MANUSCRIPT 2

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

Prepared for submission to journal

SOCIAL WORK/MAATSKAPLIKE WERK

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

The aim of this study was to develop 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, develop small-group programme content and activities (using knowledge gathered from pre-existing interventions; resilience literature; consultations with experts; people living with spinal cord injury (SCI) and personal experience) to promote resilience in spinal cord injured persons' partners (SCIPPs), that could be included in a group resilience-promoting programme (GRPP) for SCIPPs. By means of a qualitative study, the researcher attempted to design and develop a GRPP for SCIPPS that aims at promoting the resilience of SCIPPs after their partners had acquired a spinal cord injury. In the context of applied research an intervention research model, comprising six phases, was employed. From a literature overview (phase 1) and a qualitative research synthesis (phase 2), it emerged that little is known about resilience promotion in SCIPPs (worldwide). The findings from a qualitative research synthesis (phase 2) resulted in the formulation of an outline of a GRPP for SCIPPs, which was further developed during phases 3 and 4. The researcher received critical feedback from a diverse group of participants regarding the content of the formulated outline of the GRPP for SCIPPs, as well as suggestions to improve it, namely experts' review during a series of advisory panel interviews (open-ended interviews), peers (poster presentation at a conference and oral presentation at a hospital); and professionals working in the field of resilience and SCI, as well as people living with SCI (video-recorded by researcher (DVDs) and included in the programme content). The content of the GRPP for SCIPPs was also pilot tested with two SCIPPs (including an observer) in order to ensure that the programme content and format is appropriate for the population

and setting. The final GRPP for SCIPPs comprised six sessions, shaped by six resilience-promoting processes. The six sessions each have a common format, and session content for each session, including the following: (1) Information about SCI and resilience; (2) Help SCIPPs understand that their reactions to/emotions regarding these huge changes are normal; (3) Caretaking and support; (4) My dual role; (5) Own caretaking by SCIPPs; and (6) Termination and way forward. Due to ethical concerns the researcher decided not to implement the GRPP for SCIPPs with the target population. She decided to rather first subject it to further expert review for its readiness to be implemented with the target population. An evaluability assessment was thus recommended. Future directions and limitations will be discussed.

Keywords: Spinal cord, spinal cord injury (SCI), intervention research, Social group-work, spinal cord injured persons' partner (SCIPP), spinal cord injured person (SCIP), partner, cohabiting partner, qualitative research, advisory panel, design and development, group resilience-promoting programme (GRPP).

OPSOMMING

Die doel van hierdie studie was om 'n klein-groepprogram te ontwikkel bestaande uit inhoud en aktiwiteite (aan die hand van vooraf bestaande intervensies; veerkragliteratuur; konsultasies met deskundiges; mense wat spinalekoord-beserings opgedoen het, en persoonlike ervaring), ten einde veerkrag by SKBPE'e te bevorder – aspekte dus wat by 'n groepprogram ter bevordering van veerkrag ingesluit kan word (GPBVK) vir SKBPE'e. Die navorser het gepoog om deur middel van 'n kwalitatiewe studie, 'n GPBVK vir SKBPE'e te ontwerp en te ontwikkel ten einde die veerkrag van SKBPE'e, ná die spinalekoord-besering van hul gades, te bevorder. 'n Intervensie-navorsingsmodel, bestaande uit ses fases, is in die konteks van toegepaste navorsing ingespan. Dit blyk uit 'n literatuurstudie (fase 1) en 'n kwalitatiewe navorsingsintese (fase 2) dat min inligting wêreldwyd beskikbaar is (min bekend is) rakende veerkragbevordering wat tot voordeel van SKBPE'e aangewend kan word. Die bevindings van 'n kwalitatiewe navorsingsintese (fase 2) het gelei tot die formulering van 'n uiteensetting van 'n GPBVK vir SKBPE'e en is verder tydens fases 3 en 4 ontwikkel. Die navorser het kritiese terugvoer van 'n diverse groep deelnemers ontvang rakende die inhoud van die geformuleerde uiteensetting van die GPBVK vir SKBPE'e, asook voorstelle ten opsigte van verbeteringe, naamlik deskundiges se hersiening tydens adviespaneel-onderhoude (oopeinde-onderhoude); portuurgroep-kommentaar (op 'n plakkaat-aanbieding by 'n konferensie asook op 'n mondelinge aanbieding vir professionele persone wat by 'n hospitaal); en laastens terugvoer van mense wat spinalekoord-beserings opgedoen het (video-opnames deur navorser [DVD's] wat by die programinhoud ingesluit is). Die inhoud van die GPBVK vir SKBPE'e is tydens 'n loodstoets met twee SKBPE'e (insluitend 'n waarnemer) getoets ten einde te verseker dat die programinhoud en formaat toepaslik is vir die populasie en die omgewing. Die finale GPBVK vir SKBPE'e bestaan uit ses sessies, gevorm deur ses veerkrag -

bevorderingsprosesse. Die formaat van die ses sessies kom met mekaar ooreen en die inhoud van elke sessie sluit in: (1) Inligting rakende veerkrag en spinalekoord-besering; (2) Hulp aan SKBPE'e om te besef dat hul eie reaksies/emosies weens hierdie geweldige verandering normaal is; (3) Versorging en ondersteuning; (4) My tweeledige rol; (5) Selfversorging deur SKBPE'e; en (6) Terminering en die pad vorentoe. Weens etiese oorwegings het die navorser besluit om nie die GPBVK vir SKBPE'e met die teikenpopulasie te implementeer nie, maar om dit eers aan verdere deskundige hersiening te onderwerp ten einde te bepaal of die program gereed is vir die implementering met die teikenpopulasie. Daarvoor was 'n evalueringsassessering nodig. Verdere rigting en tekortkominge sal bespreek word.

Sleutelwoorde: Spinale koord, spinale koord besering (SKB), intervensie navorsing, maatskaplike groepwerk, saamwoon-maat, kwalitatiewe navorsing, adviseuringspaneel, ontwerp en ontwikkeling, groep veerkragbevorderingsprogram (GVBP).

1 INTRODUCTION

SCI is a physical disability, mostly acquired through falls, car accidents or gun wounds, and non-traumatic injuries, such as genetic disorders or acquired abnormalities, for example a tumour or infection on the spinal cord, amongst others (International Spinal Cord Society (International Spinal Cord Society [ISCoS], 2012; The medical dictionary 2012; Biering-Sørensen *et al.*, 1990:330; Burt, 2004:28; Dawodu, 2011; National Spinal Cord Injury Association, 2012). Depending on the level of the injury, people with SCI may result in being either a paraplegic – paralysis of the lower part of the body, including the legs – or a quadriplegic – which is paralysis of all four limbs (ISCoS, 2012). In addition to being permanently paralyzed other problems associated with mobility, such as altered bladder, bowel and sexual function; infections, autonomic hyperreflexia, spasticity, pressure sores, and constant pain are also prevalent (Biering-Sørensen *et al*., 2009: 510; Hampton, 2000: 72; Weaver *et al.,* 2001: 86).

The prevalence of SCI is increasing globally (Dawodu, 2011). A recent comparative analysis by Vasiliadis (2012: 336–340), which included studies from America, Europe, Africa, Asia and Oceania, reported the prevalence of SCI to be the highest in Portugal (Europe) with a 57.8 incidence per million people, and Western Canada (America) with 52.5 incidences per million people. Although the prevalence of SCI in Africa was also studied, the specific incidence per million people was only available in studies in Nigeria, which is a 34 incidence per million people. However, the study is limited with regard to statistics pertaining to the prevalence of SCI in South Africa, as it only reported that the male to female ratio is 4 to 1, per million people (Vasiliadis, 2012:342). Statistics available from an eleven-year descriptive study (from April 2003 – April 2014) at a Rehabilitation Hospital in the Western Cape (South Africa) indicates that a total of 2 042 patients were treated for SCI, 84% male, and 16% female (Sothmann *et al.,* 2014). These

findings correlate with those of the research done by Vasiliadis (2012:342), namely that more males acquire SCI in South Africa than do females.

As the prevalence of spinal cord injuries has increased over the last three decades (Dawodu, 2011), numerous studies were undertaken to understand the impact of newly acquired SCI on the relationship between cohabiting spouses/partners. Marais *et al.* (2006:22-85) found that if marriage took place (or a cohabiting relationship is formed) after the acquirement of the SCI, the couple are more prepared for what awaits them. However, this mentioned couple and/or SCIPP are sometimes also confronted with challenging situations and/or emotions that require hardiness. A body of research found that the permanent lifestyle changes, as a result of the acquirement of an SCI of one partner (after the couple had married or in a cohabiting relationship), places both partners at risk of negative outcomes and may place strain on the couple's coping options with regards to the acquired disability (Chen & Boore, 2007:647; Chen & Boore, 2008:174; Cohen & Napolitano, 2007:149; Dorset, 2010:83- 84; Golden *et al.,* 2000:33; Martz *et al.,* 2005:1182-1192; Steyn, 2008:71-76; Willemse, 2013: 1-274; Wuermser & Ottomanelli, 2005:1182; Middleton *et al.,* 2014:1313).

These potential lifestyle changes (negative outcomes) could be experienced on four different levels, namely: physical, psychological, psychosocial, and socio-economical level (Elliot *et al.,* 2008:1224 -1225; Maddick & Studd, 2011:136). The person who has acquired an SCI has to deal with the fact that his/her body has changed from an "abled-body" to a "disabled-body" with associated physical conditions, impact on psychological well-being and economic challenges. The adjustment to this life-altering injury might impact negatively on both cohabiting partners, and as such places the intimate relationship at risk, whereby the SCIPP might need to generate creative problem-solving skills in order to adjust well to the adversity. Ross and Deverell (2010:337) argue that although disability

does not usually lead to personality changes, the "healthy" partner often grieves for the loss of the person he or she knew and loved prior to the onset of the disabling condition. The couple thus has to deal with accumulative losses and daily hardships associated with SCI (Randal, 2001:109; Ross & Deverell, 2010:333-337). Consequently divorce (separation) is reported as a possible negative outcome following an SCI (Arango-Lasprilla *et al.,* 2009:1371-1378; Karana-Zebari *et al.*, 2011:120; Steyn, 2008:62 – 68).

Furthermore, the negative outcomes for the SCIPP who has to deal with his/her own frustrations and uncertainties in adapting to this adversity, coupled with the sudden care-giver burden, might have to take over more responsibilities, and dealing with his/her partner's psychological and emotional adjustment is also highlighted in literature (Steyn, 2008:62-68; Young & Keck, 2003:1–3). It is thus imperative for SCIPPs to be capable of regulating their own emotions, actions and reactions in order to adapt positively despite the hardships. If the SCIPP adapts well to the prolonged adversities caused by the SCI of the cohabiting partner, it could also ultimately contribute towards the well-being of the injured person and of that of the couple. When a person adjusts well to adversities he/she is regarded as being resilient (Masten, 2001:228). Bonanno *et al.* (2011:513) state that some people have the natural ability to resile in adverse circumstances, but Masten (2001:28) and Schoon and Bynner (2003:22) on the other hand argue that some people might need resilience-promoting assistance.

Researchers have advocated for interventions to support and empower SCIPPs (Chan *et al.*, 2000:507; Middleton *et al.,* 2014:1313). So far, however, only one international study, conducted in the US by Elliot *et al.* (2008:1226 - 1228), examined the effectiveness of an individualized problem-solving intervention, delivered in video-conferencing sessions with family caregivers of persons living with an SCI. This study was also not designed only for SCIPPs, but for any family member who has adopted the caregiver role with regard to a

person who has acquired an SCI. Elliot *et al.* (2008:1226 -1228) concluded that community-based telehealth interventions may benefit family caregivers and their care recipients, but the mechanisms of these effects still remain unclear. A recent systematic review was executed with regard to telehealth tools and interventions to support family caregivers, by means of which thirty-three articles were found with the focus on family caregivers, but no studies regarding SCI and family caregiving were reviewed, and again no specific interventions focusing on SCIPPs was discussed (Chi & Demiris, 2014:37-42). None of these studies, however, aimed at promoting the resilience of partners and caregivers.

In South Africa limited support or therapeutic services seems to be available to the SCIPP, as treatment intervention at rehabilitation centres are mainly focusing on the SCI person (Steyn, 2008: 81; van Niekerk, 2012; van Vuuren, 2013). There also are no documented resilience-promoting programmes available for SCIPPs. Supportive interventions, and specifically promoting resilience in SCIPPs in order to adapt positively to the prolonged adversities is thus a practice need, and therefore the researcher set out to address this practice need by designing an intervention research model, following the six phases of a "Design and development model" (Rothman & Thomas,1994:5; Strydom & Delport, 2011:390-496) (see figure 4).

The study informing this manuscript forms part of a larger, more encompassing intervention research study documented in this thesis. Phase one comprised the problem analysis and project planning and is documented in section A. During phase 2, information gathering and synthesis was implemented by employing a qualitative research synthesis (QRS) and is documented in manuscript 1. The aim of the QRS was to organize and synthesize previous research on resilience-promoting processes, in order to inform the development of a GRPP for SCIPPs. During phases 3 and 4 these findings were utilized

for designing, early development and pilot testing the content and format of the GRPP for SCIPPs, and will be covered in this manuscript. Furthermore, phase 5 (evaluation of the newly developed intervention), is reported in manuscript 3.

First, the researcher will discuss resilience as resilience-based framework for the study, following the objective of this manuscript, the research methodology, findings from the pilot test; advisory panel meetings and peer-review efforts, which inform the refining and further development of the GRPP for SCPPs into a fully assembled programme. This is followed by a discussion, limitations, conclusion and recommendations.

2 A RESILIENCE-BASED FRAMEWORK

The understanding of resilience has grown over the past decades. In early resilience studies researchers explored the resilience of young children and ascribed resilience to inner strengths and qualities (Masten, 2001:227). Ungar *et al.* (2012a:350-355), however, argue that resilience is influenced by context, time and culture, and also relies on complex processes which can no longer be seen as an individual trait, as found in earlier studies. Understandings of resilience have thus since advanced and recently Ungar (2011:11) advocated that resilience is a process of reciprocated interactions between an individual and his or her supportive social ecology. Recently Robertson *et al.* (2014:557) strongly argue for the use of a consistent definition of resilience as it will provide scholars with conceptual boundaries that will assist in determining the nature, direction, and veracity of resilience research enquiry. Thus, for the purpose of this study, resilience will be seen as "positive adaptation and development in the context of significant adversity" (Yates & Masten, 2004:6). In addition, Masten (2001:228) states that resilience come into play if there are two core elements that must be present, namely (1) the presence of risk; significantly enough that it threatens to disrupt normal development (such as being married

or in a cohabiting relationship with a person who has acquired an SCI), and (2) the ability to adjust well to experiencing significant risk. Masten and Wright (2010:222) further found that there are universal protective processes that contribute towards a person's resilience over the lifespan, such as individual capabilities, social supports and relationships, and protection embedded in religion, community or other cultural systems. The individual at risk, thus, identifies protective resources within his or her social ecology and navigates towards support in an attempt to capacitate him/herself to adjust well to risks (Ungar *et al.,* 2012a:350-355). The social ecology thus has to actively present support mechanisms and partner with individuals to facilitate enablement. The influential role protective processes play in assisting individuals and families to overcome risks, stress and adversity was also found in the course of the same decade, in studies undertaken by Vasquez (2000:110) and Patterson (2002:358). 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 *et al.,* 2015).

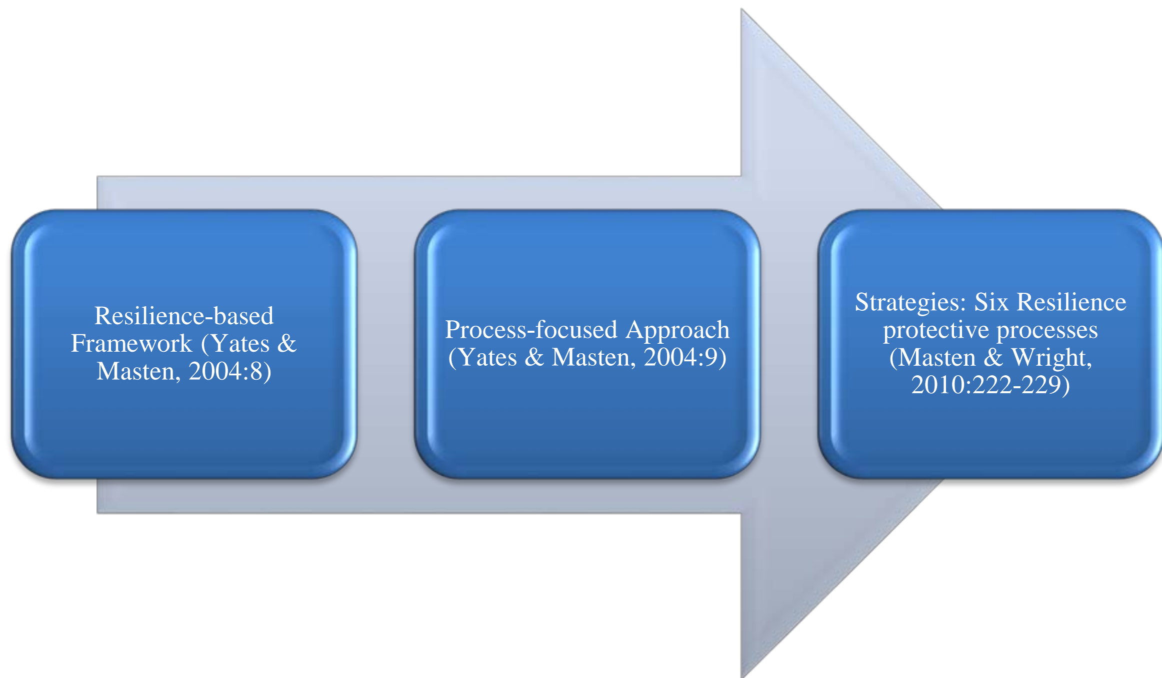
2.1 Masten and Wrights' (2010:222-229) six protective processes

Masten and Wright (2010:222-229) focus on six examples of important protective processes/ systems and consider their (those of the processes) changing role in resilience over the lifespan, namely firstly, "attachment relationships" (Masten & Wright, 2010:222), involving a bond and on-going relationships; secondly, there is "agency and the mastery-motivation system" (Masten & Wright, 2010:224), which denotes the possibility for people to thrive if they adapt positively. The third reported protective process is "intelligence" (Masten & Wright, 2010:225), involving intelligent behaviour such as problem solving, which develops over time, in accordance with socially supported learning opportunities. In the fourth place, "self-regulation" (Masten & Wright, 2010:225-226), which enables individuals to control their own behaviour in compliance with the given social ecology, as

taught and reinforced by that system; and fifthly, "making meaning" (Masten & Wright, 2010:227), which refers to making sense of life and having hope. The last protective process is "cultural tradition and religion" which refers to beliefs and practices that enable people to deal with hardship (Masten & Wright, 2010:228).

In sum, an acquired physical disability such as SCI places both the abled-body partner and the disabled partner at risk of encountering numerous negative outcomes. The focus of this study, however, is on the SCIPP, who needs skills, and more specifically, protective processes/systems to adapt well to this life-altering experience as the positive adaptation of the SCIPP would contribute to the wellbeing of the SCIPP as well as the couple's future. Positive adaptation despite exposure to adversity is called resilience. In this context, resilience is thus highly significant. One perspective on resilience, such as that of Masten and Wright (2010:222-220), who argues that there are six protective processes that could help people overcome risk, is applicable to this study, as resilience is seen as a largely dynamic and flexible phenomenon and could be promoted, and as such it is suitable for interventions. In social work, interventions are usually intended to reduce social or health problems such as the negative outcomes of SCI and, an attempt "to develop new strategies or enhance existing strategies" is called intervention research (Fraser *et al.,* 2009: 1-224). Consequently, in the absence of resilience-promoting interventions for SCIPPs, the researcher decided to develop a group resilience-promoting programme for SCIPPs in South Africa, by considering the fundamental components of a resilience-based framework for practice. Please see an illustration of how the resilience theory was utilized in this study, as depicted in figure 5.

Figure 5: Resilience theory applicable to this study



3 RESEARCH QUESTION

In this manuscript, the researcher will answer the following research question:

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?

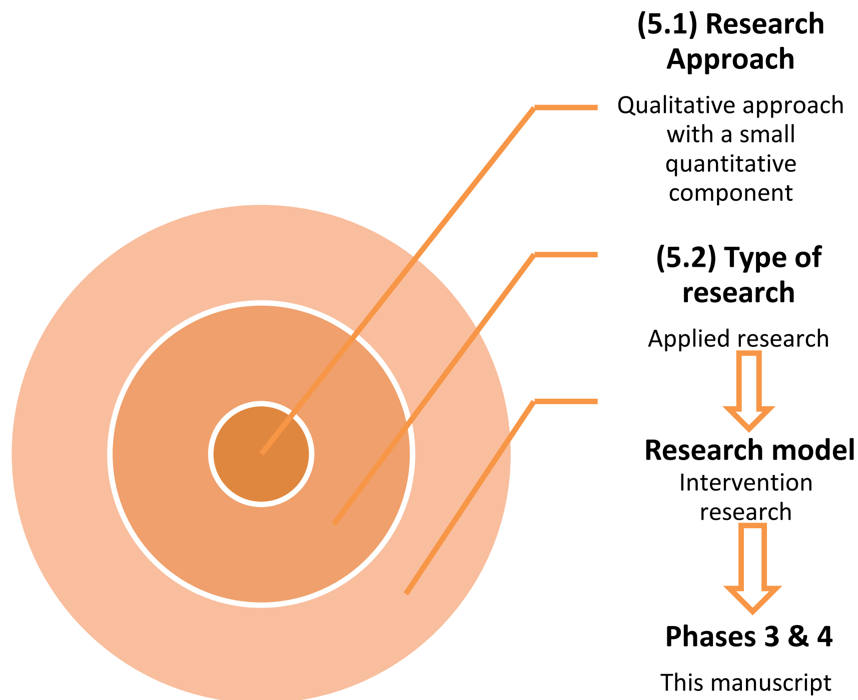
4 AIM OF THE STUDY

The aim of this manuscript was to develop 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.

5 RESEARCH METHODOLOGY

The research methodology employed during this manuscript is depicted in figure 6 and elaborated on afterwards.

Figure 6: Research methodology



5.1 Research Approach

A qualitative research approach was followed as it is more suitable for smaller studies (de Vos & Schurink, 2011:307), are more inductive in nature and are used to gather data for exploratory studies (Strydom, 2013:152).

The researcher's motivation for utilizing the qualitative approach as the primary method was based on the following discussion:

- Little is known about the content of a resilience promoting programme for SCIPPs' hence a qualitative approach was most appropriate as a more in-depth exploration of the views and experiences of experts and other participants were sought. Such an

approach elicited rich data from participants, which is typical of qualitative research (Delport & Roestenburg, 2011:188; Fraser *et al.,* 2009 1 - 224).

- The purpose of the advisory panel, the pilot study and peer feedback was to guide the development and refining of the intervention content and format (de Vos & Strydom, 2011:473-489; Fraser *et al.,* 2000:1-224) by means of critical reflection and qualitative feedback.
- The researcher mainly used qualitative research methods to obtain critical feedback from diverse groups of participants on the formulated outline, content and planned activities of the GRPP for SCIPPs. The qualitative data was generated by means of consultations with experts during a series of advisory panel interviews (open-ended interviews), peer feedback (poster presentation at a conference and oral presentation at a hospital, with a rehabilitation unit), professionals working in the field of resilience and SCI; and people living with SCI (pragmatic interviews that were recorded on DVDs and included in the programme content) (Strydom, 2011:330; Patton, 2015:433).
- The above-mentioned data collection methods fit into the qualitative approach and are exploratory in nature (Fraser *et al.,* 2009:1-224).
- The content and format of the GRPP for SCIPPs was pilot tested with two SCIPPs in the presence of an observer (Delport & Roestenburg, 2011:188). The purpose of the pilot study was to evaluate the usefulness of the programme content and activities for SCIPPs and make recommendations to improve it. The questionnaires used during the pilot study had a small quantitative component, namely individual Likert-type items (Delport & Roestenburg, 2011:188-189). Participants had to evaluate the content of the programme on a four-point scale, ranging from strongly agree (4) to strongly disagree (1). The purpose of the individual Likert-type items

was not to generate descriptive statistics, but merely to focus the participant's attention on a specific core aspect of the programme content or activity, after which they were requested to construct reasons for their rating by means of written explanations (Clason & Dormody, 1994:31). The role of the observer was mainly for quality control and monitoring purposes. She was asked to complete a checklist to ensure that the researcher had adhered to session content (Jackson, 2011:100). Written comments were made which were used to inform the refining of the content and format of the GRPP for SCIPPs. All the above-mentioned strategies involved a small number of people, eliciting mostly qualitative feedback with the aim not to generalise, but to contextualise.

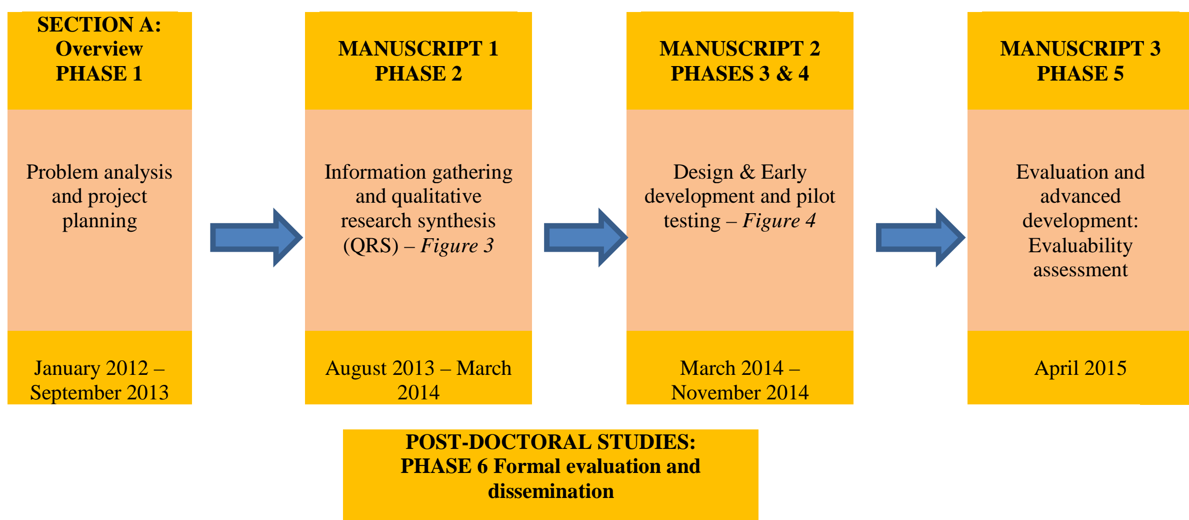
The following explanation for the chosen type of research is needed, after clarifying the research approach.

5.2 Type of research and research model

The study falls within the description of applied research (de Vos & Strydom, 2011:474). Applied research aims at practice and entails the use of existing knowledge from research or personal experience to develop and enhance services, processes, and methods (Kendra, 2013). In the context of applied research, a research model, intervention research was applied. According to Fraser *et al.* (2009: 1-24) the design and development of an intervention is what distinguishes intervention research from evaluation research. However, intervention research also includes evaluation methods. Intervention research thus consists of the development of a programme, the application of the programme (intervention), and the evaluation of the effectiveness of the intervention (de Vos & Strydom, 2011:473-489). De Vos and Strydom (2011:473-489) view intervention research to be an action undertaken by social workers or other helping agents, considering the client

or affected party, to enhance or maintain the functioning and well-being of individuals, families, groups, or communities. The study informing this manuscript forms part of a larger, more encompassing intervention study (as depicted in figure 7) aiming at addressing a practice problem, namely that there are no resilience-promoting programmes for SCIPPS who are faced with negative outcomes resulting from their cohabiting partner's acquired disability. As such, in this manuscript the researcher reports on the design, and developed a GRPP for SCIPPs aiming at equipping SCIPPS to develop and use a greater range of resilience-promoting knowledge and skills to assist them in adapting positively to adversity and in increasing the likelihood of successful reintegration of the SCIPP and his or her partner, after the injury, which will be discussed next. Please see figure 7 for an illustration of the intervention research model utilized during this study (de Vos & Strydom, 2011:473-489; Fouché, 2011:456; Rothman & Thomas, 1994:5).

Figure 7: Intervention research model of the GRPP for SCIPPs



(Adapted from de Vos & Strydom, 2011:473-489; Fouché, 2011:456 Rothman & Thomas, 1994:5)

6 DESIGN, EARLY DEVELOPMENT AND PILOT TESTING
(see figure 7 & table 5)

Although phase models, such as intervention research, are performed in a stepwise sequence, they cannot be viewed as patterns of one phase following another rigidly (de Vos & Strydom, 2011:476).

Although de Vos & Strydom (2011:482-483) identified two steps in phase 3 (designing an observational system, and specifying procedural elements of the intervention); and three steps in phase 4 (developing a prototype or preliminary intervention; conducting a pilot test; applying design criteria to the preliminary intervention concept), for the purpose of this study the researcher has adapted and combined phase 3 (design) and phase 4 (early development and pilot testing) into a research procedure that consists of an exact description of eight distinct steps. The formulated outline of the GRPP for SCIPPs was compiled from a QRS (manuscript 1; addendum 4) that synthesised previous research on resilience promoting processes and embedded in a resilience-based framework (Masten & Wright, 2010:222-231). Thus, prior to formulating the outline of the GRPP for SCIPPs the researcher firstly selected a resilience-based-framework for the intervention, as well as group work as delivery method. This resulted in the formulation of an outline of the intended programme. Secondly, a series of interviews with experts and people living with SCI (advisory panel), and the researcher's own personal and professional experience of the real world of SCI (Fraser *et al.,* 2009: 1-334) were used to design and further revise the formulated outline of the GRPP for SCIPPs. Next, DVD recordings were made to be included in the programme. Fourthly, further development of the GRPP for SCIPPs led to formulation of the GRPP for SCIPPs, which included procedural elements of the intervention such as the outcomes, strategies and activities. Fifthly data collection methods were developed to be used during the pilot study after which the content and format of the

GRPP for SCIPPs was pilot tested with two SCIPPs in the presence of an Observer. In step six the feedback from the pilot study participants and observer were discussed with the advisory panel members during a second round of interviews. The seventh step involved a further development of the GRPP for SCIPPs (formulation of the GRPP for SCIPPs) taking into consideration the feedback from the pilot study and second round of advisory panel members. Step 8 consisted of facilitating peer feedback by means of a POSTER presentation at the SASCA Congress (October, 2014) as well as a meeting with professional role-players at a hospital (with a rehabilitation unit) in North West Province of South Africa (November, 2014) for feedback and recruitment purposes. Furthermore, final amendments were made to the GRPP for SCIPPs.

Next an overview of the implementation of each of the above-mentioned eight steps will be depicted in table 5 and discussed thereafter.

Table 5: Overview of the research procedures of an adapted phase 3 and phase 4 (combined into eight distinct steps)

	STEPS & DATES OF EXECUTION		RESEARCH PROCEDURES	TABLES/FIGURES depicting outcomes of research procedures for each specific step
6.1	**STEP 1** **(March 2014)**	Identify resilience-promoting intervention strategy; protective approach & formulating outline of GRPP for SCIPPs	6.1.1 Identified and selected: (1) Group work as social work method for the GRPP for SCIPPs; (2) Processes-focussed intervention approach 6.1.2 Formulating of the GRPP for SCIPPs	Table 6: Formulating of a GRPP for SCIPPs

	STEPS & DATES OF EXECUTION		RESEARCH PROCEDURES	TABLES/FIGURES depicting outcomes of research procedures for each specific step
6.2	**STEP 2** (March – April 2014)	Advisory Panel meeting 1 (AP – 1) (Pre-pilot study)	Purposive and snowball sampling; 6 Advisory panel members 6.2.1 Participants and sampling 6.2.2 Procedure, data collection and Ethics Open-ended interviews; programme for pilot study (addendum 17); informed consent 6.2.3 Data analysis Thematic content analysis; refining outline of GRPP for SCIPPs 6.2.4 APMs reflections and recommendations	Table 7: Demographics of Advisory Panel members (AP-1) Table 8: Self-administered data analysis technique (AP-1) Figure 8: *AP-1: Protocol and reflections/ Recommendations* Table 9: Refining the GRPP for SCIPPs after AP 1
6.3	**STEP 3** (May – June 2014)	Recording video's (DVDs) for use as media during group sessions	Purposive and snowball sampling; 28 participants; informed consent; video recordings and editing; reflection; inclusion in programme. 6.3.1 Participants and sampling 6.3.1.1 Demographics of participants on DVDs: A summary 6.3.2 Procedure and ethics 6.3.3 Researcher's critical reflection	Table 10: Programme development after video recordings (DVDs) See addendum 8 for complete demographics Figure 9: Table of contents of DVDs
6.4	**STEP 4**	Further development and first formulation of a GRPP for SCIPPs	Development of procedural elements per session (outcomes;Icebreakers; DVDs; resilience-promoting activities; anchors and survival kit).	Table 11: Formulated GRPP for SCIPPs
6.5	**STEP 5** (17-18 July 2014)	Pilot study	Purposeful sampling; 2 SCIPPs & 1 Observer; informed consent; reflection on findings. 6.5.1 Procedure 6.5.2 Participants and sampling 6.5.3 Data collection and analysis 6.5.4 Ethical considerations 6.5.5 Researcher's critical reflection on data analysis of findings 6.5.6 Findings	Table 12: Demographics of participants Table 13: Demographics of observer Table 14: Self-administered technique/guidance for researcher's critical reflection/data analysis *Figure 11: Findings*
6.6	**STEP 6** (July – August 2014)	Advisory Panel meeting 2 (post-pilot study)	4 Advisory Panel members; one added performance 6.6.1 Procedure, data collection and analysis 6.6.2 One added performance: Two more video recordings	*Figure 12: Analysis and reflection on recommendations* *Table 16: Further programme development: Two more video recordings*

	STEPS & DATES OF EXECUTION		RESEARCH PROCEDURES	TABLES/FIGURES depicting outcomes of research procedures for each specific step
6.7	**STEP 7** (September 2014)	Further development f GRPP for SCIPPs	Compiling final draft of the GRPP for SCIPPs	Table 17: Final-formulated GRPP for SCIPPs
6.8	**STEP 8** (October – November 2014)	Peer review and recruitment	SASCA Congress Presentation at Hospital Recommendations and way forward	Addendum 22 (Poster) Addendum 35 (Power point at presentation)

6.1 STEP 1: Identify Resilience-promoting strategy and formulate outline of GRPP for SCIPPs (March 2014)

6.1.1 Identified and selected:

(1) Group work as social work method for the GRPP for SCIPPs

During the design phase, planning the appearance of the intervention, took place. Since the intended GRPP for SCIPPs was decided to be a group work programme, the procedural element in this intervention (de Vos & Strydom, 2011:483) was firstly determined by the process of Social group-work (Toseland & Rivas, 2014:2). Social group-work sets a platform where members come together for group sessions including a series of activities, with a common aim (purpose or function); carried out by a group facilitator during the existence of a group (Barker, 2003:342), where group members can support one another (Toseland & Rivas, 2014:16). Basic principles conerning the nature of communication and interaction patterns in groups (Toseland & Rivas, 2014:78); the forming of group cohesion (Toseland & Rivas, 2014:81); the culture a group develops (Toseland & Rivas, 2014:89); and the stages of group work (namely planning; beginning; assessment; middle; ending and evaluation) should guide the group facilitator in the planning and execution of a planned group (Toseland & Rivas, 2014:2, 93-94). Importantly the group facilitator should educate herself in the use of different group leadership skills and styles (e.g. facilitation

skills; data gathering and assessment skills; action skills; leadership styles) in order to lead and empower the group effectively (Toseland & Rivas, 2014:97-104). Furthermore, the GRPP for SCIPPs will also be managed as closed groups which means the group begins and ends with the same membership and frequently meets for a pre-determined number of sessions, so that resilience-promotion with the SCIPPs can effectively take place, moreover so that the presence of new members will not impede the progress of the original members (Toseland & Rivas, 2014:180).

The GRPP for SCIPPs will also be a "formed group", as the participants will be called together for a particular purpose (Toseland & Rivas, 2014:13), which is to promote their resilience after the acquired SCI of their cohabiting partners (Ungar *et al.,* 2007:307). Furthermore, the GRPP for SCIPPs also aimed at being a "treatment group", with the emphasis on two of the primary six purposes of treatment groups, namely *education* and *support.* The main purpose of the latter is to assist members in gaining new information and skills, and supporting group members, so that they will be able to effectively adapt to, and cope with future stressful life events, especially regarding the acquired SCI of their cohabiting partners (Reich *et al.,* 2010:218; Maddick & Stud, 2011:132; Toseland & Rivas, 2014:20; Ungar *et al.,* 2012b:675-693). It is therefore also imperative that a group facilitator utilize social work administration (management) as an important way of documenting what has been done in any social work intervention. Documentation of all administrative procedures regarding the group work and detail process notes after each group session must be done to be able to render professional and effective services to group members (SCIPPs) (Toseland & Rivas, 2014: 183-197).

Thus, Social group-work can be a perfect counterpart to the ecological approach of resilience, as psychological resilience is a process of reciprocated interactions between an individual and his or her supportive ecology (Toseland & Rivas, 2014:52; Ungar,

2008:218-235; Ungar, 2011:1-17), negotiating for resources to be provided, as cohesion and relationships are also resilience resources (Ungar, 2008:218-235).

(2) Processes-focused intervention approach

It is imperative to plan a resilience-promoting programme within a suitable intervention approach. Masten *et al.* (2009: 117-131) identified three approaches to resilience promotion, namely a risk-reduction approach (focussing on risk reduction and aiming at reducing exposure to adversity), secondly assets-focused approach (interested in increasing the number and quality of resources), and lastly a process-orientated approach (influencing processes that will improve the life of the person at risk instead of merely limiting exposure to risks or increasing the number of resources). For the purpose of this study, the process-orientated approach was chosen as it is very unlikely that the SCIPPs' exposure to risks would be reduced or that they will necessarily have access to more resources. Such a process-focussed resilience promotion approach could thus be implemented to promote the resilience promotion process of SCIPPs. The intervention could be implemented at rehabilitation centres where persons with an SCI are treated and visited by their partners.

6.1.2 Formulating of the GRPP for SCIPPs

After having chosen the process-orientated resilience approach, as well as a resilience-based framework, and Social group-work as delivery method for the GRPP for SCIPPs, the researcher identified the main resilience-protective processes that emerged from the QRS (manuscript 1), and which were embedded within Masten and Wrights' (2010:222-229) six protective processes, and translated those into themes and outcomes (Toseland & Rivas, 2014:163-165). Administrative aspects such as the number and duration of the sessions and nature of media to be used had to be taken into consideration (Becker, 2010:82-100;

Toseland & Rivas, 2014:162-198). Furthermore, **an outline of the GRPP for SCIPPs was formulated (please see Table 4, manuscript 1).**

During this process the researcher had to ensure that the procedural elements of the intervention (de Vos & Strydom, 2011:483; Toseland & Rivas, 2014:163-165), with included outcomes, strategies and activities and methods according to which data would be collected and evaluation would take place were connected with the aim. The aim was to develop and explore the usefulness of a GRPP for SCIPPs to promote SCIPPs resilience, so that, by being more resilient, they and their cohabiting partners can positively adapt to the prolonged risk and potential negative outcomes after SCI. As the researcher is an experienced social worker with advanced training in addressing trauma and adversities, she applied her knowledge and skills and incorporated it with the resilience-based framework for this study when choosing specific material and programme content. Please see table 6 for a formulated programme.

Table 6: Formulating a GRPP for SCIPPs

Session	**Themes**	**Outcomes**	**Strategies: Resilience-protective Processes (Masten & Wright, 2010:222-229)**
1	Information on SCI and resilience	* Contracting (Becker, 2010:35) * Introduce potential negative outcomes of SCI, resilience-protective processes and a resilience-promoting activity (RPA) to survive the negative outcomes (Fouché & Williams, 2005:18)	* Agency and mastery-motivation system * Intelligence (problem solving)
(Aiello *et al.*, 2011:15-20; Chen, 2011: 230-233; de Villiers & van den Berg, 2012:93-102; Dodding *et al.,* 2008:41-49; Elliot *et al.,* 2008:1220-1229; Graham, 2004:317-321; Hernandez & Medonza, 2011:375-393; Johnson *et al.,* 2001:145-255; Kellett *et al.,* 2013:134-141; Liossis *et al.,* 2009:97-112; Loprinzi *et al.,* 2011:364-368; Masten & Wright, 2010:222-229; Min *et al.,* 2013:1190-1197; Mitchelson *et al.*, 2010:342-254; Pillay *et al.,* 2013:310-326; Steinhardt & Dolbier, 2013:445-453; van der Westhuizen, 2011:1-286; Yorganson, Piercy & Piercy, 2007:215-228)			

Session	Themes	Outcomes	Strategies: Resilience-protective Processes (Masten & Wright, 2010:222-229)
2	Help SCIPPs to understand/realize that their reactions to/emotions regarding these huge changes are normal	* Continue creating awareness of potential negative outcomes of SCI, resilience-protective processes and an RPA that could assist SCIPPs in surviving the negative outcomes * Educate about loss and the trauma process * RPA that could assist SCIPPs in surviving the negative outcomes (de Kooker, 2005:82; Fouché & Williams, 2005;33)	* Agency and mastery-motivation system * Intelligence (problem solving) * Self-regulation * Making meaning
(Aiello *et al*., 2011:15-20; Chen, 2011: 230-233; de Villiers & van den Berg, 2012:93-102; Dodding *et al,* 2008:41-49; Elliot *et al.,* 2008:1220-1229; Graham, 2004: 317-321; Hernandez & Medonza 2011: 375-393; Johnson *et al.,* 2001:145-255; Kellett *et al.,* 2013:134-141; Liossis *et al.*, 2009:97-112; Loprinzi *et al.,* 2011:364-368; Masten & Wright, 2010:222-229; Min *et al.,* 2013:1190-1197; Mitchelson *et al.,* 2010: 243-254; Pillay *et al.,* 2013:310-326; Steinhard & Dolbier, 2013:445-453; van der Westhuizen, 2011 :1-286; Yorganson, et al., 2007:215-228)			
3	Caretaking and support	* Continue creating awareness of potential negative outcomes of SCI, resilience-protective processes and an RPA that could assist SCIPPs to survive the negative outcomes * Educate about physical caretaking of the partner who has acquired an SCI * RPA that could assist SCIPPs in surviving the negative outcomes (Childre, 1997:21; Chapman, 2010:192-195; de Kooker, 2005:72)	* Agency and mastery-motivation system * Intelligence (problem solving) * Cultural tradition and religion * Self-regulation * Making meaning
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 to survive the negative outcomes * Educate about how physical caretaking of the partner can influence the relationship and attachment between the partners * RPA that could assist SCIPPs in surviving the negative outcomes (Chapman, 2010:9-202)	* Agency and mastery-motivation system * Intelligence (problem solving) * Attachment relationships * Self-regulation

Session	Themes	Outcomes	Strategies: Resilience-protective Processes (Masten & Wright, 2010:222-229)
(Aiello *et al.,* 2011:15-20; Chen, 2011: 230-233; de Villiers & van den Berg, 2012:93-102; Dodding *et al.,* 2008:41-49; Elliot *et al*., 2008:1220-1229; Graham, 2004: 317-321; Hernandez, & Medonza, 2011: 375-393; Johnson *et al*., 2001:145-255; Kellett *et al.,* 2013:134-141; Liossis *et al.,* 2009:97-112; Loprinzi *et al.,* 2011:364-368; Masten, et al., 2010:222-229; Min *et al.,* 2013:1190-1197; Mitchelson *et al.,* 2010: 243-254; Pillay *et al.,* 2013:310-326; Steinhardt & Dolbier, 2013:445-453; van der Westhuizen, 2011 :1-286; Yorganson, et al., 2007:215-228)			
5	Own caretaking by SCIPP	* Continue creating awareness of potential negative outcomes of SCI, resilience-protective processes and an RPA that could assist SCIPPs to survive the negative outcomes * Creating awareness of the importance of own caretaking in order to deal better with stress and cope competently with the adversity * RPA that could assist SCIPPs in surviving the negative outcomes (Fouché & Williams, 2005:11; de Kooker, 2007:74)	* Agency and mastery-motivation system * Intelligence (problem solving) * Cultural tradition and religion * Self-regulation * Making meaning
(Aiello *et al*., 2011:15-20; Chen, 2011: 230-233; de Villiers & van den Berg 2012:93-102; Dodding *et al.,* 2008:41-49; Elliot *et al.,* 2008:1220-1229; Graham, 2004 : 317-321; Hernande & Medonza, 2011: 375-393; Johnson *et al*., 2001:145-255; Kellett *et al.,* 2013:134-141; Liossis *et al*., 2009:97-112; Loprinzi *et al.,* 2011:364-368; Masten & Wright, 2010:222-229; Min *et al.,* 2013:1190-1197; Mitchelson *et al*., 2010: 243-254; Pillay *et al*., 2013:310-326; Steinhardt & Dolbier, 2013:445-453; van der Westhuizen, 2011 :1-286; Yorganson, et al., 2007:215-228)			
6	Termination and way forward	* Continue creating awareness of potential negative outcomes of SCI, resilience-protective processes and an RPA that could assist SCIPPs to survive the negative outcomes * Addressing emotional reactions of SCIPPs due to termination * Evaluation and termination of group sessions with SCIPPs after termination (Toseland & Rivas, 2014:407-433)	* Agency and mastery-motivation system * Intelligence (problem solving) * Cultural tradition and religion * Attachment relationships * Self-regulation * Making meaning
(Aiello *et al*., 2011:15-20; Chen, 2011: 130-133; de Villiers & van den Berg, 2012:93-102; Dodding *et al.,* 2008:41-49; Elliot *et al.,* 2008:1220-1229; Graham, 2004: 317-321; Hernandez & Medonza, 2011 :375-393:; Johnson *et al*., 2001:145-255; Kellett *et al.,* 2013:134-141; Liossis *et al.,* 2009:97-112; Loprinzi *et al.,* 2011:364-368; Masten & Wright, 2010:222-229; Min *et al.,* 2013:1190-1197; Mitchelson *et al.,* 2010:243-254; Pillay *et al.,* 2013:310-326; Steinhardt & Dolbier, 2013:445-453; van der Westhuizen, 20111-286 ; Yorganson, et al., 2007:215-228)			

The formulated outline of the GRPP for SCIPPs, as depicted in table 4, illustrates that the proposed GRPP for SCIPPs consist of six group-work sessions, with outcomes that stipulate the specific resilience-protective processes (proposed strategies) (Masten & Wright, 2010:222-229), in an effort to promote SCIPPs' resilience.

After the formulation of the outline of the GRPP for SCIPPs, it was ready to be subjected to expert review by an advisory panel. This is discussed in step 2.

6.2 STEP 2: Advisory panel meeting 1 (AP-1) (Pre-pilot study) (March – April 2014)

The researcher consulted an advisory panel (AP), consisting of experts in the field of SCI and resilience, as well as the opinions from SCIPPs and people living with SCI in order to scrutinize the proposed outcomes, content and strategies that won't fit and can help the researcher to reject proposed content that may not suit the target population (Fraser *et al.,* 2009:1-224). Utilizing advisory panels has been used widely in resilience-focussed studies, both internationally and in South Africa (Ungar *et al.,* 2007:294; Theron *et al.,* 2013:67; Truter *et al.,* 2014:312). The role of the AP was for them to give critical feedback on the relevance and feasibility of the outcomes, planned content, and intended strategies and activities sketched in the formulated outline of the GRPP for SCIPPs (table 4). They were further requested to critically comment on the resilience-protective processes synthesised from previous research (manuscript 1), and included in the resilience-based framework of the GRPP for SCIPPs. In addition, their suggestions were sought on the mode of delivery, duration of the programme and the length of the sessions. Adding, the AP was also consulted on the role and format of a pilot study to evaluate the content of the GRPP for SCIPPS as well as applicable data collection methods for evaluation purposes. Furthermore, the advisory panel members' (APMs') recommendation was sought on the

possibility of including video (DVD) recordings (figure 8 & Step 3) as programme media in the intervention which aimed at strengthening the resilience-promoting activities in the GRPP for SCIPPs (Masten & Wright, 2010:222-229) by including life interviews/recordings of professionals, with profound knowledge of SCI, as well as people with SCI and SCIPPs (Patton, 2015:434).

6.2.1 Participants and sampling

The composition and use of an AP would be worthless, had the appropriate participants been approached; therefore the researcher sought efficient sampling methods in order to include paramount participants (Niewenhuis, 2012:99-117). Sampling refers to the process that has been used to make decisions regarding people, settings, events or behaviours to include in the study (Bertram & Christiansen, 2014:59; Niewenhuis, 2012:99-117). Participants for this AP were selected by combining different sampling methods, namely purposeful sampling and snowball sampling (Strydom, 2011:232-233). Purposive sampling takes place when a researcher selects participants according to pre-selected criteria relevant to a particular research question (Niewenhuis, 2012:99-117; Strydom, 2011:232). Furthermore, snowball sampling is a method whereby participants, with whom contact has already been made, are used to enter their social networks to denote the researcher to other participants who often used to find "hidden populations", that is, groups not easily reachable to reach through other sampling strategies (Niewenhuis, 2012:99-117; Strydom, 2011:233). The following criteria were used to purposively sample participants: they had to be Social workers and Physiotherapists who had at least five years of experiences in working within the field of SCI; intervention research specialists; experts on resilience; SCIPPs who had already lived in a cohabited relationship for at least five years with a spinal cord injured partner (SCIP) who had acquired this

injury after they were married; therefore they could give guidance from their lived experiences (Patton, 2015:434).

For this study, a total of six participants were recruited and included in the AP. The first four chosen participants were thus selected by means of purposeful sampling and complied with the criteria of possessing sufficient knowledge and skills pertaining to SCI and/or resilience respectively, and who also assisted the researcher through snowball sampling to recruit more participants for the AP (Niewenhuis, 2012:00-117; Strydom, 2011:232-233).

As depicted in table 7, the members included in AP-1 consisted of two social workers who are working at rehabilitation centres in Vereeniging and Johannesburg respectively. They were selected due to their experience in the field of SCI (5 years and 22 years respectively). A Physiotherapist with her own practice/association, rendering therapeutic services at different rehabilitation centres, was included because of her pioneering work regarding SCI in South Africa (she was one of the founders of the South African Spinal Cord Association (SASCA) in 1993), and her extensive experience in the field of SCI (more than 30 years). One social work academic, with expertise pertaining to intervention research and resilience (more than 30 years), was selected and therefore had to advise the researcher on the resilience-based framework of resilience (Masten & Wright, 2010:222-229; Yates & Masten, 2004:8), as well as the planned research model to be used (de Vos & Strydom, 2011:473-489). Two SCIPPs, who also participated in the researcher's MA studies (Steyn, 2008:55), were included because both SCIPPs' cohabiting partners had acquired their spinal cord injuries after they married, therefore they could give guidance from their lived experiences (Patton, 2015:434), cohabiting with their SCI partners for10 years and 8 years respectively.

Table 7: Demographics of advisory panel members (AP-1)

ADVISORY PANEL MEMBER (APM)	RACE	GENDER	AGE	LANGUAGE	PROFESSION	YEARS' EXPERIENCE
APM 1	White	Female	40	Afrikaans	Spinal cord injured person's partner (SCIPP)	Married to partner with SCI (partner acquired SCI 10 years ago, post-marriage)
APM 2	White	Female	38	Afrikaans	Spinal cord injured person's partner (SCIPP)	Married to partner with SCI (partner acquired SCI 8 years ago, post-marriage)
APM 3	Black	Female	64	Sesotho	Social worker	22 years' experience in working with spinal cord injury
APM 4	White	Female	40	Afrikaans	Social worker	5 years' experience in working with spinal cord injury
APM 5	White	Female	55	Afrikaans	Physiotherapist	30 years' experience in working with spinal cord injury
APM 6	White	Male	64	Afrikaans	Professor in Social Work at an University in South Africa	More than 30 years' experience in intervention research and resilience

6.2.2 Procedure, data collection and ethics

Due to logistical constraints the AP took the form of individual open-ended interviews with APMs, at a convenient time and place for everyone.

Clear, generally written informed consent forms (see addendum 5) were sent to each APM prior to the interviews, allowing a "cooling off" period of five to seven days (Greeff, 2011:341-374). The informed consent forms provided them with a background and explanation of the study as well as a description of the process of designing and developing the GRPP for SCIPPs. The informed consent forms also explained that participation was voluntary, that they could withdraw from the proceedings at any time, that confidentiality will be encouraged and also how the information gathered by them will be diffused (Yegidis *et al.*, 2012:37-38). Permission for a follow-up discussion was also

obtained, as argued that member checking is an important way of enhancing trustworthiness and of eliminating any misunderstandings (as in this study); the researcher is "the instrument" of qualitative data collection (Niewenhuis, 2012:99-117; Marshall & Rossman, 2016:444, 446)

At commencement of the interviews, the researcher provided the APMs with a road map to guide the conversation (figure 8: number 1 & see addendum 6) (Greeff, 2011:348; Patton, 2015:433). The formulated outline of the GRPP for SCIPPs, containing the content, outcomes and proposed strategies (resilience-protective processes) were presented to the APMs. Their critical feedback was thus invited on the resilience-promoting processes identified during the QRS and included in the programme content, outcomes and strategies and group work as model of delivery. The interviews with all the APMs, except APM-6 was audio recorded and transcribed. Hence, a comprehensive process note was completed after the interview with APM-6 (Strydom, 2011:117-118). The researcher conducted the conversations with the APMs in either Afrikaans or English, depending on the APM's preference. Unfortunately the researcher is not fluent in SeSotho, but the SeSotho APM was willing to speak English to the researcher. This APM is a qualified Social Worker, who often has to perform her professional duties in English, and is therefore fluent in English, and comfortable expressing herself in English.

6.2.3 Data analysis

The researcher employed a process of thematic content analysis, followed by inductive processes, as suggested by Tesch (in Creswell, 1994:154-155; 2009:186) and Braun and Clarke (2006:77-101, 2013:5-23). The researcher read and reread the transcripts, coded and categorised all feedback per session according to seven procedural elements of the GRPP for SCIPPs, namely: outcomes; icebreakers; DVDs (SCIPPs & SCIPs); DVDs

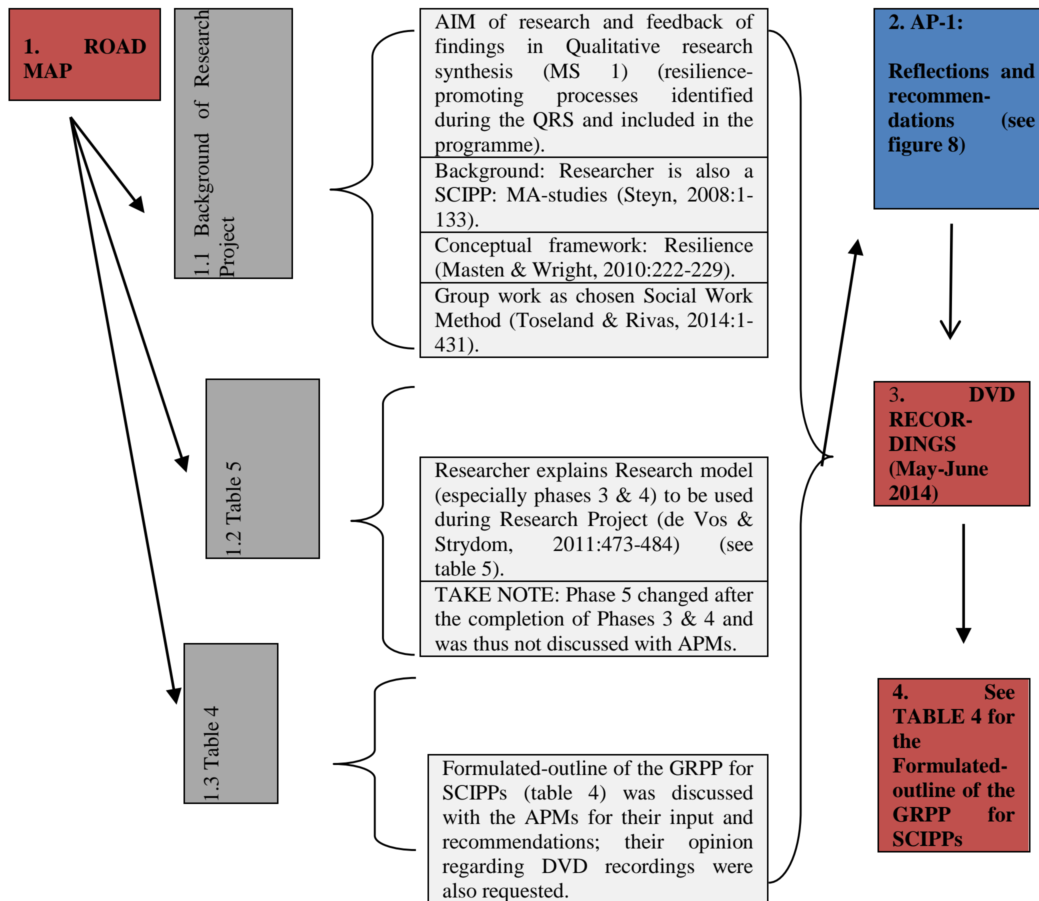
(Professionals) resilience-promoting activities (RPAs); Anchors and survival kits". Next, the feedback was subdivided into "aspects in agreement"; "suggestions" and "general feedback". Hereafter the feedback on the GRPP for SCIPPs was furthermore inserted in a word document by means of track changes using the three categories as mentioned above (see table 8). See addendum 7 for the coding procedure.

Table 8: Self-administered data-analysis technique (AP-1)

Participant (advisory panel members) abbreviations	**APMs 1 – 6**
Aspect/s in AGREEMENT	**Green** (including the APM abbreviation, e.g. APM-1) and aspect/s in AGREEMENT
SUGGESTION/S	**Grey** (including the participant abbreviation, e.g. APM-1) and SUGGESTION/S
COMMENT/S	**Orange** (including the participant abbreviation, e.g. AMP-1) and COMMENT/S

Hereafter the researcher synthesised and color-coded comments that were related (comparable), reflected upon it, compared with literature and amended the Formulated-outline.

Figure 8: AP-1: Protocol and Reflections/Recommendations



6.2.4 APMs' reflections and recommendations (figure 8, number 2)

The APMs were in mutual agreement that the design and development of a tailor-made GRPP for SCIPPs is much needed in South Africa. APM-6, who is an expert on intervention research and resilience theory, scrutinized the intended planning for the project and commented: "[the process is] *clear, concise and well-organized*" (APM-6), and furthermore was in agreement upon the chosen resilience-based framework for the GRPP for SCIPPs, as the contents and resilience-protective processes (Masten & Wright, 2010:222-229) complement one another.

A valuable suggestion was made by APM-2 with regard to the resilience-promoting activity of the session regarding "caretaking and support", namely that the chosen activities for this session should assist SCIPPs in really understanding the relationship-

changes that might take place, and therefore suggested the inclusion of "The 5 Love Languages" (Chapman, 2010:11-189), as an important skill that could enhance the romantic relationship: APM-2: "*I want to tell you......mine [love language] totally changed [after the acquirement of her husbands' SCI], and I only realized it this weekend....mine is [now] acts of service, and that was his [husband's] normal way to show his love to me before the accident ....he would pull out the car....put everything in the car...that is why I married him....now things have changed, now that [acts of service]is my love language, but my love language before [the acquired SCI of husband] was "physical touch".*

The APMs also approved the selected social work method, namely Social group-work, will be a beneficial method to apply, as this method can assist SCIPPs in supporting each other. APMs – 1, 2 and 3 suggested the group to be a "closed group" and that the number of group members to be included should not be more than six, as the newly acquired SCI of their partners is a life-changing event, and a small group therefore might allow more time for questions and reflection than would larger groups.

APM-5 highlights the need for the GRPP for SCIPPs to cater for all culture groups as she indicated that patients in the rehabilitation centre are diverse: "*We accommodate different cultures and language groups [in the rehabilitation centre]",* and therefore the researcher was alerted to be culture sensitive during further development of the GRPP for SCIPPs, by including (amongst others) people from different cultures in the video recordings (DVDs to be included in the programme). APM-6 encouraged the researcher to make use of a research journal: "*A research journal will enhance the trustworthiness of the process"* (APM-6).

The researcher explored the APMs' views on including video recordings (to be included in the GRPP for SCIPPs as DVDs) of live interviews with SCIPPs and SCIPs on their lived

experiences and skills that helped them to adapt positively with the prolonged adversity of an SCI. The inclusion of video-recorded interviews with professional role-players addressing content such as resilience, trauma, and information on SCI, and was also suggested and approved by all six APMs. All six APMs also availed themselves of being part of the video recordings during May – June 2014, as they recommended that such a contribution has the capacity of enhancing the quality and effectiveness of the GRPP for SCIPPs.

Advisory panel members recommended that the pilot study be conducted with SCIPPs who have been in a cohabiting relationship with a SCIP for at least five years; thus people who have experience, but have also had time to adapt to the adversity and would be in a good position to critically reflect on the usefulness of the content and activities of the GRPP for SCIPPs. In addition, suggestions were made with regard to a data collection method, namely a questionnaire with individual Likert-type items that could focus participants' attention on the core aspects of the programme following invitation to construct reasons for their writing by means of written explanations. Please see table 9 for a summary of the APMs' suggestions which were considered during further programme development.

Table 9: Refining the GRPP for SCIPPs after AP-1

STEP 2: Programme development after APM-1 (view combined with table 10 and figure 8)						
Outcomes	**Icebreaker**	**DVDs: SCIPPs and/or people with SCI**	**DVDs: Professionals**	**Resilience-promoting activities (RPAs)**	**Anchor**	**Survival kit (SK)**
* AP approved all the suggested outcomes as seen in table10).	* The AP agreed that icebreakers should fit the contents of the specific session. They could, however, not comment on the icebreakers as they had not been compiled yet.	* The suggested inclusion of interviews (recorded on video/DVDs) with SCIPPs and/or people with SCI was approved by all APMs (to assist SCIPPs in adapting positively to the prolonged adversity of an SCI.	The inclusion of DVD interviews with professional role-players addressing focuses (subjects/themes) such as resilience, trauma, information on spinal cord injuries was suggested and approved by all six APMs.	* Valuable suggestion by APM-2: Inclusion of "The 5 Love Languages" (Chapman, 2010:19-202) in session 4.	* Not discussed with AP yet (was not planned yet).	*The rationale behind including a survival kit as part of the GRPP for SCIPPs (DVDs; hand-outs; & questionnaires) are confirmed by all APMs, saying that this might be a helpful strategy to further promote the SCIPPs' resilience.

6.3 STEP 3: Recording video's (DVDs) for use as media during group sessions (May 2014 – June 2014)

As including diverse resources (during intervention) may offer the potential for resilience to be promoted (Ungar *et al.,* 2012:675-693), the inclusion of DVDs as programme media is thus to strengthen the resilience-protective processes in the GRPP for SCIPPs (Masten & Wright, 2010:222-229) by including life interviews/recordings of professionals, with profound knowledge of SCI/resilience, as well as the inner perspectives of people who have acquired SCI and of SCIPPs (Patton, 2015:426, 434).

Furthermore, since the rehabilitation team, working with SCI, consists of various professionals, it would be a challenge for the researcher to truthfully include the professionals' responsibilities (during the acute rehabilitation phase; as well as after dismissal of the SCI patient), in this intervention programme. The researcher therefore decided to identify content (focuses) for the video recordings that could promote resilience-protective processes in SCIPPs and that are aligned with the content and outcomes in the outline (table 4) of the GRPP for SCIPPs, to support the programme

media in the intervention, and ultimately strengthen the resilience-protective processes advocated by Masten and Wright (2010:222-229).

As a result, the researcher decided to video-record various role-players, rendering services to SCI people during their rehabilitation; experts on resilience; people living with SCI and SCIPPs, by adopting two interview approaches, namely "in-depth interviews", and "life-story interviews" as both focus on capturing lived experiences (Patton, 2015:433) in the words of the person telling the story (Patton, 2015:434; Strydom, 2011:330). The video recording of professionals were mainly aimed at including their professional expertise regarding either SCI or resilience, therefore no specific approach was followed; hence the pragmatic interview-approach could have relevance in this particular interviewing as Patton (2015:436) argued that pragmatic interviews can yield useful insights, results in problem-solving and tend to be relatively brief, focused interviews, often lasting an hour or less, as was the case during video recording with these included professionals.

Although these are video recordings (on DVDs), which implies that participants of the GRPP for SCIPPs won't be able to communicate directly with the people on the DVDs, this method can also be seen as peer-support (Toseland & Rivas, 2014:14), and correspond with the ecological approach of resilience, as resilience is a process of shared interactions between an individual and his or her supportive ecology (Ungar, 2008:225; Ungar, 2011:11), as in this case the group facilitator will be available for participants' reflections after the group has viewed the DVDs.

6.3.1 Participants and sampling

All six the APMs availed themselves to participation in the video-recordings, and by means of snowball sampling they then assisted the researcher to recruit other participants for more video-recordings to take place (Niewenhuis, 2012:99-117; Strydom, 2011:232).

6.3.1.1 Demographics of participants on DVDs: A summary

A total number of 28 persons were included in the video recordings. Twenty of the twenty-eight included video recordings were recorded by the researcher and the other twelve recordings were extracted from YouTube. The YouTube extractions comprise four experts regarding resilience; one expert on marital issues (such as the love languages), one on stress management and two others sharing their perspectives on trauma and religion. The recorded videos by the researcher and videographer entailed recording the following persons: two social workers addressing emotional adaptation after SCI; a trauma therapist addressing the processing of trauma; two social work academics, giving information regarding resilience; two occupational therapists (seating specialists) addressing different paraphernalia which are much needed for people with SCI; one physiotherapist with information and awareness on the rehabilitation process of a person with SCI; one nurse with extensive knowledge in the treatment of pressure sores and bladder-, and bowel-care; two sexologists addressing sexuality after SCI; seven SCIPPs and seven people with acquired spinal cord injuries, sharing their lived experiences. Please see figure 9 for the table of contents of the DVDs with the included content. Please note that comprehensive tables of complete demographical information and other important details regarding all the participants on the DVDs can be found attached (see addendum 8).

6.3.2 Procedure and ethics

The researcher arranged appointments with each APM and other recruited participants to perform on the video-recordings (with the help of a videographer), at a convenient time and place. Clear, generally written informed consent forms were sent to each participant prior to the video recordings, providing them with a description of the process of designing and developing the GRPP for SCIPPs, as well as the anticipated aim with these video recordings (see addendum 9). Patton (2015:499-450) reports that informed consent does

not automatically mean that confidentiality has to be maintained, as participants might desire to "own their stories" and therefore might want their identity to be known, which was especially in this case the situation with the people with SCI and SCIPPs, who availed themselves of participation in the video recordings, which enhanced the trustworthiness, reliability and validity of these recordings (Marshall & Rossman, 2016:43-47).

Each participant then signed the consent forms before commencement of the video recordings (Patton, 2015:497; Yegidis *et al*., 2012:37). The informed consent forms also clarified that participation was voluntary, possible risks and benefits were highlighted as well as information on the dissemination of the DVDs (Yegidis *et al.,* 2012:37-38). Interviews are interventions which affect people in one way or another, and occasionally people may become aware of things about themselves they were unaware of prior to the interview (intervention) (Patton, 2015:495). As neither the researcher nor the participants could know this in advance, the researcher assured them that debriefing could be arranged, if necessary (Patton, 2015:495-497). No participant requested to be debriefed afterwards. Participants were also afforded the opportunity of indicating, after the recordings had been made, whether any of the information that had been captured on the DVD had to be omitted.

As the two adopted interview approaches with SCIPs and SCIPPS for the video recordings were "in-depth interviews", and "life-story interviews", the researcher didn't guide the interviews with formal questionnaires, with the intention of affording the SCIPs and SCIPPs the opportunity of sharing their expertise and lived experiences in their own words (Patton, 2015:434). Last-mentioned was also applicable during the video-recorded interviews with the professionals (pragmatic interviews) (Patton, 2015:436).

The researcher therefore held telephone conversations with some of the participants, and sent every participant an e-mail prior to commencement of the video-recording, informing him/her of the aim and content of the GRPP for SCIPPs. The professionals (social workers; physiotherapist; occupational therapists; wound nurse; sexologists and trauma therapist) were requested to provide information on his/her field of specialisation, as much as he/she deemed necessary. The people with spinal cord injuries and SCIPPs were requested to share their lived experiences concerning the acquired SCI, in their own words.

Hence the researcher edited the recordings (with the help of a videographer) to fit the video-recorded information with the suited sessions and content. Each footage that was not recorded in English, was translated into English (and language edited), by including subtitles. To enrich the information on the DVDs, the researcher also included some YouTube videos (twelve) in the recordings, especially including experts on specific focuses (subjects/themes), such as resilience and one person on religion (as explained previously).

The researcher compiled in total two different sets of DVDs. The first set of DVDs was prepared for the facilitator of the GRPP for SCIPPs, to be used during the group sessions; and the Survival Kit-DVDs were prepared to be given to each participating SCIPP, as part of a survival kit-package ("tool-kit"), to take home. Please see figure 9 for the table of contents of both sets of DVDs. Please see DVDs provided to you with the thesis (please find the following DVDs: DVDs to be used during group sessions; Survival Kit DVDs & Examination copy).

6.3.3 Researchers' critical reflections and considerations

During the DVD recordings (video shoots) the researcher became aware of the element that most of the shared information by the professionals and people living with SCI and

their partners are supporting the findings of AP-1, and match the content of the formulated outline of the GRPP for SCIPPs and therefore the researcher made entries in her researcher's journal regarding this valuable realization. Please see table 10 for a summary of further programme development after the video recordings (DVDs).

Table 10: Programme development after video recordings (DVDs)

STEP 3: Programme development after video recordings (DVDs)						
Outcomes	**Icebreaker**	**DVDs: SCIPPs and/or people with SCI**	**DVDs: Professionals**	**Resilience-promoting activities (RPAs)**	**Anchor**	**Survival kit (SK)**
* No action needed during this step.	* No action needed during this step.	* Video recordings of SCIPPs and people with SCI; edited with help of videographer; translated where needed. * Fit the content of the recordings with the outcomes of the appropriate sessions of the GRPP for SCIPPs. * Compiling the table of contents for DVD covers & creating DVD covers.	* Video recordings of professionals; edited with the help of videographer; no translation was needed as all the recordings were done in English. * Fit the content of the recordings with the outcomes of the appropriate sessions of the GRPP for SCIPPs. * Compiling the table of contents for DVD covers & creating DVD covers.	* No action needed during this step.	* No action needed during this step.	* Video recordings of SCIPPs; people with SCI, & professionals to be included in the survival kit DVDs; edited with the help of videographer; translated where needed; compiling table of contents for DVD covers & creating DVD covers.

Please see figure 9 for the table of contents used in the mentioned DVDs for more clarity on the content of the recordings.

Figure 9: Table of Contents of DVDs to be used in GRPP for SCIPPs

DVDs to be used during programme sessions (To be used as media during sessions)		**Survival-Kit DVDs** (For SCIPPs to take home)	
SESSION 1 **DVD 1 - INFORMATION ON SCI AND RESILIENCE** **PART 1** 1) **Researcher**: Yolinda Steyn - Background information on programme and welcoming 2) **SCIPP**: Elna de Waal 3) **SCIPP**: Renet van Rooyen 4) **SCIPP**: Rene Pieters 5) **SCIPP**: Mpho Dladla **PART 2** 1) **Marcy (Brain.org)**: Different levels of spinal cord injury 2) **Prof Michael Ungar**: Resilience (Social ecology) 3) **Dr Elmien Truter:** Resilience (definition) 4) **Dr Robert Brooks** (2014): Resilience (definition)	**SESSION 4** **MY DUAL ROLE** **PART 1** 1) **SCIPP**: Elna de Waal 2) **SCIPP**: Renet van Rooyen 3) **SCIPP**: Rene Pieters 4) **SCIPP**: Mpho Dladla 5) **SCIPP**: Illse du Preez **PART 2** 1) **Mareli Pottas**: Social Worker 2) **Dr Richard Holmes**: Psychologist 3) **Willem Stighlingh**: Sexologist 4) **Dr Gary Chapman**: Love Languages	**SESSION 1** 1) Marcy Newsome (Brain.org): Different levels of spinal cord injury 2) Mareli Pottas (Social worker): Social work and SCI 3) Ilse du Preez (Occupational therapist): Wheelchairs & cushions 4) Denise van Heerden (Occupational therapist): Wheelchairs and adapted cars 5) Joey van Tonder (Private nurse): Pressure sores; burn wounds, colostomy	**SESSION 4** 1) Willem Stighlingh (Sexologist): SCI and sexuality 2) Dr Richard Holmes (Psychologist & quadriplegic): SCI and sexuality 3) Five keys of saving your marriage now 4) Pastor Royal Farris: One person can save a marriage
SESSION 2 **HELP SCIPPS TO UNDERSTAND/REALIZE THAT THEIR REACTIONS TO/EMOTIONS REGARDING THESE HUGE CHANGES ARE NORMAL** **PART 1** 1) **SCIPP**: Elna de Waal 2) **SCIPP**: Renet van Rooyen 3) **SCIPP**: Rene Pieters **PART 2** 1) **Yvonne Retief**: TRAUMA	**SESSION 5** **OWN CARETAKING BY SCIPP** 1) **Prof Herman Strydom** – Professor in Social Work 2) **SCIPP**: Elna de Waal 3) **SCIPP**: Renet van Rooyen 4) **SCIPP**: Rene Pieters 5) **SCIPP**: Mpho Dladla	**SESSION 2** 1) Alexander McFarlane: Resilience 2) Robyn Walser: Acceptance and the treatment of trauma 3) Monica Dube (social worker): Trauma 4) Eric Brown: Resilience	**SESSION 5** 1) Overcoming depression 2) Why you should care about emotional resilience 3) SCIPP: Elna de Waal (religion) 4) SCIPP: Mpho Dladla (religion)

DVDs to be used during programme sessions (To be used as media during sessions)		**Survival-Kit DVDs** (For SCIPPs to take home)	
SESSION 3	**SESSION 6**	**SESSION 3**	**SESSION 6**
CARETAKING AND SUPPORT	**Termination and way forward**	1) Monica Dube (Social worker): Rehabilitation and SCI	1) SCIP: Mathys Roets: Song ("In my lewe") 2) SCIP: Pieter du Preez (Still running) 3) SCIP: Pieter du Preez (Motivational thoughts) 4) Dr Richard Holmes (Motivational thoughts)
PART 1	**PART 1**		
1) **Prof. Herman Strydom**: Professor in Social Work	**SPINAL CORD INJURED PEOPLE (SCIP) – SURVIVOR STORIES**		
2) **SCIPP**: Elna de Waal			
3) **SCIPP**: Renet van Rooyen			
4) **SCIPP**: Rene Pieters	1) Johan de Waal		
5) **SCIPP**: Mpho Dladla	2) Jakkie Pieters		
6) **SCIPP**: Lydia Holmes	3) Pieter du Preez		
	4) Robert Dladla		
PART 2	5) Dr Richard Holmes		
	6) Mathys Roets		
1) **Rita Henn**: Physiotherapist	7) Johan Steyn		
2) **Denise van Heerden**: Occupational therapist/Seating specialist			
	PART 2		
3) **Illse du Preez**: Occupational therapist/Seating specialist	1) **Researcher: YolindaSteyn** – Closure		
4) **Monica Dube**: Social Worker			

6.4 STEP 4: Further development and formulation of a GRPP for SCIPPs (table 6 of this document)

In preparation for the pilot study, the outline of the GRPP for SCIPPs had to be further developed and refined in order to provide a comprehensive structure for each session so that it could be implemented with participants in a pilot study. Further development and formulation (table 6 in this document) of the GRPP for SCIPPs took place, with included findings from AP1. In addition, reflections on entries in the researcher's journal were also incorporated (Becker, 2010:82-100; Schurink, *et al.*, 2011:397-496; Toseland & Rivas, 2014:162-198).

Every session covers some key procedural elements, namely outcomes; icebreakers; specific content pertaining to resilience-protective processes, resilience-promoting activities (RPAs); DVDs; Survival Kit DVDs, hand-outs and "anchors" (survival "tool"-kit). As the SCIPPs need to have adequate knowledge of how to deal with the challenges which accompany an SCI, the researcher included important information on the survival kit DVDs, such as the Occupational therapists' information regarding paraphernalia and the wound nurses' facts regarding bladder- and bowel-care, as well as the prevention of pressure sores. Taking into account that the resilience-based framework "guided" the compilation of the programme, the researcher hand-picked and adapted techniques and activities from literature (workshops the researcher attended between 1997 – 2014 (Childre,1997:21; de Kooker, 2005; 2007; Fouché & Williams, 2005:11); and Chapman (2010:192-195); and practice experience from her eighteen-year career as social worker, that suited the applicable resilience-protective processes, and included it in the GRPP for SCIPPs to be either icebreakers or resilience-promoting activities (RPAs) (please see figure 10 for an extract from the formulated programme for clarification):

Figure 10: Icebreakers and RPAs for the GRPP for SCIPPs

SESSION	ICEBREAKERS	RESILIENCE-PROMOTING ACTIVITIES (RPAs)
1: Information on SCI and resilience	"Get-to-know-each-other"	Strong foot (Fouché & Williams, 2001:18)
2: Help SCIPPs to understand/realize that their reactions to/emotions regarding these huge changes are normal	"Picture"	PNI- goal exercise (de Kooker, 2005:82) & Powerful arm (Fouché & Williams., 2005:33)
3: Caretaking and support	"Money vs. Seconds"	"Finding your heart" (de Kooker, 2005:72) & "Freeze-Frame" (Childre, 1997:21)
4: My dual role as SCIPP	"Tie-me-up-and-let-me-eat"	"The 5 Love Languages" (Chapman, 2010:9-202)
5: Own care-taking by SCIPP	"Hour glass OR Faces?"	Energy Investment (Fouché 7 Williams, 2005:11) & PNI-Awareness exercise (de Kooker, 2007:74)
6: Termination and way forward	"Fairy tale"	Self-recorded DVD of SCIPs

After formulating the GRPP for SCIPPs as seen in the depicted expert in table 11, the researcher compiled a folder with content to be used during the pilot study, arranged the pilot study, which will be further explained after table 11 (see step 5).

Table 11: Formulated GRPP for SCIPPs

STEP 4: Formulated GRPP for SCIPPs						
Outcomes	**Icebreaker**	**DVDs: SCIPPs and/or people with SCI**	**DVDs: Professionals**	**Resilience-promoting activities (RPAs)**	**Anchor**	**Survival kit (SK)**
* No changes were made to the outcomes – stay the same as outlined in table 2)	* Compiling all six icebreakers, one icebreaker per session of the GRPP for SCIPPs (see figure 6 above)	* Please see addendum 8 for the order in which the DVDs were placed in the GRPP for SCIPPs	* Please see figure 9 for the order in which the DVDs were placed in the GRPP for SCIPPs	* For each session an RPA was developed to fit the outcomes and resilience-protective processes of the specific session. Please see figure 6 above).	* At this stage, no anchors had yet been developed.	* Six survival kit information (DVDs, as compiled during step 5), for instance, hand-outs and questionnaires were prepared (to be handed out to the SCIPPs for utilization between the six sessions). Please see addendum 26 for details.

6.5 STEP 5: Pilot study (17 – 18 July 2014)

The purpose of the pilot study was to ensure that the programme content and format is appropriate for the population and setting (de Vos & Strydom, 2011:483-484). The researcher planned to pilot test the GRPP for SCIPPs with two SCIPPs (de Vos & Strydom, 2011:483-484), using six self-administered questionnaires containing individual Likert-type items and written explanations (Babbie & Mouton, 2012:153-154; Delport & Roestenburg, 2011:188; Neuman, 2012:135) (see addenda 10 - 15). Due to the dual role of the researcher, namely that of a researcher and interventionist, and a SCIPP herself, an observer's role was to ensure that the researcher implemented the GRPP for SCIPPs as planned (Trondsen & Sandaunet, 2009:13-20). As such, a checklist was developed that comprised all the elements that needed to be covered in the programme (see addendum 16)

(Jackson, 2011:110). The qualitative feedback generated from the written explanations was incorporated to amend the GRPP for SCIPPs.

6.5.1 Procedure

The researcher invited four SCIPPs and one social worker (observer), to participate in the pilot study on 17 – 18 July 2014, at the Vaal Triangle Campus of the North-West University, but only two SCIPPs and the Social worker could attend. The GRPP for SCIPPs, with its six small-group sessions, was facilitated by the researcher over a period of two days (see programme: addendum 17). The sessions were audio-recorded with the participants' permission (see addendum 18). After the presentation of each session, the participants filled out self-administered questionnaires with individual Likert-type items and written explanations for scores given and also encouraging suggestions (Clason & Dormody, 1994:31; Neuman, 2012:135) with included "statements" (Delport & Roestenburg, 2011:188). The Observer filled out the same questionnaires as the two SCIPPs, as well as a checklist as described earlier (Jackson, 2011:100; Patton, 2015:335, 368, 373).

6.5.2 Participants and Sampling

Purposeful sampling was used to select the participants (Strydom, 2011:232). A definition as well as the strengths of this sampling method was documented earlier in this manuscript (see AP-1).

In this case, two of the three recruited participants live in pre-injury cohabiting relationships with partners who had acquired spinal cord injuries; therefore they are representatives of the target population (Bertram & Christiansen, 2014:59). The researcher adopted these sampling criteria, as well as other inclusion criteria to select the most suitable participants, namely that they had to be female SCIPPs, living in a cohabiting

relationship with their SCI partner for longer than 5 years (after the acquired SCI); that they should be able to communicate in English; the participants should represent different cultures; and they should make themselves available for a two-day pilot study at NWU, Vaal Campus, to assist the researcher to understand whether the content of the GRPP for SCIPPs holds the potential of promoting SCIPPs resilience.

The third participant in the Pilot Study was also selected through purposeful sampling (Niewenhuis, 2012:99-117) with the task to be an observer during the Pilot study. The inclusion criteria for an observer were the following: the observer should be a registered social worker, with more than five years' experience as practising social worker; and should have extensive experience in the method of Social group-work (Toseland & Rivas, 2014:11-12). Therefore, the selected Observer met all the criteria, with more than ten years' experience as social worker and also extensive experience in group-work as a method in social work.

Patton (2015:335) further argued that a researcher can benefit from what the observer learns during the observation, and therefore the observer should, amongst others, pay attention to planned programme activities, keeping in mind a question, amongst others, such as: "What goes on in the programme?. The observer should also consider nonverbal forms of communications, which can be cues to how participants experience the programme. Thus, the observer in this pilot study had a dual purpose, namely: (a) Making notes and filling out the checklist/protocol (previously mentioned), in assisting the researcher with rich descriptions, providing a distanced opinion of the course of the pilot study, as well as documenting the other two participants' reactions; and (b) It was ultimately important that the observer assisted the researcher with observations which might have been over-looked by the researcher (Patton, 2015:335-373), as the researcher is a SCIPP herself.

The facilitation and participation was conducted in English, as this was the common language spoken by all, and they indicated to be comfortable using English, although this was not their mother tongue. The role of the observer was clarified to the observer and the other two participants alike prior to commencement of the pilot study.

Table 12: Demographics of participants

PARTICIPANTS	RACE	GENDER	AGE	LANGUAGE	YEARS LIVING WITH SCI PARTNER
P1	Black	Female	28	SeSotho	Living with SCI partner for 12 years (partner acquired SCI 15 years ago)
P2	White	Female	38	Afrikaans	Married to SCI partner for 9 years (partner acquired SCI 8 years ago)

Table 13: Demographics of observer

OBSERVER	RACE	GENDER	AGE	LANGUAGE	PROFESSION	YEARS EXPERIENCE
O	White	Female	34	Afrikaans	Social Worker	More than10 years' experience as social worker

Furthermore the data collection and data analysis during this step will be elaborated on.

6.5.3 Data collection and analysis

The researcher developed six self-administered questionnaires (one questionnaire per session of the GRPP for SCIPPs) based on individual Likert-type items (questions, with four response alternatives: completely agree (4); mostly agree (3); disagree (2); completely disagree (1) (Babbie & Mouton, 2012:153-154; Clason & Dormoday,1994:31; Neuman, 2012:135), including "statements" (Delport & Roestenburg, 2011:188), and also inviting written explanations for rating provided to obtain data of a subjective nature (Delport & Roestenburg, 2011:188) (previously referred to). The purpose of the individual Likert-type items in the questionnaire was merely to focus the participant's mind on a specific aspect and thereafter they were requested to construct written explanations (with regard to their attitudes and opinions) for the rating they gave (Clason & Dormody,1994:31). There

are no right and wrong ways for analysing data from Likert-type items, rather to answer the research questions meaningfully by employing these Likert-type items (Clason & Dormody, 1994:34). Due to the small sample (n=2) (pilot study participants) and (n=1) (the observer) the numerical data were not processed. However, the qualitative data were used to amend and refine the programme, as Boone and Boone (2012:1-5) argue that if Likert questions are unique and stand-alone, they must be analysed as Likert-type items.

Furthermore, the observer had to fill out a self-developed checklist that served as an intervention protocol which contained items pertaining to the structure of the sessions, activities and processes followed (which were designed by the researcher), to assist with more structured and objective data collection (Jackson, 2011:110). The advantage of the latter is that a checklist enables observers to focus on a limited number of specific behaviours, but the disadvantage of checklists is that the behaviours and characteristics to be observed are determined when the checklist is devised (Jackson, 2011:100).

6.5.4 Ethical considerations

Participating in the pilot study was voluntary and the participants were therefore not intimidated to participate (Babbie & Mouton, 2012:521; Maschi & Youdin, 2012:49-50). The researcher took special note to handle the participants' information as being confidential as Maschi and Youdin (2012:34) stipulates that the right to privacy is a social work professional value and relates closely to confidentiality, also in research by treating participants' information confidentially. Furthermore, the participants were provided with informed consent forms (previously mentioned), signed by them, as well as by the observer, before commencement of the first day's sessions of the pilot study (Patton, 2015:497-480; Yegidis *et al.,* 2012:36). The forms were designed to protect the participants from unknowingly getting themselves into this pilot study, and provided them

with a description of what to expect (Neuman, 2012:59; Machi & Youdin, 2012:50; Yegidis *et al.,* 2012:37). Furthermore, when requesting participants to partake in a study, the participants must be fully informed about any risk or possible damage from participating and must be offered debriefing (Maschi & Youdin, 2012:139). As a result uncertainties were dispelled before commencement of the pilot study.

Strydom (2011:124) argues that a researcher must ensure the participants that he/she is competent and adequately skilled to undertake the investigation at hand; thus the researcher informed the participants that she is a SCIPP herself; a registered social worker at the South African Council for Social Service Professions (SACSSP); has obtained a Master's degree titled: [Egpare se belewenis na 'n spinalekoordbesering van 'n egmaat] (Steyn, 2008:1-114); and has 18 years' experience in the field of social work.

All the participants voluntarily signed the informed consent forms before commencement of the pilot study (Jackson, 2011:54; Neuman, 2012:59-60).

6.5.5 Researcher's Critical Reflection on data analysis and findings

All written feedback as well as verbal feedback given during the course of the two-day pilot study and documented in transcriptions of the sessions was thematically analysed. For the purpose of data analysis transcriptions of the sessions with the pilot study, written feedback from the pilot participants as well as that from the observer was used. The first round of coding, the extraction of themes and sub-themes pertaining to recommendations, as well as suggestions on the GRPP for SCIPPs, were done separately by the researcher and an independent coder. After having completed this process, the two coders convened and held a consensus discussion on emerging themes, which were extracted from the content of each session of the GRPP for SCIPPs (Braun & Clarke, 2006:77-101; 2013:5-

23). The researcher then used the framework as depicted in table 14 to categorise the extracted themes into changes to be made, areas of uncertainty and general feedback.

Table 14: Self-administered technique/guideline for researcher's critical reflection/data analysis

<table>
<tr><td>PARTICIPANT ABBREVIATION</td><td><table><tr><td>Observer</td><td>O</td></tr><tr><td>Pilot Member 1</td><td>PM-1</td></tr><tr><td>Pilot Member 2</td><td>PM-2</td></tr></table></td></tr>
<tr><td>Changes, per session and focuses (subjects/themes) as suggested by participants (included in figure 11)</td><td>Green (including the participant abbreviation, e.g. PM-1) and comment/suggestion</td></tr>
<tr><td>Areas of uncertainty (included in figure 11 to be discussed during APM-2)</td><td>Grey (including the participant abbreviation, e.g. PM-1) and comment/suggestion</td></tr>
<tr><td>General, overall feedback on the GRPP for SCIPPs (included in figure 11)</td><td>Orange (including the participant abbreviation, e.g. PM-1) and comment/suggestion</td></tr>
</table>

Hereafter these recommendations and suggestions were documented in track changes on the GRPP for SCIPPs (see addendum 19 with an expert of this document), whereby recommendations, reflection and "general feedback" were illustrated, to be yet again discussed with the APMs during AP-2 (see figure 11), to obtain their input and suggestions in order to further enhance the effectiveness of the GRPP for SCIPPs.

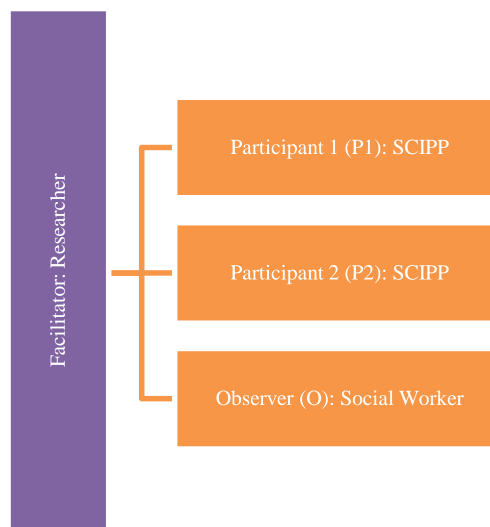
6.5.6 Findings (table 15 & figure 11)

In figure 11 the recommendations and suggestions of the participants are tabulated and in table 15 the narratives of participants are included. Figure 11 thus entails narratives describing each session of the GRPP for SCIPPs. Furthermore, general, overall feedback from the three participants on other technicalities are also elaborated on and specified separately in figure 11.

Table 15: Further programme development after Pilot Study

STEP 5: Further programme development after Pilot Study (view combined with figure 11)						
Outcomes	**Icebreaker**	**DVDs: SCIPPs and/or people with SCI**	**DVDs: Professionals**	**Resilience-promoting activities (RPAs)**	**Anchor**	**Survival kit (SK)**
* See suggestion regarding the concept of resilience (figure 5; session 1).	* Suggestion regarding icebreaker for session 6 (figure 11; session 6)	* Suggestion regarding technicalities (figure 11: General, overall feedback on the GRPP for SCIPPs)	* Suggestion regarding video recordings on the content of SCI and sexuality to be included (figure 11: session 4)	* Suggestion regarding technicalities (figure 11: sessions 2 & 4) *Suggestion regarding RPA of session 5 (figure 11: session 5)	* Not yet included	* Suggestion regarding video recordings on the content of SCI and sexuality to be included (figure 11: session 4)

Figure 11: Findings



SPECIFIC RECOMMENDATIONS/REFLECTIONS concerning changes to the content of the GRPP for SCIPPs (view combined with table 15)		
SESSION	**Content (focus)**	**RECOMMENDATION/SUGGESTION**
1	Information on SCI and Resilience	* The definition/concept of resilience should be simplified by the researcher for participants to clearly understand the concept: "*What does it mean to be resilient? What if you are not resilient? Why do some people adjust better than others?*" (O).
2	Help SCIPPs to understand/realize that their reactions to/emotions regarding these huge changes are	* The facilitator should explain the concept "trauma" before viewing the DVD of Yvonne Retief (Trauma Councillor), and also advising them to keep at hand the hand-outs regarding trauma while viewing the DVD.

	normal	
3	Caretaking and support	* The researcher should place the "husband and wife"-questionnaires of "The 5 Love Languages" (Chapman, 2010: 190-201) in the survival kit, between session 3 and session 4, for completion by both the SCIPP and her partner before viewing session 4. This will give the group members the opportunity of attending the fourth session with a better understanding of the five love languages, and might assist them *"to know what they don't know"* (P2) regarding the focuses (subjects/themes) at the start of session 4.
4	My dual role as SCIPP	* The icebreaker in this session was seen as "very powerful" (O); "Fantastic"(P1) and "It showed us we must work together as a team" (P2) and supports the outcomes of this session well. The included RPA was seen by P1 as "*A very difficult exercise but I feel necessary for SCIPPs to know themselves"*; and P2 "*...so we can do things that our partners love and show them we love them through communication*" furthermore the observer also sees this RPA as needed: "*Gives some perspective on what the couple will need to deal with"* (O), therefore this RPA will stay included in this session, by adhering to the recommendations in session 3 (see above). * The information regarding "SCI and sexuality" was not sufficiently addressed during this session, although hand-outs were given. The participants advised linking sexuality and SCI by also including a DVD recording of one or more specialists in this field.
5	Own caretaking by SCIPP	Regarding the resilience-promoting activity (RPA) in this session, two suggestions were made: (1) The facilitator should start the RPA with the second action, as this will enhance SCIPPs awareness more effectively; and (2) the task of listing "10 good things and people" in their lives, should be reduced to maybe "5 good things and people", as "*at this time and place in their lives it might be difficult to think of 10 things"* (P2).
6	Termination and Way forward	* The participants assisted the researcher/facilitator by brainstorming on a suitable icebreaker for this session: their suggestions were that a popular fairy tale should be chosen and that the researcher then writes different realistic and positive "endings" to this story. All these endings should be given to the group members and then they should decide which ending they would prefer. This icebreaker might be a valuable addition to the RPA of this session. * The song (video) of Mathys Roets (on the survival kit 6 – DVD) should also be translated into English, to assist non-Afrikaans participants to also "follow" the song, as this song (video) provides hope.

General, overall feedback on the GRPP for SCIPPs
* The fact element that this research was "born" from the researcher's personal experience might be valuable for the group members and might enhance the capacity, amongst others, to assist in resilience promotion (Masten & Wright, 2010:222-229; Ungar, 2008:225). P1: *"The researcher knows why a programme is important, because she has first-hand knowledge personally"*; P2: *"...this helps to relate to other people's situations"*. * Including the DVDs of experts in the field of SCI and Resilience; as well as including people living with an SCI and SCIPPs, are influential and much needed *"DVDs provide hope"* (O); *"Very, very well – all aspects are covered*"(P1); *"Ten out of ten. It was wonderful and very clear and has a lot of information"*(P1),and "*You can understand where they come from and how to deal with the problems and partners*" (P2). * The DVDs should be used before the RPAs during each session, as this might enhance group members' understanding and processing of the given resilience-promoting information. * Providing the group members with survival journals is positive and will assist in facilitating and normalizing emotional reactions at the beginning of each session of the GRPP for SCIPPs: "*....most needed starting every session with this*" (P2). * The idea of creating a WhatsApp-group might be valuable in supporting the SCIPPs in between sessions, and also after termination of the group sessions, as this might be another way of creating support for the SCIPPs. * Including a quote per session is a good idea and will be something to "*hold on to*" (P2) between the sessions.

The above-mentioned recommendations, were furthermore discussed with the AP members during AP-2, and will be elaborated on henceforth.

6.6 STEP 6: Advisory Panel meeting 2 (AP-2) (Post-Pilot study) (July – August 2014)

Another round of interviews was conducted with the Advisory panel. The purpose was (1) to obtain their critical feedback on the amended GRPP for SCIPPs (2) as well as giving feedback regarding the pilot study (figure 12 & addendum 19); and discussing the researcher's critical reflection as well as recommendations and suggestions (figure 12). The same APMs participated, except APMs one and five as they could not avail themselves of the opportunity of being part of AP-2. Thus, in the course of AP-2, two

social workers (APMs-3 and 4), one SCIPP (APM-2); and one Social Work Academic (APM-6) participated.

6.6.1 Procedure, data collection and data analysis

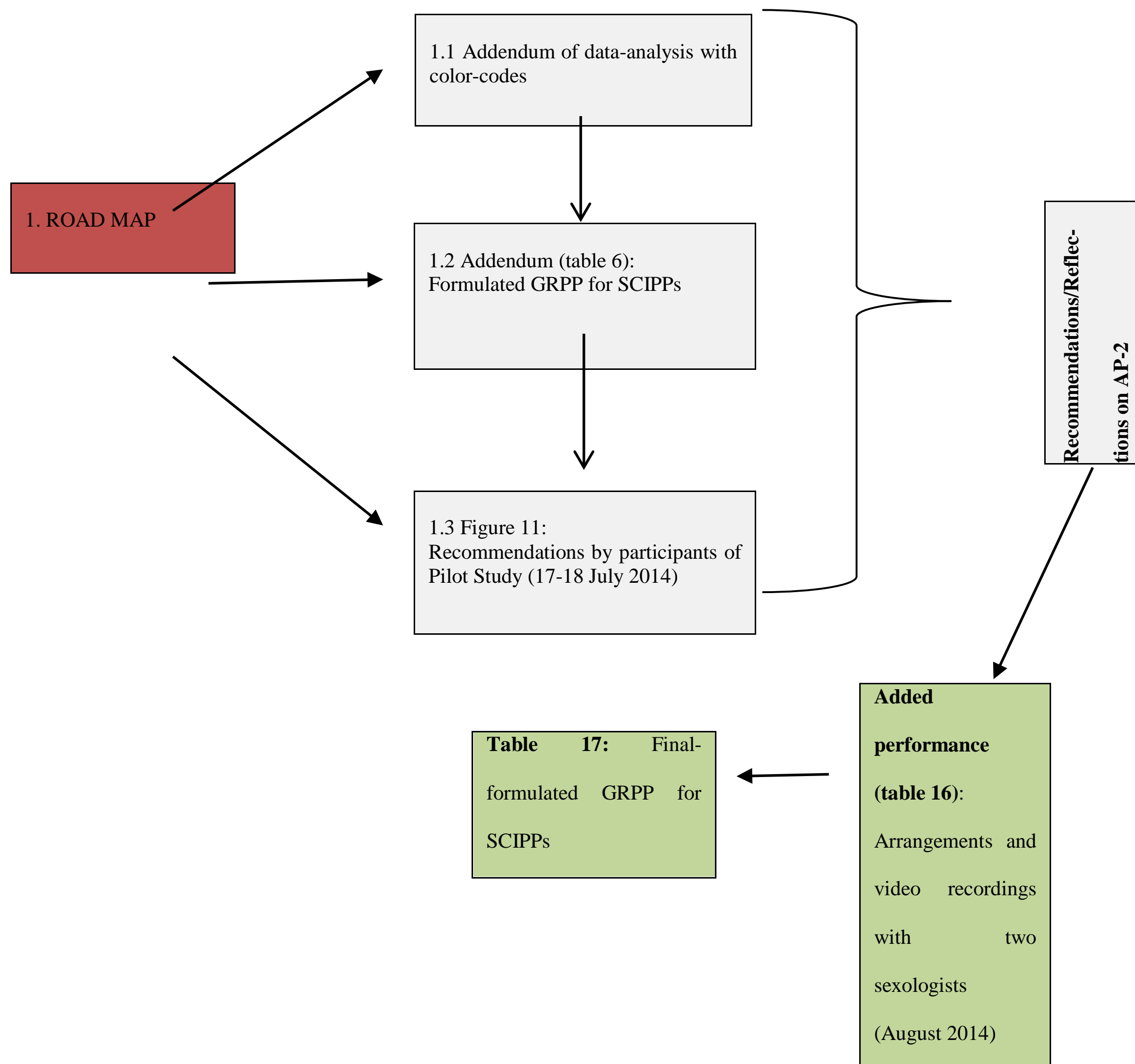
Due to logistical constraints AP-2 also took the form of two individual interviews with APMs two and six; and a combined consultation with the two social workers (APMs' 3 and 4); again at a convenient time and place for everyone. As all participants signed the consent forms during AP-1, they were furthermore merely reminded of the ethical considerations, which were still applicable.

At commencement of the interviews with the APMs, the researcher guided the conversations pursuant to road map (Greeff, 2011:348; Patton, 2015:433), including the following: researcher's critical reflection (figure 12 & table 15); the proposed amendments to the GRPP for SCIPPs (figure 8 & table 16); and the recommendations of the participants during the pilot study (figure 11 & table 15).

The interviews with all the AP members, were audio recorded and transcribed. The researcher again followed a process of inductive content analysis, as suggested by Tesch (in Creswell, 1994:154-155, 2009:186) and Braun and Clarke (2006:77-101, 2013:5-23) in analysing the latter mentioned data. The researcher thus read and reread the transcripts and categorised feedback and recommendations pursuant to the different sessions, as outlined in the formulated GRPP for SCIPPs (table 11). Hereafter the researcher used track changes, with color-codes, to analyse and reflect on recommendations. See addendum 20 for the coding procedure.

Furthermore, the analysis after AP 2 and the reflection on recommendations will be depicted in figure 12 and described afterwards.

Figure 12: Analysis and reflection on recommendations



All APMs received a detailed road map informing them of the course of the pilot study (figure 12); and the analysed recommendations (table 16) thereafter. One important recommendation was made, in accordance with table 16, namely that the researcher should include video recording/s of professional/s with specialized knowledge of SCI and sexuality. Both APMs 3 and 4 provided the researcher with names and numbers of professionals who could be approached.

6.6.2 One added performance: Two more video recordings

Furthermore the researcher contacted these two recommended experts. Only the one sexologist, Dr Holmes, could make himself available to attend the video recording, as the other professional informed the researcher that he had not worked with SCI and sexuality for a very long time; hence he no longer considers himself an expert in this field. However, he provided a name of another sexologist, Mr Willem Stighlingh, who was approached, and who fortunately consented to participation. These two professionals were thus sampled by means of snowball sampling (Niewenhuis, 2012:99-117), as described earlier in this manuscript.

The researcher made arrangements with the two sexologists for video recordings; gave them informed consent forms to sign (Yegidis *et al.,* 2012:37-38), and then again edited the recordings afterwards with the help of a videographer. These recordings were also added to the DVD to be used during session 4 of the GRPP for SCIPPs, and to the survival kit, DVD-4 (SK-DVD4). Then the Final-formulated GRPP for SCIPPs (table 17) was compiled before it being subjected to further peer review by means of a POSTER presentation at the South African Spinal Cord Association (SASCA), 11th Biennial SASCA Congress, 2 – 4 October 2014, to obtain peer-feedback on the GRPP for SCIPPs.

Table 16: Further programme development: Two more video recordings

STEP 6: Further programme development (view combined with figure 12)						
Outcomes	**Icebreaker**	**DVDs: SCIPPs and/or people with SCI**	**DVDs: Professionals**	**Resilience-promoting activities (RPAs)**	**Anchor**	**Survival kit (SK)**
* No changes.	* No changes.	* No changes.	* Two more video recordings with two sexologists to be included in session 4 (as also suggested during pilot study).	* No changes.	* Not included yet.	* Two more video recordings with two sexologists to be included in survival kit DVD of session 4 (as also suggested during pilot study).

6.7 STEP 7: Assembling the Final-formulated GRPP for SCIPPs (September 2014)

The findings from the pilot study and feedback during AP-2 were incorporated to amend and further develop the GRPP for SCIPPs (table 16). In summary, the major amendments to the first draft were that two extra video-recordings were made to include the subject regarding "SCI and sexuality" on the DVDs (Note for examiners: please see DVDs provided to you).

Table 17: Final-formulated GRPP for SCIPPs

STEP 7: Assembling the final-formulated GRPP for SCIPPs (view combined with figure 12)						
Outcomes	**Icebreaker**	**DVDs: SCIPPs and/or people with SCI**	**DVDs: Professionals**	**Resilience-promoting activities (RPAs)**	**Anchor**	**Survival kit (SK)**
* No changes	* No changes	* No changes	* Two more video recordings with two sexologists to be included in session 4 (as also suggested during pilot study) * Edited recordings with the help of videographer; no translation was needed as all the recordings were done in English. * Fit the content	* No changes	* Researcher compiled anchors for sessions 1 – 5 for the first time during this step, as she realized the value anchors can add to resilience promotion of SCIPPs.	* Two more video recordings with two sexologists to be included in survival kit DVD of session 4 (as also suggested during pilot study) * Edited recordings with help of videographer; no translation was needed as all the recordings were

			of the recordings with the other recordings for session 4 of the GRPP for SCIPPs * Include these two recordings in the table of contents of session 4.			done in English. * Fit the content of the recordings with the other recordings for session 4 of the GRPP for SCIPPs * Include these two recordings in the table of contents of the Survival Kit-DVD of session 4. *Session 5: "Invitation for SCIPPs partners to attend session 6). * Session 6: "Letter-to-myself-exercise". *Session 6: Survival Kit DVD – Inclusion of Dr Richard Holmes (he is a sexologist but also a person with SCI).

The researcher decided to subject the Final-formulated GRPP for SCIPPs to peer review at a conference, where not only professionals attended, but also people living with SCI. This is discussed in the next step.

6.8 STEP 8: Peer-review and recruitment

The aim of presenting a poster on the GRPP for SCIPPs at the South African Spinal Cord Association (SASCA) congress (2-4 October 2014) (see addendum 21 for congress programme), was to receive verbal feedback from other professionals and people living with SCI, regarding the proposed GRPP for SCIPPs and also invited feedback, via a poster presentation, on the evaluation of the GRPP for SCIPPs with the target population (Bertram & Christiansen, 2014:59) (see addendum 22 for poster).

The researcher established, during the feedback at the SASCA Congress (2014), that it might be more ethical to consider setting aside the purpose of evaluating the GRPP for SCIPPs with the target population (Fouché, 2011:464-472) (which would have been

SCIPPs ("new" SCIPPs) whose partners are still in the rehabilitation centre after acquiring a spinal cord injury) to rather do an evaluability assessment with the assistance of experts, with a view to avoid any possible harm (Patton, 2015;76; Strydom, 2011:6-9).

On 14 November 2014 different professionals, employed at the rehabilitation unit of a hospital in North West Province (social workers; psychologists; occupational therapists; physiotherapists and medical doctors) attended a presentation on the GRPP for SCIPPs (see addendum 35). The purpose was to get professionals to refer SCIPPs to the researcher to be included in the research. The general, verbal feedback from the professional team was that this is a much needed intervention, but they mutually suggested (and confirmed what was said during the SASCA conference) that this intervention needed to first be evaluated by professionals in the field of SCI, before exhibition it to the target population ("new" SCIPPs, whose partners are still in acute care after the acquirement of an SCI).

With this feedback in mind, the researcher started investigating the possibility of approaching SCIPPs whose partners had obtained spinal cord injuries longer than a year ago ("old" SCIPPs), thus their cohabiting SCI partners had completed their acute rehabilitation phase (ISCoS, 2012), and was back at home, as these mentioned SCIPPs (Marshall & Rossman, 2016:50-52) can also be seen as the target population (Bertram & Christiansen, 2014:59), but maybe a lower risk group, due to the fact that they might have adapted somehow after the SCI of their partners (due to the time lapse). The researcher managed to find SCIPPs who were willing to participate, but due to logistical constraints it would have been a time-consuming and costly process for these participants to commit themselves to six or more weeks of participation, which might cause harm to them and has the potential of this evaluation resulting in being performed unethically and being unfair to the participants (Marshall & Rossman, 2016:50-52; Neuman, 2012:53).

The latter situation was discussed with one of the AP members (APM-6) who is an expert in intervention research and ethics literature, and consequently the researcher decided to rather conduct an evaluability assessment (Fouché, 2011:456-457), deviating from her original plan to implement the GRPP for SCIPPs with the target population (Bertram & Christiansen, 2014:59) during phase 5 of this thesis (see manuscript 3).

7 DISCUSSION

The design and development of the GRPP for SCIPPs was an intense and lengthy process as the researcher aimed to answer the following research question: *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?* This process was informed by several rounds of data collection. The advisory panel members as well as pilot study participants' suggestions regarding the sequence in which certain activities had to take place, as well as the inclusion of certain literature (Chapman, 2010:11-189) and procedural elements of the intervention (de Vos & Strydom, 2011:473-489) were all taken into consideration, also their support regarding the recordings of the intended video's (DVDs) (Patton, 2015:433-434).

Furthermore, the researcher implemented that which was suggested after peer-review, namely that the Final-drafted GRPP for SCIPPs needed to be evaluated by professional role-players in the field of SCI, before exhibition it to the target population. The researcher thus decided to deviate from her original plan of implementing the GRPP for SCIPPs with the target population (thus "new" as well as "old" SCIPPs) (Bertram & Christiansen, 2014:59), but rather conduct an evaluability assessment during phase 5 of this study

(manuscript 3). The researcher had taken into consideration an ethical aspect in research of "doing no harm" (Jackson, 2011:54) as well as Bonnano's (2011:532) warning directed at researchers that new interventions that are not tested/evaluated could do more harm than good. As such, a decision was made to set aside the evaluation purpose and rather conduct an evaluability assessment. During manuscript 3 the latter will be elaborated on.

8 CONTRIBUTION TO KNOWLEDGE

The design and development of this GRPP for SCIPPs was thus continually subjected to a resilience-based framework (Masten & Wright, 2010:222-231); and the selected design (de Vos & Strydom, 2011:473-489) which includes evaluation, reflection and recommendations of/by different participants (de Vos & Strydom, 2011:484; Jackson, 2011:110; Hospital in North-West Province, South Africa, 2014; Theron *et al.,* 2013:67; Truter *et al.,* 2014:312; SASCA Congress, 2014; Ungar *et al.,* 2007:294). Accordingly the clinical relevance of these findings for the target population, namely SCIPPs, was repetitively reflected on and improved, and therefore increases the objectivity, validity and overall the trustworthiness of this newly developed (final-drafted) GRPP for SCIPPs (Marshall & Rossman, 2016:43).

9 LIMITATIONS

Statistics from different studies (Sothmann *et al.,* 2014; Vasiliadis, 2012:342) conclude that the percentage of males acquiring SCI is higher in South Africa than that of females acquiring SCI. Divergences in the nature of the different sexes (Conner, 2006), amongst others, sensitized the researcher to the possibility that males and females might experience the acquirement of the SCI of their partners differently, and that the different sexes should be exposed to therapeutic intervention, separately. Therefore this GRPP for SCIPPs was developed specifically for female SCIPPs, seen in the light of above-mentioned statistics.

As a result of the latter, this GRPP for SCIPPs might not address the unique needs of male SCIPPs as such, as some of the programme media (especially some media on the DVDs), exclusively cater for female SCIPPs.

The researcher considers, however, that male SCIPPs might also experience unique hardships of their own. Therefore the provision of a GRPP only for female SCIPPs can be seen as a possible limitation. Consequently the researcher suggests this restriction to be addressed during another intervention study; perhaps evaluating which programme media of this newly developed GRPP for female SCIPPs can be utilized or adjusted to fit the needs of male SCIPPs. Furthermore this study was also only focusing on pre-injury cohabiting relationships, which might also exclude the inclusion of SCIPPs in post-injury cohabiting relationships, and the research acknowledges that post-injury cohabiting relationships might also have unique diversities of their own.

10 CONCLUSION

To conclude, the researcher therefore achieved the objective of this study by designing and developing an appropriate GRPP for SCIPPs (de Vos & Strydom, 2011:473-489), using knowledge gathered from pre-existing interventions; resilience literature, and by consulting with experts and people living with SCI, with the potential to nurturing/promoting resilience in SCIPPs (Masten & Wright, 2010:222-229), but also further found it imperative to test the effectiveness of this GRPP for SCIPPs by subjecting it to an evaluability assessment (Fouché, 2011:456), as documented in manuscript 3.

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INSTRUCTIONS TO AUTHORS

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PREFACE

Professional Perspectives on the readiness of Group Resilience-Promoting activities to be implemented with Spinal Cord Injured Persons' Partners (SCIPPs)

This manuscript forms part of a larger, more encompassing intervention research study, which consists of six phases (de Vos & Strydom, 2011:473-489; Fouché, 2011:456). Phase 1, Problem analysis and project planning, was reported in section A. Phase 2, Information gathering and synthesis, and 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 SCIPPs. Manuscript 2 reported on phase 3, the design, and phase 4, early development and pilot testing of a GRPP for SCIPPs.

This manuscript that follows, reports on phase 5, the evaluation and advanced development: Evaluability assessment of the GRPP for SCIPPs.

The secondary question driving this part of the study was:

How will South African professional role-players working within the field of spinal cord injury evaluate the newly developed GRPP for SCIPPs?