital workers in anticipation of an influenza pandemic (Aiello et al., 2011); people experiencing anxiety and/or depression (and a significant other of their choice) (Dodding et al., 2008); women with substance abuse problems (Hernandez & Mendoza, 2011); and breast cancer survivors (Loprinzi et al., 2011). Importantly furthermore, assisting people to express vulnerability, with couples where hearing impairment are experienced (Johnson et al., 2001); to engage in positive reappraisal, as was done with people suffering depression /or anxiety disorders (Min et al., 2013), and to be optimistic, similar to enhancing college students' coping strategies (Steinhardt & Dolbier, 2013) and being assertive, for example children who had to respond to change, loss and grief (Graham, 2004), and adolescent orphans in foster care affected by HIV and AIDS (van der Westhuizen, 2011).

Pertaining to SCI, a SCIPP also experiences high levels of stress, amongst others, as he/she might feel the pressure to "be strong", and consequently might deny his/her own overwhelming feelings of confusion; adjustment to changes in his/her daily life, while also adapting to being a partner of a disabled person (Marais et al., 2006; Retief, 2014; Steyn, 2008). Therefore the SCIPPs must be sensitized regarding their own possible feelings of vulnerability, anxiety and probable feelings of depression and burn-out by being given the correct information and resilience-promoting "tools" on stress management (Childre, 1997; Fouché & Williams, 2005; Jude, 2006); trauma (Retief, 2014) and relaxation-methods (de Kooker, 2005; 2007), to be able to resile despite the hardship (Masten & Wright, 2010).

### 4.7 Adaptive Coping

Adaptive coping is a term used in the resilience theory (Wright, Masten, & Narayan, 2013) and refers to healthy strategies of dealing with the root of the problem, and assists people in self-regulation and making meaning (Masten & Wright, 2010). Adaptive coping skills seemed to be an important resilience-protective factor, as this was found to be significant in 10 studies that focused on resilience training for hospital workers (Aiello et al., 2011); males' experiences of their sexuality after SCI (Basson et al., 2003); children confronted with changes, loss and grief (Graham, 2004); people returning to work after illness (Kellett et al., 2013); and promotion of adult resilience in the workplace (Liossis et al., 2009). Furthermore an HIV and AIDS group-work programme empowering adolescents for the possible death of their caregivers (Olivier, 2009); an intervention to promote resilience in young children of HIV-infected mothers in South Africa (Visser et al., 2012); enhancing resilience of adult survivors of childhood abuse (Orbke & Smith, 2013); exploring 13 learners with behavioural, emotional, and social difficulties,

experiences after reintegration into mainstream education (Pillay et al., 2013); which therefore places the emphasis on a balance between dependence and autonomy, similar to a study by Yorgason et al. (2007) which explored couple resilience processes in the presence of hearing impairment in older couple relationships. SCIPPs occasionally neglect their "own being". Amongst others the possible unspoken feelings or thoughts of "survival guilt" (Retief, 2014), and also due to the possibility that they don't want to fail their partner, children or other family members. If SCIPPs are guided with applicable resilience-promoting activities (de Kooker, 2005; 2007; Fouché & Williams, 2005), programme media and other resources (Retief, 2014) to understand why their own caretaking is so important, they might be able to cope competently and move towards the possibility of living a balanced, resilient life, despite the long-lasting presence of SCI.

### 4.8 Acceptance

The importance of acceptance and making meaning was found in studies pertaining to group therapy for people experiencing anxiety and/or depression (and a significant other of their choice) (Dodding et al., 2008); providing problem-solving training to family caregivers of persons with SCI (Elliot et al., 2008); a study understanding couples with attachment injuries (Johnson et al., 2001); breast cancer survivors (Loprinzi et al., 2011); and cognitive behavioural therapy for patients with depression and/or anxiety disorders (Min et al., 2013). To be solution-focused seems to be imperative in studies pertaining to empowering adolescents for the possible death of their caregivers (Olivier, 2009); as well as when developing a framework for enhancing resilience of adult survivors of childhood abuse (Orbke & Smith, 2013). Furthermore to be able to resist failure is important, as can be seen in a study by Chen (2011) who focused on problem-based learning to develop resilience in nursing students; and research done by Hernandez and Mendoza (2011)

whereby they developed a strategy to empower women in treatment for substance abuse, in order to have a sense of purpose and move on with life; and is also perceptible in an intervention programme by Graham (2004) that focused on children's response to change, loss and grief.

When SCI comes into play, SCIPPs must be guided to come to terms with things they can change (for instance their attitude); as well as things they cannot change (for example their partners' sudden disability), by affording them the opportunity of doing introspection (de Kooker, 2005; 2007; Fouché & Williams, 2005) and being served with analytical thinking "tools" (Childre, 1997) for developing their interpersonal competencies and being more skilled in managing their own experiences of loss (Retief, 2006; 2014) and working towards promoting their own resilience on a daily basis.

## 5 DISCUSSION

No studies that report resilience-promoting processes in SCIPPs, or any tailor-made resilience-promoting programme for SCIPPs, could be traced in literature. The synthesized studies do offer some insight into the processes that can nurture resilience in adults and children who are faced with adversities, and which could indeed be applied in resilience-promoting activities for SCIPPs. These identified resilience-promoting processes in literature can be represented in a GRPP for SCIPPs. The results of this QRS demonstrate that, when individuals are experiencing adversity and are confronted with resulting negative outcomes; resilience-promoting processes can moderate the impact of adversity on adaptation which is in line with resilience theory (Ungar, 2010; Wright , Masten, & Narayan, 2013). As a result of this, the formulation of a group resilience-promoting programme (GRPP) for spinal cord injured persons' partners (SCIPPs), embedded in six resilience-protective processes (Masten & Wright, 2010), can be suggested.

From these studies, eight categories were identified that could be included in a process-focused intervention approach (Masten et al., 2009) for SCIPPS, namely information; thinking/problem solving; spirituality; support; on-going relationships; stress management; coping and acceptance. These eight categories were aligned with resilience theory, embedded in the six protective processes of Masten and Wright (2010), which emerged in formulating an outline for such a programme, as depicted in table 4.

**Table 4: Formulated outline of the GRPP for SCIPPs**

| Session | Themes | Outcomes | Resilience-protective Processes (Masten & Wright, 2010) |
|---|---|---|---|
| 1 | Information on SCI and resilience | *Contracting (Becker, 2010)<br>* Introduce potential negative outcomes of SCI, resilience-protective processes and a resilience-promoting activity (RPA) to survive the negative outcomes<br>(Fouché & Williams, 2005) | * Agency and mastery motivation system<br>* Intelligence (problem solving)<br>(Masten & Wright, 2010) |
| 2 | Assist SCIPPs in understanding/realising that their reactions/emotions to these huge changes are normal | * Continue creating awareness of potential negative outcomes of SCI, resilience-protective processes and an RPA that could assist SCIPPs to survive the negative outcomes<br>* Educate about loss and the trauma process<br>* RPA that could assist SCIPPs in surviving the negative outcomes<br>(de Kooker, 2005; Fouché & Williams, 2005) | * Agency and mastery motivation system<br>* Intelligence (problem solving)<br>* Self-regulation<br>* Making meaning<br><br>(Masten & Wright, 2010) |
| 3 | Caretaking and support | * Continue creating awareness of potential negative outcomes of SCI, resilience-protective processes and an RPA that could assist SCIPPs in surviving the negative outcomes<br>* Educate about physical caretaking of the partner who has acquired an SCI<br>* RPA that could assist SCIPPs in surviving the negative | * Agency and mastery motivation system<br>* Intelligence (problem solving)<br>* Culture, tradition and religion<br>* Self-regulation<br>* Making meaning<br>(Masten & Wright, 2010) |

| Session | Themes | Outcomes | Resilience-protective Processes (Masten & Wright, 2010) |
|---|---|---|---|
| | | outcomes<br>(Childre, 1997; Chapman, 2010; de Kooker, 2015) | |
| 4 | My dual role as SCIPP | * Continue creating awareness of potential negative outcomes of SCI, resilience-protective processes and an RPA that could assist SCIPPs in surviving the negative outcomes<br>* Educate about how physical caretaking of the partner can influence the relationship and attachment between the partners<br>* RPA that could assist SCIPPs in surviving the negative outcomes<br>(Chapman, 2010) | * Agency and mastery motivation system<br>* Intelligence (problem solving)<br>* Attachment relationships<br>* Self-regulation<br>(Masten & Wright, 2010) |
| 5 | Own caretaking by SCIPP | * Continue creating awareness of potential negative outcomes of SCI, resilience-protective processes and an RPA that could assist SCIPPs in surviving the negative outcomes<br>* Creating awareness of the importance of own caretaking in order to maintain stress better and cope competently with the adversity<br>* RPA that could assist SCIPPs in surviving the negative outcomes<br>(de Kooker, 2007; Fouché & Williams, 2005; Jude, 2006) | * Agency and mastery motivation system<br>* Intelligence (problem solving)<br>* Culture, tradition and religion<br>* Self-regulation<br>* Making meaning<br>(Masten & Wright, 2010) |
| 6 | Termination and way forward | * Continue creating awareness of potential negative outcomes of SCI, resilience-protective processes and an RPA that could assist SCIPPs in surviving the negative outcomes<br>* Addressing emotional reactions of SCIPPs due to termination<br>* Evaluation and termination of group sessions with SCIPPs after termination<br>(Toseland & Rivas, 2014) | * Agency and mastery motivation system<br>* Intelligence (problem solving)<br>* Culture, tradition and religion<br>* Attachment relationships<br>* Self-regulation<br>* Making meaning<br>(Masten & Wright, 2010) |

## 6 RECOMMENDATIONS

The outline of the GRPP for SCIPPs consists of the themes that could be included in an intervention programme. However, the outline needs to be further developed into an intervention that could be implemented with SCIPPs. Bonanno et al. (2011) warned that interventions could be harmful if not tested in advance. In order to do no harm, further development of the programme will be done with the assistance of an advisory panel, and pilot tested with SCIPPS, before it is subjected to an evaluability assessment thereafter (manuscript 3). In the next manuscript, the researcher will explain how the GRPP for SCIPPs was further developed.

## 7 LIMITATIONS

The researcher excluded studies prior to 2003, and also studies after 2014, she thus acknowledges that the publications being used might be incomplete, even though she sampled until data saturation was reached. Furthermore, the exclusion of studies in languages other than English and Afrikaans might have caused the exclusion of studies answering the research questions. This implies that the researchers' sampling was biased, and thus reported findings may need to be interpreted cautiously.

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**REFERENCES**

Aguirre, R. T. P., & Bolton, M. W. (2013). Why do they do it? A qualitative interpretive meta-synthesis of crisis volunteers' motivations. *Social Work Research*, *37*(4), 327–338. doi:10.1093/swr/svt035

Aiello, A., Khayer, M. Y., Raja, S., Peladeau, N., Romano, D., Leszcz, M., Schulman, R. B. (2011). Resilience training for hospital workers in anticipation of an influenza pandemic. *Journal of Continuing Education in the Health Professions*, *31*(1), 15–20. doi:10.1002/chp.20096

Arango-Lasprilla, J. C., Ketchum, J. M., Francis, K., Premuda, P., Stejskal, T., & Kreutzer, J. (2009). Influence of race/ethnicity and divorce/separation 1, 2, and 5 years past spinal cord injury. *Archives of Physical Medicine and Rehabilitation*, *90*(8), 1371–1378. doi:10.1016/j.apmr.2009.02.006

Basson, P. J., Walter, S., & Stuart, A. D. (2003). A phenomenological study into the experience of their sexuality by males with spinal cord injury. *Health SA Gesondheid*, *8*(4), 3–11. doi:10.4102/hsag.v8i4.141

Becker, L. (2010). *Working with groups*. Cape Town, South Africa: Oxford University press.

Boerner, K., & Jopp, D. (2010). Resilience in response to loss. In J. W. Reich, A. J. Zautra, & J. S. Hall (Eds.), *Handbook of adult resilience* (pp. 126–145). New York, NY: Guilford press.

Bonanno, G. A. (2004). Loss, trauma, and human resilience. Have we underestimated the human capacity to thrive after extremely aversive events? *American Psychologist*, 5*9*(1), 20–28. doi:10.1037/0003-066X.59.1.20

Bonanno, G., & R. L. Giudice (2009). Vegetation of the Acquicella stream, urban water course of Catania (Sicily, South Italy). *Webbia, 64*(2), 213–234. doi:10.1080/00837792.2009.10670860

Bonanno, G. A., Westphal, M., & Mancini, A. D. (2011). Resilience to loss and potential trauma. *Annual Review of Clinical Psychology, 7*(1), 511–535. doi:10.1146/annurev-clinpsy-032210-104526

Canadian Partnership Against Cancer. (2015, June 23). Definition of quality appraisal [Video file]. Retrieved from https://www.youtube.com/watch?v=AsD9Lp-q45Y

Chan, R. C. K., Lee, P. W. H., & Lieh-Mak, F. (2000). The pattern of coping in persons with spinal cord injuries. *Disability and Rehabilitation, 22*(11), 501–507. doi:10.1080/096382800413998

Chapman. G. (2010). *The 5 love languages: The secret to love that lasts*. Chicago, IL: Northfield publishing.

Chappell, P., & Wirz, S. (2003). Quality of life following spinal cord injury for 20-40 year old males living in Sri Lanka. *Asia Pacific Disability Rehabilitation Journal, 14*(2), 162–178. Retrieved from http://english.aifo.it/disability/apdrj/apdrj203/scord-srilanka.pdf

Chen, J. Y. (2011). Problem-based learning: Developing resilience in nursing students. *The Kaohsiung Journal of Medical Sciences, 27*(6), 230–233. doi:10.1016/j.kjms.2010.11.005

Childre, D. (1997). *Teaching children to love: 80 Games and fun activities for raising balanced children in unbalanced times* (4th ed.). Boulder Creek, CA: Planetary Publications.

Coast, E. (2015). Research synthesis: What, why and how? (PowerPoint presentation). Retrieved from http://webcache.googleusercontent.com/search?q=cache:DLcz_SOy0wIJ:personal.lse.ac.uk/coast/ouaga%2520coast%2520presentation%2520research%2520synthesis.ppt+&cd=1&hl=en&ct=clnk&gl=za

Cohen, C. B., & Napolitano, D. (2007). Adjustment to disability. In F. K. O. Yuen, C. B. Cohen, & K. Tower (Eds.), *Disability and social work education: Practice and policy issues* (pp. 135–155). Binghamton, NY: Haworth Press.

Cooper, H., Hedges, L. V., & Valentine, J. C. (2009). *The handbook of research synthesis and meta-analysis*. New York, NY: Russell Sage Foundation.

Crewe, N. M., Athelstan, G. T., & Krumberger, J. (1979). Spinal cord injury: A comparison of pre-injury and post-injury marriages. *Archives of Physical Medicine and Rehabilitation*, *60*(6), 252–256. Retrieved from http://www.ncbi.nlm.nih.gov/pubmed/454118

Crewe, N. M., & Krause, J. S. (1988). Marital relationships and spinal cord injury. *Archives of Physical Medicine and Rehabilitation*, *69*(6), 435–438. Retrieved from http://www.ncbi.nlm.nih.gov/pubmed/3377669

Davis, K., Drey, N., & Gould, D. (2009). What are scoping studies? A review of the nursing literature. *International Journal of Nursing Studies*, *46*(10), 1386–1400. doi:10.1016/j.ijnurstu.2009.02.010

Dawodu, S. T. (2011). *Spinal cord injury – definition, epidemiology, pathophysiology.* Retrieved from http://www.medicinenet.com/medterms-medical-dictionary/article.htm

Dawson, A., Jackson, D., & Nyamati, A. (2012). Children of incarcerated parents: Insights to addressing a growing public health concern in Australia. *Children and Youth Services Review*, *34*(12), 2433–2441. doi:10.1016/j.childyouth.2012.09.003

De Kooker, M. (2005). Mind, immunity and health: Clinically applied Psychoneuroimmunology (Training manual). Workshop presented at Rooiribbokstreet, Pretoria.

De Kooker, M. (2007). The Science of Happiness (Training manual). Workshop presented at the Public Library, Vanderbijlpark.

De Villiers, M., & Van den Berg, H. (2012). The implementation and evaluation of a resiliency programme for children. *South African Journal of Psychology*, *42*(1), 93–102. doi:10.1177/008124631204200110

De Vos, A. S., & Strydom, H. (2011). Intervention research. In A. S. De Vos, H. Strydom, C. B. Fouché, & C. S. L. Delport (Eds.), *Research at grass roots: For the social sciences and human service professions* (4th ed., pp. 273–389). Pretoria, South Africa: Van Schaik Publishers.

De Vos, A. S., Strydom, H., Fouché, C. B., & Delport, C. S. L. (2011). *Research at grass roots: For the social sciences and human service professions* (4th ed). Pretoria, South Africa: Van Schaik Publishers.

Dickson, A., O'Brien, G., Ward, R., Flowers, P., Allan, D., & O'Carroll, R. (2011). Adjustment and coping in spousal caregivers following a traumatic spinal cord injury: An interpretative phenomenological analysis. *Journal of Health Psychology*, *17*(2), 247–257. doi:10.1177/1359105311411115

Dixon-Woods, M., Sutton, A., Shaw, R., Miller, T., Smith J., Young, B., Jones, D. (2007). Appraising qualitative research for inclusion in systematic reviews: A quantitative

and qualitative comparison of three methods. *Journal of Health Services Research and Policy*, *12*(1), 42–47. doi:10.1258/135581907779497486

Dodding, C. J., Nasal, D. D., Murphy, M., & Howell, C. (2008). All in for mental health: A pilot study of group therapy for people experiencing anxiety and/or depression and a significant other of their choice. *Mental Health in Family Medicine*, *5*(1), 41–49. Retrieved from http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2777547/pdf/MHFM-05-041.pdf

Dunn, D. S., Uswatte, G., & Elliott, T. R. (2009). Happiness, resilience, and positive growth following physical disability: Issue for understanding, research, and therapeutic intervention. In S. J. Lopez & C. R. Snyder (Eds.), *Oxford handbook of positive psychology* (pp. 651–654). New York, NY: Oxford University Press.

Elliot, T. R., Brossart, D., Berry, J. W., & Fine, P. R. (2008). Problem-solving training via videoconferencing for family caregivers of persons with spinal cord injuries: A randomized controlled trail. *Behaviour Research and Therapy*, *46*(11), 1220–1229. doi:10.1016/j.brat.2008.08.004

Flemming, K. (2009). Synthesis of quantitative and qualitative research: An example using critical interpretive synthesis. *Journal of Advanced Nursing*, *66*(1), 201–217. doi:10.1111/j.1365-2648.2009.05173.x

Fouché, A., & Williams, H. (2005). Therapeutic tools for adolescents & adults: 8 & 9 (Training manual). Workshop presented at the North-West University, Vaal Triangle Campus, Vanderbijlpark.

Fronek, P., Kendall, M., Booth, S., Eugarde, E., & Geraghty, T. (2011). A longitudinal study of sexuality training for the interdisciplinary rehabilitation team. *Sex Disability*, *29*(2), 99–100. doi:10.1007/s11195-010-9177-1

Gilad, D., Lavee, Y., & Innes-Kerig, O. (2009). The structure of dyadic support among couples with and without long-term disability. *Journal of Behavioral Medicine*, *32*(5), 453–465. doi:10.1007/s10865-009-9216-5

Graham, A. (2004). Life is like seasons: Responding to change, loss, and grief through a peer-based education program. *Childhood Education*, *80*(6), 317–321. doi:10.1080/00094056.2004.1052127

Hassim, J., & Wagner, C. (2013). The cultural context in psychopathology formulations. *The South African Journal of Psychiatry*, *19*(1), 4–10. doi:10.7196/SAJP.400

Hawker S., Payne S., Kerr C., Hardy, M., & Powel, J. (2002). Appraising the evidence: Reviewing disparate data systematically. *Qualitative Health Research*, *12*(9), 1284–1299. doi:10.1177/1049732302238251

Hernandez, V. R., & Mendoza, C. T. (2011). Shame resilience: A strategy for empowering woman in treatment for substance abuse. *Journal of Social Work Practice in the Addictions*, *11*(4), 375–393. doi:10.1080/1533256X.2011.622193

Higgins, J. P. T., & Green, S. (2008). *Cochrane handbook for systematic reviews of interventions Version 5.00*. Retrieved from https://scholar.google.co.za/citations?view_op=view_citation&hl=en&user=EYQIr1sAAAAJ&citation_for_view=EYQIr1sAAAAJ:J-pR_7NvFogC

Hopwood, N. (2015, May 21). Qualitative analysis 3: Practical framework [Video file]. Retrieved from https://www.youtube.com/watch?v=9zDmNXg0gMM

International Spinal Cord Society (ISCoS). (2012). eLearning. http://www.iscos.org.uk/elearning Date of access: 20 November 2014 .

Isaksson, G., Josephsson, S., Lexell, J., & Skär, L. (2008). Men's experiences of giving and taking social support after their wife's spinal cord injury. *Scandinavian*

*Journal of Occupational Therapy*, *15*(4), 236–246. doi:10.1080/11038120802194265

Johnson, S. M., Makinen, J. A., & Millikin, J. W. (2001). Attachment injuries in couple relationships: A new perspective on impasses in couples therapy. *Journal of Marital and Family Therapy*, *27*(2), 145–255. doi:10.1111/j.1752-0606.2001.tb01152.x

Jude, B. (2006). *Get what you set*. Retrieved from http://www.worldcat.org/title/get-what-you-set-y-dr-brain-l-jude/.../233526925

Kalke, Y. B. (2014, October). *International perspectives on spinal cord injury*. Paper presented at the 11th Biennial SASCA Congress. Pretoria, South Africa.

Karana-Zebari, D., De Leon, M. B., & Kalpakjin, C. Z. (2011). Predictors of marital longevity after new spinal cord injury. *Spinal Cord*, *49(1)*, 120–124. doi:10.1038/sc.2010.63

Kastner, M., Tricco, A. C., Soobiah, C., Lillie, E., Perrier, L., Horsley, T., Straus, S. E. (2012). What is the most appropriate knowledge synthesis method to conduct a review? Protocol for a scoping review. *BMC Medical Research Methodology*, *12*(1), 114. doi:10.1186/1471-2288-12-114

Keleher, C. A., Danny, R., Dixon, P. H. D., Holliman, D., & Vodde, R. (2008). Spinal cord injury: A biopsychosocial perspective and primer for social workers. *Journal of Social Work in Disability & Rehabilitation*, *2*(1), 57–77. doi:10.1300/J198v02n01_04

Kellett, S., Purdie, F., Bickerstoffe, D., Hopper, S., & Scott, S. (2013). Predicting return to work from health related welfare following low intensity cognitive behavior

therapy. *Behaviour Research and Therapy*, *51*(3), 134–141. doi:10.1016/j.brat.2012.12.002

Leamy, M., Bird, V., & Le Boutillier, C., Williams, J., & Slade, M. (2011). Conceptual framework for personal recovery in mental health: Systematic review and narrative synthesis. *The British Journal of Psychiatry*, *199*(6), 445–452. doi:10.1192/bjp.bp.110.083733

Lee, T. T., & Green, B. A. (2002). Advances in the management of acute spinal cord injury. *Orthopedic Clinics of North America*, *33*(2), 311–315. doi:10.1016/S0030-5898(02)00004-4

Liossis, P. L., Shochet, I. M., Millear, P. M., & Biggs, H. (2009). The Promoting Adult Resilience (PAR) Program: The effectiveness of the second, shorter pilot of a workplace prevention program. *Behaviour Change*, *26*(2), 97–112. doi:10.1375/bech.26.2.97

Loprinzi, C. E., Prasad, K., Schroeder, D. R., & Sood, A. (2011). Stress Management and Resilience Training (SMART) program to decrease stress and enhance resilience among breast cancer survivors: A pilot randomized clinical trial. *Clinical Breast Cancer*, *11*(6), 364–368. doi:10.1016/j.clbc.2011.06.008

Maddick, R., & Stud, G. (2011). 'Naming the unnamable and communicating the unknowable': Reflections on a combined music therapy/social work program. *The Arts in Psychotherapy*, *38*(2), 130–137. doi:10.1016/j.aip.2011.03.002

Major, C., & Savin-Baden, M. (2010). *An introduction to qualitative research synthesis managing the information explosion in social science research*. Retrieved from http://www.worcester.ac.uk/pdfs/maggi-savin-baden.pdf

Marais, P., Marais, S., Booyens, L., Bester, F., Weyers, A., Nel, M., & Maartens, M. (2006). Deur die trauma van liggaamlike gestremdheid en verlamming. In M. Maartens (Ed.), *Deur trauma* (pp. 22–85). Pretoria, South Africa: LAPA uitgewers.

Masten, A. S. (2001). Ordinary magic: Resilience processes in development. *American Psychologist*, *56*(3), 227–238. doi:10.1037//0003-066x.56.3.227

Masten, A. S. (2011). Resilience in children threatened by extreme adversity: Frameworks for research, practice and translational synergy. *Development and Psychopathology*, *23*(2), 493–506. doi:10.1017/S0954579411000198

Masten, A. S., Cutuli, J. J., Herbers, J. E., & Reed, M. J. (2009). Resilience in development. In S. J. Lopez & C. R. Snyder (Eds.), *Oxford handbook of positive psychology* (pp. 117–131). New York, NY: Oxford University Press.

Masten, A. S., & Wright, M. O. (2010). Resilience over the lifespan: Developmental perspectives on resistance, recovery, and transformation. In J. W. Reich, A. J. Zautra, & J. S. Hall (Eds.), *Handbook of adult resilience* (pp. 213–235). New York, NY: The Guilford press.

Mayo Clinic. (2012). *Bladder control changes, bowel control, loss of skin sensations, circulatory control, respiratory problems, muscle tone problems, pain and depression*. Retrieved from http://www.mayoclinic.com/health/spinal-cord-injury/DS00460

Mays, N., Pope, C., & Popay, J. (2005). Systematically reviewing qualitative and quantitative evidence to inform management and policy-making in the health field. *Journal of Health Services Research & Policy*, *10*(1), (Suppl.), S6–S20. doi:10.1258/1355819054308576

McFarlane, A. (2011, July 28). Post traumatic experiences [Video file]. Retrieved from https://www.youtube.com/watch?v=9_H_pFiLssE

Migliorini, C., & Tonge, B. (2009). Reflecting on subjective well-being and spinal cord injury. *Journal of Rehabilitation Medicine, 41*, 445–450. doi:10.2340/16501977-0358

Min, J., Yu, J. J., Lee, C., & Chae, J. (2013). Cognitive emotion regulation strategies contributing to resilience in patients with depression and/or anxiety disorders. *Comprehensive Psychiatry*, *54*(8), 1190–1197. doi:10.1016/j.comppsych.2013.05.008

Mitchelson, M. R., Erskine, H. E., Ramirez, E., Suleman, F., Prosad-ldes, R., Siskind, D., & Harris, M. (2010). Brita Futures: A resilience building program for children and young people from culturally and linguistically diverse backgrounds – Program description and preliminary findings. *Advances in Mental Health: Promotion, Prevention and Early Intervention*, *9*(3), 243–254. doi:10.5172/jamh.9.3.243

Morgan, P. (2009). Get up. Stand Up. Riding to resilience on a surf-board. *Child & Family Social Work, 15*(1), 56–65. doi:10.1111/j.1365-2206.2009.00637.x

Newsome, M. (2009, July 23). The spinal cord injury treatment team [Video file]. Retrieved from https://www.youtube.com/watch?v=wieRY4SL2BU

Norris, J. M., & Ortega, L. (2000). Effectiveness of L2 instruction: A research synthesis and quantitative meta-analysis. *Language learning*, *50*(3), 417–528. doi:10.1111/0023-8333.00136

North, N. T. (1999). The psychological effects of spinal cord injury: A review. *Spinal Cord*, *37*(10), 671–679. Retrieved from http://www.nature.com/sc/journal/v37/n10/pdf/3100913a.pdf

O'Connor, D. L., Young, J. M., & Saul, M. J. (2004). Living with paraplegia: Tensions and contradictions. *National Association of Social Workers, 29*(3), 207–218. doi:10.1093/hsw/29.3.207 207-218

Olivier, K. (2009). *An HIV and AIDS group work programme empowering adolescents for the possible death of their caregivers* (Doctoral dissertation). Retrieved from http://dspace.nwu.ac.za/handle/10394/5103

Orbke, S., & Smith, H. (2013). A development framework for enhancing resiliency in adult survivors of childhood abuse. *International Journal for the Advancement of Counselling*, *35*(1), 46–56. doi:10.1007/s10447-012-9164-6

Pargament, K. I., & Cummings, J. (2010). Anchored by faith: Religion as a resilience factor. In J. W. Reich, A. J. Zautra, & J. S. Hall (Eds.), *Handbook of adult resilience* (pp. 193–212). New York, NY: Guilford press.

Patterson, J. M. (2002). Integrating family resilience and family stress theory. *Journal of Marriage and Family*, *64*(2), 349–360. doi:10.1111/j.1741-3737.2002.00349.x

Patton, M. Q. (2015). *Qualitative research & evaluation methods* (4th ed.). Thousand Oaks, CA: Sage Publications.

Phelps, J., Albo, M., Dunn, K., & Joseph, A. (2001). Spinal cord injury and sexuality in married or partnered men: Activities, function, needs and predictors of sexual adjustment. *Archives of Sexual Behaviour*, *30*(6), 591–602. doi:10.1023/A:1011910900508

Pillay, J., Dunbar-Krige, H., & Mostert, J. (2013). Learners with behavioural emotional and social difficulties' experiences of reintegration into mainstream education. *Emotional and Behavioural Difficulties*, *18*(3), 310–326. doi:10.1080/13632752.2013.769709

Priebe, M. M., Chiodo, A. E., Scelza, W. M., Steven, M. D., Kirshblum, C., Kirshblum, M. D., & Ho, M. D. (2007). Spinal cord injury medicine. 6. Economic and societal issues in spinal cord injury. *Archives of Physical Medicine and Rehabilitation*, *88*(3), (Suppl.), S84–S88. doi:10.1016/j.apmr.2006.12.005

Reeve, C., & Reeve, D. (2012). *Paralysis resource centre*. Retrieved from http://www.chistopherreeve.org/site/c.ddJFKRNoFIG/b.6398725/k.5F

Retief, Y. (2006). *Genesing vir trauma: In die Suid-Afrikaanse konteks*. Paarl, Suid-Afrika: Struik Christelike Boeke.

Retief, Y. (2014). The trauma process. (PowerPoint presentation and DVD).

Roberts, S. H., & Bailey, J. E. (2011). Incentives and barriers to lifestyle interventions for people with severe mental illness: A narrative synthesis of quantitative, qualitative and mixed methods studies. *Journal of Advanced Nursing*, *67*(4), 690–708. doi:10.1111/j.1365-2648.2010.05546.x

Robertson, I. T., Cooper, C. L., Sarkar, M., & Curran, T. (2014). Resilience training in the workplace from 2003 to 2014: A systematic review. *Journal of Occupational and Organizational Psychology*, *88*(3), 533–562. doi:10.1111/joop.12120

Ross, E., & Deverell, A. (2010*). Health, illness and disability: Psychosocial approaches* (2nd ed.). Pretoria, South Africa: Van Schaik Publishers.

Sadelowski, M., Leeman, J., Knafl, K., & Crandell, J. L. (2012). Text-in-context: A method for extracting findings in mixed methods mixed research synthesis studies. *Journal of Advanced Nursing*, *69*(6), 1428–1437. doi:10.1111/jan.12000

Saini, M., & Shlonsky, A. (2012). *Systematic synthesis of qualitative research*. Oxford, United Kingdom: Oxford University press.

Saulino, M., & Keenan, B. T. (2012). *Rehabilitation of persons with spinal cord injuries*. Retrieved from http://www.aneuroa.org

Schoon, I., & Bynner, J. (2003). Risk and resilience in the life course: Implications for interventions and social policies. *Journal of Youth Studies, 6*(1), 21–31. doi:10.1080/1367626032000068145

Schurink, W., Fouché, C. B., & De Vos, A. S. (2011). Qualitative data analysis and interpretation. In A. S. De Vos, H. Strydom, C. B. Fouché, & S. C. L. Delport (Eds.), *Research at grass roots. For the social sciences and human service professions* (pp. 397–423). Pretoria, South Africa: Van Schaik publishers.

Shanenyfelt, T. (2015, June 23). Definition of quality appraisal [Video file]. Retrieved from https://www.youtube.com/watch?v=Ly__U-n4fiQ

Simpson, G., & Jones, K. (2012). How important is resilience among family members supporting relatives with traumatic brain injury or spinal cord injury? *Clinical Rehabilitation, 27*(4), 367–377. doi:10.1177/0269215512457961

Sothmann, J., Stander, J., & Dunn, R. (2014, October). *Epidemiology of acute spinal cord injuries in the ASCI (Acute Spinal Cord Injury) unit at GSH (Groote Schuur Hospital) over the past 11 years*. Paper presented at the 11th Biennial SASCA Congress. Pretoria, South Africa.

South African Spine Society. (2012). www.saspine.org/conditions/spinalcord_injuries.htm Date of access: 12 Aug. 2012.

Srivastava, P., & Hopwood, N. (2009). A practical iterative framework for qualitative data analysis. *International Journal of Qualitative Methods, 8*(1), 76–84. Retrieved from

http://www.researchgate.net/publication/215472971_A_Practical_Iterative_Framework_for_Qualitative_Data_Analysis

Steinhardt, M., & Dolbier, C. (2013). Evaluation of a resilience intervention to enhance coping strategies and protective factors and decrease symptomatology. *Journal of American College Health*, *56*(4), 445–453. doi:10.3200/JACH.56.44.445-454

Steyn, Y. (2008). *Egpare se belewenis na 'n spinalekoordbesering van 'n egmaat* (Unpublished master's thesis). University of South Africa, Pretoria.

Suri, H. (2011). Purposeful sampling in qualitative research synthesis. *Qualitative Research Journal*, *11*(2), 63–75. doi:10.3316/QRJ1102063

*The Medical Dictionary.* (2012). Dictionary.reference.com. http://www.intelihealth.com/IH/ihtIH/WSRNM000/331/9276.html Date of access: 12 Dec. 2012.

Thomas, J., & Harden, A. (2008). Methods for the thematic synthesis of qualitative research in systematic review. *BMC Medical Research Methodology*, *8*(1), 45. doi:10.1186/1471-2288-8-45

Toseland, R. W., & Rivas, R. F. (2014). *An introduction to group work practice* (7th ed.). London, United Kingdom: Pearson.

Tracy, S. J. (2013). *Qualitative research methods: Collecting evidence, crafting analysis, communicating impact*. New Jersey, NJ: Wiley-Blackwell.

Ungar, M. (2010). What is resilience across cultures and contexts? Advances to the theory of positive development among individuals and families under stress. *Journal of Family Psychotherapy*, *21*(1), 1–16. doi:10.1080/08975351003618494

Ungar, M. (2011). The social ecology of resilience: Addressing contextual and cultural ambiguity of a nascent construct. *American Journal of Orthopsychiatry*, *81*(1), 1–17. doi:10.1111/j.1939-0025.2010.01067.x

Van der Westhuizen, J. (2011). *A social group work programme with adolescent orphans in foster care affected by HIV and AIDS: North West Province* (Unpublished doctoral thesis). North-West University, Potchefstroom.

Van Zyl, M. (2008). Pitfalls in the long-term bladder management after spinal cord injury. *CME: The SA Journal of CPD*, *26*(2), 95–96. Retrieved from http://hdl.handle.net/10520/EJC63436

Vasquez, G. (2000). Resiliency: Juvenile offenders recognize their strengths to change their lives. *Corrections Today*, *62*(3), 106–111. Retrieved from http://people.ucalgary.ca/~cll/brochure/Resiliency%20in%20Children%20and%20Families-1.pdf

Visser, M., Finestone, M., Sikkema, K., Boeving-Allen, A., Ferreira, R., Eloff, I., & Forsyth, B. (2012). Development and piloting of a mother and child intervention to promote resilience in young children of HIV-infected mothers in South Africa. *Evaluation and Programme Planning*, *35*(4), 491–500. doi:10.1016/j.evalprogplan.2012.04.001

Weed, M. (2008). A potential method for the interpretive synthesis of qualitative research: Issues in the development of 'meta-interpretation. *International Journal of Social Research Methodology*, *11*(1), 13–28. doi:10.1080/13645570701401222

Wright, M. O., Masten, A. S., & Narayan, A. J. (2013). Resilience processes in development: Four waves of research on positive adaptation in the context of

adversity. In S. Goldstein & R. B. Brooks (Eds), *Handbook of Resilience in Children* (pp. 15–37). New York, NY: Springer Science + Business Media.

Yorgason, J. B., Piercy, F. P., & Piercy, S. K. (2007). Acquired hearing impairment in older couple relationships: An exploration of couple resilience processes. *Journal of Aging Studies*, *21*(3), 215–228. doi:10.1016/j.jaging.2006.10.002

Young, W., & Keck, W. M. (2003). *Family and spinal cord injury*. Retrieved from http://sci.rutgers.edu/dynarticles/family_adjustment.pdf

Zautra, A.J., Hall, J.S. & Murray, K.E. (2010). Resilience over the lifespan. In .J.W. Reich, A.J. Zautra, & J.S. Hall (Eds), *Handbook of adult resilience* (pp.213-235). New York: Guilford Press.

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# INSTRUCTIONS TO AUTHORS

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Peltzer, K. (2001). Factors at follow-up associated with adherence with directly observed therapy (DOT) for tuberculosis patients in South Africa. *Journal of Psychology in Africa, 11,* 165-185.
Sternberg, R. J. (2001, June). *Cultural approaches to intellectual and social competencies*. Paper presented at the Annual Convention of the American Psychological Society, Toronto, Canada.
Cook, D. A., & Wiley, C. Y. (2000). Psychotherapy with members of the African American churches and spiritual traditions. In P. S. Richards & A. E. Bergin (Ed.), *Handbook of psychotherapy and religiosity diversity* (pp. 369-396). Washington, DC: American Psychological Association.
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## PREFACE

## Design and development of a group resilience-promoting programme for spinal cord injured persons' partners (SCIPPs)

This manuscript forms part of a larger, more encompassing intervention research study, which consist of six phases (de Vos & Strydom, 2011:473-490). Phase 1, Problem analysis and project planning, was reported in section A. Phase 2, Information gathering and synthesis, a qualitative research synthesis, was reported in manuscript 1, and mainly aimed at organizing and synthesizing previous research on resilience-promoting processes in order to inform the design and development of a group resilience-promoting programme (GRPP) for spinal cord injured persons' partners (SCIPPs).

This manuscript, which follows, reports on phase 3, the design, and phase 4, early development and pilot testing of a group resilience-promoting programme for SCIPPs.

*The secondary research question driving this part of the study was:*

What programme content and outcomes, that focus on developing skills critical to the construct of resilience and tailored from resilience-promoting processes and that could be applied in a small-group context, as gathered from literature, pre-existing interventions, experts, and people living with SCI, should be included in a GRPP for SCIPPs?