Returning to the Community with a Spinal Cord Injury: Implications for Therapeutic Recreation Specialists

John Dattilo, Linda Caldwell, Youngkhill Lee, and Douglas A. Kleiber

This study examined the relevance of leisure and social relationships to the community integration of people with recent spinal cord injury (SCI). The primary data source was in-depth interviews with participants one to eight months after being discharged from a rehabilitation center. The constant comparative method of data analysis (Strauss, 1987) was employed. When discussing their leisure participation within the community, participants communicated enjoyment associated with “getting out” and being with friends and family members. In addition, participants described constraints to leisure participation within their communities related to support, companionship, transportation, physical ability, and physical accessibility. Although many participants indicated that the therapeutic recreation (TR) program they attended during the course of rehabilitation assisted them in returning to their communities; they identified problems associated with TR and the entire process of rehabilitation experienced at the center. The importance of social contacts in facilitating community integration and the value of leisure as a context for the establishment of such contacts were documented in the findings.

KEY WORDS: Spinal Cord Injury, Therapeutic Recreation, Integration, Social Support, Leisure Education

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According to the National Spinal Cord Injury (SCI) Statistical Center (1995), approximately 9,000 people acquire SCI annually in the United States. The life expectancy of people with SCI has increased as a result of advances in medical technology (Dunnum, 1990; Frank, Kashni, Wonderlich, Lising, & Visot, 1985; National SCI Statistical Center, 1995). This increased longevity in people with SCI may result in more people attempting to integrate themselves back into their respective communities. According to DeVivo and Richards (1992), the long term goal of SCI rehabilitation is to achieve community integration.

Benefits of becoming involved in community leisure activities may not be experienced by many people with SCI for a variety of reasons (Kennedy & Smith, 1990). For example, high unemployment rates (DeVivo, Rutt, Stover, & Fink, 1987; Levi, Hultling & Seiger, 1996) as well as restricted options may result in boredom, stress, and depression (Coyle & Kinney, 1990; Frank, Kashni, Wonderlich, Lising, & Visot, 1985; Graitcer & Maynard, 1990; Lewis, 1985; Stotts, 1986; Tucker, 1987). Anson and Shepherd (1990) presented some alarming data, noting that 31% of their sample of people with SCI reported leaving home less than once a week, with many never leaving home.

Yerra and Locker (1990) reported that once adults with SCI return to their communities, their most common leisure activities are passive, non-social and home-based, and they are often restricted to watching television. Levi et al. (1996) noted that, when compared to their peers, people with SCI have fewer contacts with neighbors and less engagement in community leisure activities (e.g., travel, going to movies, attending the theater, hiking). Restrictions to leisure participation for people with SCI may be one factor contributing to findings reported by Fuhrer, Rintala, Hart, Clearman and Young (1992, p. 554) that "...on average, people with SCI who are living in the community report a lower level of satisfaction with life than do people in the general population."

Adjustment to SCI has been studied from a variety of perspectives addressing a number of important issues. One important issue in this literature that has not received adequate examination is the relevance of leisure to integration. When examining the integration of people with SCI, researchers have focused on adjustment to specific social contexts in life, such as work (e.g., Crisp, 1990), residence (e.g., DeVivo & Richards, 1992), and marriage (e.g., Simmons & Ball, 1984), and social adjustment problems including alcohol abuse (e.g., Heinemann, Goranson, Ginsburg, & Schnoll, 1989) and suicide (e.g., Charlifue & Gerhart, 1991). In addition, several studies of people with SCI have been concerned with general issues related to life satisfaction (Crewe & Krause, 1991; DeVivo & Richards, 1992; Fuhrer et al., 1992; Krause, 1990, 1992). However, limited case studies (Armstrong, 1991; Blake, 1991) and research studies (Coyle, Lesnik-Emas, & Kinney, 1994; Coyle, Shank, Kinney, & Hutchins, 1993; Henderson, Beldini, & Hecht, 1994; Kinney & Coyle, 1992) have been conducted which specifically examine leisure in the lives of people with SCI. Considering that the meaningful use of free time may be critical to the integration of people with SCI into active community life (Decker & Shulz, 1985; Dunnum, 1990; Yerra & Locker, 1990), researchers (Coyle et al., 1993, 1994; Henderson et al., 1994; Kinney & Coyle, 1992) have agreed that further investigation into the role of leisure in the lives of people with SCI is needed.

Unfortunately, little is known about the leisure of people with SCI (Lee et al., 1993). It is not clear how people with SCI who reside within their communities experience leisure. Since positive leisure experience has been linked to the adjustment of people with SCI (e.g., DeVivo & Richards, 1992; Krause, 1992), leisure experience may be implicated in the process of integration. In spite of its significance, no single investiga-
tion has examined the perceptions of people with SCI regarding the value of and obstacles to their leisure participation in the community. This study was designed to provide such an examination.

Data reported here are part of an extensive research project examining leisure in the lives of people with SCI. The overall impact of TR reported by participants (Caldwell, Dattilo, Kleiber, & Lee, 1995), the relevance of leisure in the illness experience (Kleiber, Brock, Lee, Dattilo, & Caldwell, 1995), and the meaning of continuity of recreation activity in early stages of adjustment (Lee, Dattilo, Kleiber, & Caldwell, 1996), have been described. This paper contains an examination of the relevance of leisure and social relationships to the community integration of people with SCI.

Methods

Since information providing insight into the perceptions of people with SCI about leisure, transitions and community integration is limited, an interpretive approach was adopted for this study. The interpretive approach permits "... revelation of subjective experience and interpretations as well as the exploration of unknown phenomena where no clear theoretical framework exists" (Lee, Brock, Dattilo, & Kleiber, 1993, p. 206). Although an interpretive approach offers insight from participants' perspective (Patton, 1990), Salisbury, Palombaro, and Hollowood (1993) concluded that there are remarkably limited data on perceptions of integration by people with disabilities. According to Schnorr (1990), people with disabilities and their peers are the only legitimate sources for some answers needed to understand and promote integration of people with disabilities "... because it is their world, not ours, that defines it" (p. 240). While leisure was of particular interest in this study, participants were encouraged to "tell their stories" wherever that might lead. After participants completed discussion of a particular topic, probes were used to focus discussion on leisure and community integration.

Interviews allowed the actual words of respondents to reveal their level of emotion, the way in which they organized their world, their thoughts about what was happening, their experiences, and their perceptions (Patton, 1980). This approach "... empowers devalued groups within our society by giving them voice" (Ferguson, Ferguson, & Taylor, 1992, p. 301). Ferguson and colleagues noted that people with disabilities historically have been identified as one of these devalued groups.

Sampling

Theoretical sampling (Glaser & Strauss, 1967) was used to identify and recruit people from a rehabilitation center in a large metropolitan area in southeastern United States for initial interviews used in the original study. This process involved selection of participants on the basis of their potential for leading to new insights or for expanding and refining insights (Glaser & Strauss, 1967). It is "purposeful" sampling based on participants' relevance to emerging theories (Patton, 1980). Consideration was given to maximizing diversity of severity of injury, age and gender. Individuals excluded were those who had experienced a traumatic brain injury, since previous research and participant observation indicated that verbal elaboration and reflective accounts are often difficult for them. Although theoretical sampling was used to obtain the sample for the original interview conducted at one rehabilitation center, since only a portion of the sample were available or consented to be interviewed in the community, the specific sample for this study is a convenient sub-sample of a larger purposeful sample.

Participants

Ten males and four females who ranged in ages from 17 to 59 (M = 30) participated in the study (see Table 1). Prior to their in-
Table 1.
Participants' Personal Profile

<table>
<thead>
<tr>
<th>Name</th>
<th>Age/Gender</th>
<th>Previous Schooling/Job</th>
<th>Injury Level</th>
<th>Accident Type</th>
<th>Months at Center</th>
<th>Months Post d/c interviewed</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adam*</td>
<td>18 Male</td>
<td>High School Student</td>
<td>T-7 (Para)</td>
<td>Automobile</td>
<td>3.5</td>
<td>8</td>
</tr>
<tr>
<td>Wanda**</td>
<td>19 Female</td>
<td>College Student</td>
<td>C-6 (Quad)</td>
<td>Automobile</td>
<td>3</td>
<td>6</td>
</tr>
<tr>
<td>Mark*</td>
<td>47 Male</td>
<td>Mechanic</td>
<td>T-9 (Para)</td>
<td>Fall</td>
<td>3</td>
<td>6</td>
</tr>
<tr>
<td>Donald*</td>
<td>26 Male</td>
<td>Carpet Mill Worker</td>
<td>C-5/6 (Quad)</td>
<td>Fall</td>
<td>3.5</td>
<td>6</td>
</tr>
<tr>
<td>Amie**</td>
<td>19 Male</td>
<td>College Student</td>
<td>C-4/5 (Quad)</td>
<td>Diving</td>
<td>7</td>
<td>5</td>
</tr>
<tr>
<td>Mike**</td>
<td>24 Male</td>
<td>MBA Student</td>
<td>C-6 (Quad)</td>
<td>Automobile</td>
<td>3.5</td>
<td>2.5</td>
</tr>
<tr>
<td>George**</td>
<td>18 Male</td>
<td>High School Student</td>
<td>T-12 (Para)</td>
<td>Automobile</td>
<td>2</td>
<td>5</td>
</tr>
<tr>
<td>Martin*</td>
<td>42 Male</td>
<td>Driver</td>
<td>C-4/5 (Quad)</td>
<td>Automobile</td>
<td>7</td>
<td>1.5</td>
</tr>
<tr>
<td>Brandon*</td>
<td>19 Male</td>
<td>College Student</td>
<td>T-4 (Para)</td>
<td>Automobile</td>
<td>2.5</td>
<td>3</td>
</tr>
<tr>
<td>Tina**</td>
<td>17 Female</td>
<td>High School Student</td>
<td>T-8 (Para)</td>
<td>Natural Disaster</td>
<td>2.5</td>
<td>1.5</td>
</tr>
<tr>
<td>Tony*</td>
<td>30 Male</td>
<td>Health Club Manager</td>
<td>C-2; T-12</td>
<td>Fall</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>Lynn**</td>
<td>36 Female</td>
<td>Reporter</td>
<td>C-4 (Quad)</td>
<td>Automobile</td>
<td>2</td>
<td>2.5</td>
</tr>
<tr>
<td>James*</td>
<td>59 Male</td>
<td>Civil Service Worker</td>
<td>T-5 (Quad)</td>
<td>Automobile</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Daniel**</td>
<td>39 Male</td>
<td>Driver</td>
<td>C-6/7 (Quad)</td>
<td>Automobile</td>
<td>4</td>
<td>1</td>
</tr>
</tbody>
</table>

* Indicates those individuals who had face-to-face interview.  ** Indicates those who had telephone interview.

Injury, participants reported either being employed (N = 8) or students (N = 6). The most common cause of injury was automobile accident (N = 9) followed by falls (N = 3). Six of the participants had paraplegia and the remaining eight had quadriplegia. The average length of stay at the rehabilitation center for people with paraplegia was seven weeks while people with quadriplegia remained for approximately nine weeks. Table 1 lists the principle characteristics of participants (identified with pseudonyms).

Although the group may appear age and gender biased, proportions in this sample are...
consistent with those at the rehabilitation center and with the larger population of people with SCI (Trieschmann, 1988). Specifically, 75% of people who incur a SCI each year are males between the ages of 16-30 (National SCI Statistical Center, 1995).

Data Collection

All participants (N = 14) were interviewed after they resided in the community for an average of three and one-half months (range = 1-8 months). The interview was conducted either face-to-face in the community (N = 7) or on the telephone (N = 7) since participants returned to the original community which, in some cases, was hundreds of miles away from the researchers.

The interviewer (third author) was trained in qualitative research methods while completing an interpretive investigation (Lee, Dattilo, & Howard, 1994). The interviews required flexibility with ordering of questions and the ability to examine experiences unique to each individual; the basic information solicited, however, remained the same. A flexible interview guide which evolved based on analysis of each previous interview allowed for in-depth, detailed probing with each participant while permitting coverage of similar questions across participants. (See Table 2 for the nine primary questions listed on the interviewer guide. An additional 23 probing questions were included as well.)

A purpose of the interviews was to allow participants to discuss the relevance of leisure and social relationships to their community integration.

Interviews ranged from 30-90 minutes, reflecting differences in participants’ fatigue, willingness to continue, and expressive ability. Five minute breaks approximately every 30 minutes were used to provide participants a chance to complete their necessary weight shifts.

With permission, interviews were tape recorded and transcribed into verbatim accounts for data analysis. Before tape-recording, the interviewer assured the participant of confidentiality and secured informed consent. Over 765 (single spaced) pages of transcriptions were compiled from the 14 in-depth interviews. Variation in time elapsed between discharge and the community-based interviews permitted collection of data from participants at different points in time as they returned to their communities.

Data Analysis

The constant comparative method of data analysis (Strauss, 1987), requiring analysis of data simultaneously with its collection, was employed. Analysis was facilitated through coding and memoing. Three members of the research team analyzed data with primary responsibility for interpretation being assumed by the interviewer. Weekly or bi-weekly meetings permitted sharing of perceptions and interpretations.

The coding process was used to identify categories of ideas. Coding is the process of categorizing and sorting data to label, separ-
rate, compile and organize data (Charmaz, 1991). A category was regarded as a theme that emerged from various incidents reported in the transcripts that held similar ideas rather than being pre-formulated. Various categories were analyzed in terms of what Strauss (1987) termed the “coding paradigm.” Coding in this investigation involved initial coding and focused coding.

In the focused coding stage, coding became selective and conceptual. A limited set of codes developed during initial coding were applied to large amounts of data. This process enabled categories to be developed rather than simply labeling topics or themes and culminated in discovery of conceptual categories. Codes raised sorting of data to an analytic level, rather than being merely a description of large amounts of data. A conceptual category was developed and clarified by examining all data for correspondence with that category. As data were examined and re-examined, associations with newly developed categories were checked. Sub-categories were sought to explicate and exhaust more general categories. Refinement of categories helped to: (a) explain variation, (b) promote understanding of contexts, (c) facilitate understanding of conditions and consequences under which categories operated, (d) clarify each category’s dimensions and distinguish it from other categories, and (e) enhance analytic precision in dealing with ambiguous and experientially mixed categories.

Findings

The data from the interviews call to mind a perspective offered by Edgerton (1991), who stated that adults with disabilities “are highly varied, and if we are to understand them as people, we must recognize that in many ways each one of them is quite different from every other.” (p. 268) While consideration of the uniqueness of adults with disabilities is thus important, major themes emerged from the data that suggested some common experiences.

When discussing their leisure participation within the community, participants consistently communicated that they liked “getting out” and being with friends and family members. In addition, participants described constraints to leisure participation within their communities. Many participants said that TR assisted them in returning to their community.

“Getting Out”

Although the degree to which participants were integrated into the community varied, they often reported that they liked it when they did venture into the community. Participants who reported being active expressed interest in continued social interaction with family and friends, and stated that they enjoyed their social interaction and community involvement. Expressions such as “getting out,” “always doing something,” and “not sitting around,” or “not staying at home” were used to describe their active social and community involvement. Descriptions from Tina, George and Amie, respectively, illustrate “getting out.”

I’m home very seldom, not very often at all. I don’t like staying home. I like to go places and see my friends and just do whatever.

We go to town, we’ll go shoot pool . . . I just like to get out, you know, and see people. It’s fun, you know. I’m pretty active.

Well I don’t like to sit inside and just sit here. I like to get out and do things. So when things come up we just go . . . I’ve been out to some movies and some friends and my sister and boyfriend and a lot of shopping and lunch. We go out to lunch and dinners, just whatever comes up . . . I just like getting out, period.

Amie, who tried to get out of the house every day, helped identify the value of get-
ting out into the community when she stated: "If I was just sitting around thinking about my situation I'd probably be depressed all the time. And going out and doing things just makes it easier." Similarly, Donald reported that it is important to "get out and not wait for it to come to you," he stated that he gets out five days a week. He provided this advice:

Get with friends, get with family, do more. Don't sit around waiting on recreation to come to you because it never will. The sooner you get out and get to doing more recreation, I guarantee you, the better you'll feel.

Constraints to Community-Based Leisure Participation

Participants reported a variety of constraints to leisure participation. The quotes used in this section of the paper reflect what Goffman (1961) called "sad tales." Those constraints which relate most directly to community-based leisure participation were lack of: (a) support, (b) companionship, (c) transportation, (d) physical ability, and (e) physical accessibility.

Lack of Support

Although TR and the entire rehabilitation received at the center was identified as valuable, some problems emerged from the data. Although Caldwell et al. (1995) identified problems with TR generally, problems associated with integration have not been described previously in the literature. One reported problem was that participants returned to their communities where leisure opportunities were not nearly as abundant as in the rehabilitation center and the surrounding community. This lack of leisure opportunity coupled with reduced supportive staff was reported to be disconcerting for many participants. After being encouraged to engage in leisure while in the rehabilitation facility, the lack of opportunity in the community and/or lack of companionship appeared to be problematic. Lynn communicated this when she stated:

I was used to having somebody there I could call on at any time, you know, the 24 hour staff members I miss. I miss [city] ... I mean having a lot of things to do. I live out in the country which is wonderful but, as far as activities there aren't many around here, especially, you know, activities tailored to handicapped people as there were at [agency], and you know, when you could go out in a group, that was nice. ... I do miss having fellow quadriplegics around and people who know what it's like.

As discussed, comfort provided by the rehabilitation staff helped participants gain confidence to engage in enjoyable activities. After returning to their communities, however, the absence of such support resulted in some participants terminating participation, as reported by Dan:

... I wouldn't dare try to go swimming now. Because when I was at [agency] they had at least like two, three lifeguards in the swimming pool with you to help you out, because we were doing mostly exercises in the swimming pool.

In describing the desired leisure activity of dancing, Wanda contrasted dancing when she was on an agency outing with how she felt upon returning to her community:

It's different dancing when you're the only one in the wheelchair dancing than when you go out with a group of wheelchair dancers. In a group, it's different. I feel like I really stand out and I'm really self-conscious.

Mike summarized many participants' senti-
ments regarding the unanticipated problem of not really knowing what it was going to be like upon return to his community. He stated that he felt the rehabilitation center was:

... an insulated shell, and you get home and you're not insulated anymore, and you realize how much you're going to have to do yourself.

Lack of companionship. While some participants reported the desire of getting out, similar to results of Lyons (1991), others reported the loss or lack of companionship as a constraint to community involvement. When they described this constraint, the desire for social interaction and lack of such interaction often were mentioned. For example, Lynn, Wanda, and Mike, respectively, stated:

I'd like to be around . . . some people who have common interests and, you know, who would have an influence on me to motivate me to do different things. I'm not around many people like that right now.

Well, I don't . . . go out as much. And, I don't have as many friends around me as much because I live way out in the country.

I don't do much during the day since there's nobody here to do much with . . . it would be nice if there was somebody here I could do something with . . .

Although participants returned to their original communities, the lack of companionship may have been influenced by participants residing in their communities for only a short time after leaving the rehabilitation center and they may have not yet had sufficient opportunities to develop new meaningful relationships. However, Trieschmann (1988) reported that social isolation is typical of post discharge life of people with SCI and, according to Buckelew, Hanson, and Frank (1991), social support appears to be an important variable associated with the adjustment of people with SCI.

Lack of transportation. Consistent with previous research on people with physical disabilities (Coyle & Kinney, 1990), another leisure constraint identified was lack of transportation. Lack of transportation prevented some participants from going places they would normally frequent, or participating in activities that were important to them. It appeared that some individuals were forced into a more passive lifestyle due to this lack of transportation. Some participants reported that since their vehicles were not yet adapted with hand controls, they were dependent on others for transportation, as reported by Mike and George, respectively:

I don't have a car. I don't have a van yet so there’s no way I can get out by myself . . . I just don't have the transportation.

I mean, I usually don’t get to go many places because I still ain’t got my car fixed. I have to wait on everybody else but . . . that’s about all I’ve got to do.

This constraint was especially problematic for Adam because it impaired his ability to date:

Oh, see I haven’t got my hand controls yet for my car so it's kind of, that's kind of hard, you know. My parents, my parents, I go with my parents, you know, because I haven’t got my hand controls yet. I have to go with my parents or with, you know, another couple.

Lack of physical ability. Although lack of physical ability is described elsewhere as a defining characteristic of the SCI experience (Kleiber, Brock, Lee, Dattilo, & Caldwell, 1995), loss of physical ability was an im-
portant constraint to returning to the community as well. As can be seen from statements by Mark, Martin, Tony, and Donald, the inability to physically perform different recreation activities due to loss or lack of physical balance, mobility, and strength was a constraint to leisure participation in their communities.

I like to hunt a lot; and before, you know, I could hold a rifle like this, but now when I hold it I fall forward because I don’t have the balance. I haven’t been hunting yet . . .

I used to be able to play baseball. You could run. Now you’re stuck in a chair, and you can’t do nothing really. You can’t, you know.

I tried playing racquetball for the first time two weeks ago, after like two or three games I was exhausted where normally I could go five or six games, so it’s definitely more tiresome for me now.

The difference in hunting is you could always climb up in a tree stand or pick your own spot, or you could go by yourself; but now being a ‘quad’; you have to have somebody there to help you. You could shoot your deer before you got injured, and you could go get it yourself. You can’t do that no more; you’ve got to have somebody there to help you get a deer and drag it back.

Lack of physical accessibility. While many individuals cited numerous instances of accessible recreation facilities and activities, there were also instances cited where participation was blocked due to lack of access or difficult terrain (natural environment). The following remarks by Wanda, Martin, Amie, Mike, and Lynn illustrate the constraining effect of inaccessible environments and facilities.

. . . lack of accessibility of the place . . . we may be going sometimes gets in the way and prevents me from going out and doing certain activities.

Sand, soft ground, rocks . . . there’s no concrete or black top to get around on . . . where you have to require somebody to push around . . .

. . . you’re there looking at a baseball game or something at a park and you’ve got to go use the rest room, but if that doorway isn’t wide enough you’re not going to be able to get in there to use the bathroom.

I don’t get out to my friends’ houses as much as I used to just because a lot of them have steps and it would just take extra planning. I can’t get down to the lake there because it’s so steep. So I haven’t been fishing . . .

Uhmm, you know most of the places that I’ve gone since I’ve been here have not been handicap accessible . . . there’s so many places I can’t get into. I can’t get close to anything, you know, and really look at something. . . . in shopping stores, you know; it’s hard to get around.

Therapeutic Recreation Contributes to Integration

Caldwell et al. (1995) briefly identified respondents reporting that the TR program conducted at the rehabilitation center helped them in returning to their communities. However, a more in-depth analysis revealed participants reporting that TR assisted them in identifying possibilities in themselves and raised expectations about what they could do in the community. They reported that TR helped prepare them for life after rehabilitation. For example, Daniel and Brandon, respectively, stated:

. . . recreation gets you prepared mentally and gets you stronger, gets your mind ready to deal with the
world, that you haven’t dealt with in this position before.

Recreational therapists show you the outside world, ok? And they show you that you can still maneuver around and you can still do the things in the outside world.

When contrasting TR specialists with other allied health professionals (e.g., physical therapy, occupational therapy), Tony highlighted the value of outings and the entire TR program in facilitating community involvement:

Rec was more like enjoying . . . the time that you have because you’re not completely out of it, you know. Just because you’re in a wheelchair doesn’t mean you can’t do things in your life. And they were trying to show you all things you could do . . . . . . rec therapy . . . you can go to the airport, you can go to the train station, you can go out to dinner, you can go shopping . . .

Wanda, Donald and Tina, respectively, expressed the following positive outcomes of TR and associated outings that directly influenced their confidence and their ability to become connected with their communities:

[TR] helped me to feel comfortable with going out in public and doing things that I like to do anyway. And it’s helped me realize that there are still a lot of things that I can do. And so I’ll go out and do them now. If I had never gone out on any outings while I was at [agency] I may have been hesitant to go out now, to go out to dinner or to go to the movies or something, I may have been more hesitant, but I’m not.

You learn to accept the community, to be able to go out when you want, not to be ashamed of the wheelchair, to be able to ask for help when you need it. Like if you’re going into a mall and you seen a shirt way up high and you couldn’t reach it, ask somebody for it. Ask somebody to help you get it.

Well, now that I’ve gone out on outings . . . I know that I can do the outings, when I want to. So that’s changed, because before I didn’t think I could.

Discussion

Participants interviewed reported an interest in “getting-out” into community-based leisure activities, but they varied in their abilities and opportunities to do so. The social networks and associated accepting relationships made the difference in some cases. According to Taylor and Bogdan (1989), an accepting relationship is one that is between a person with a disability and a person without a disability. This relationship, characterized by closeness and affection, is long-standing and disability does not have a stigmatizing or morally discrediting character in the eyes of the person without a disability. For example, Brandon stated:

Sitting around talking with my friends is, I don’t know, it’s like I said, it’s just one of the best things that I’ve, you know, some of the best times I’ve ever had in my life. We like to sit around and make jokes and just chill out and just laugh and talk . . .

Since “getting out” was a major theme that emerged from the data and lack of support and companionship were critical constraints to active community leisure participation, further examination of social support and friendship formation may provide some insight for practice. According to Berndt (1989), social support is characterized by:
(a) emotional support, including statements and actions convincing people of their worth, (b) informational support containing problem-solving advice, (c) instrumental support involving resources or services for solving practical problems, and (d) social companionship consisting of opportunities to share activities with another person. It may be useful for TR specialists to consider these aspects of social support when designing leisure education programs for people with SCI. For example, a component of leisure education, social skills training, was deemed effective by Belgrave and Mills (1981) in improving the social contacts of participants with physical disabilities.

Statements from participants suggested that the constraints of lack of support and companionship are plausible explanations for their problems with integration. Availability of support staff, family members, and friends decreased for many participants upon discharge for the rehabilitation center. Considering findings by Trieschmann (1988), it is possible that feelings of isolation and lack of support to participate in desired activities contributed to negative feelings experienced by some of the participants after discharge. Overall, the literature seems to endorse the importance of social support to successful integration of people with physical disabilities (e.g., Krause & Crewe, 1987; Lyons, 1991). The role of continued social support in the community to assist individuals with SCI to participate in desired activities is worth further investigation.

In addition to the constraints of a lack of support and companionship, constraints of lack of transportation, physical ability and physical accessibility identified by participants are consistent with previous research findings concerning people without disabilities (e.g., Hultsman, 1995; Jackson, 1993). Constraints of lack of transportation and physical accessibility highlight the need for enforcement of federal mandates that promote integration, such as The Americans with Disabilities Act.

To interpret the constraints to community-based leisure participation reported by participants, the model described by House, Umberson, and Landis (1988) may be helpful. The authors proposed that a framework containing social inclusion, social networks, and relational content can be useful when conceptualizing individuals' social contacts and their integration into the community. According to House et al., social inclusion refers to the quantity of social contacts (e.g., type of relationship, frequency of contact, size of network, changes in networks); social network refers to the structure characterizing a set of relationships (e.g., reciprocity, durability, homogeneity, contact context); and relational content refers to the quality of the relationships (e.g., social support, social conflict). Considering House and colleagues' model, it becomes clear that participants experienced leisure-related problems associated with social inclusion, social networks, and relational content. To improve social contacts of people with SCI, it may be helpful for TR specialists to focus services and evaluations on the three aspects of House and colleagues' social contact model.

Participants reported several positive aspects of TR that facilitated their integration into community life. Specifically, TR was reportedly helpful in providing and demonstrating resources designed to facilitate active community involvement. Participants stated that TR provided opportunities that exposed them to situations where they could practice skills needed for community adjustment. TR taught participants how to make adjustments while living in the community that were intended to facilitate integration and help the person cope with various constraints. These findings were consistent with those of Shank, Coyle, Kinney, and Lay (1995) who reported a strong positive correlation between improvement in community integration and a TR community integration program for participants discharged from a rehabilitation center.

Coyle et al. (1994) stated that a vital ser-
vice to people with SCI after their discharge from a rehabilitation hospital is leisure education. Based on the suggestion of Coyle and colleagues and findings of this study, TR specialists may wish to consider models for leisure education that incorporate systematic procedures for transitioning people into active community life to help them overcome constraints to leisure participation. For example, Dattilo and Murphy (1991) proposed a leisure education model that included systematic assistance from, and subsequent fading of, a leisure coach. Involvement of a leisure coach with ongoing participation by a person’s family and friends were suggested by Dattilo and Murphy to enhance the transition of individuals into their community.

Limitations and Implications for Research

Data analysis focused on participants’ perceptions of their return to the community and how leisure was implicated in this return. Considering that interviews with participants were conducted one to eight months after being discharged from the rehabilitation center, participants’ statements are based on having spent a relatively short time in their communities with a SCI. This is important when considering the statement of Krause (1992) that many issues encountered after SCI may surface months or years after initial hospitalization. Longitudinal studies of people with SCI who have returned to their communities would be useful in determining long term effect of rehabilitation and the integration of people with SCI.

Decisions regarding how “actively” involved participants were in community leisure activities were made by the participants themselves. Therefore, it is possible that although one participant may have been engaged less frequently in community leisure activities than another, the person with less participation may have reported a sense of satisfaction with her current lifestyle and characterized her participation as “active.” In contrast, the other person may have reported dissatisfaction with his participation and viewed himself as not connected to his community. Furthermore, perceptions of leisure participation in the community may have been influenced by leisure participation patterns prior to participants’ injuries. Research that explores these issues and uses other data collection procedures in addition to interviews may provide further insight into participants’ leisure participation.

Conclusions

Leisure skills learned in a rehabilitation center may not generalize to life in the community (Caldwell, Adolph, & Gilbert, 1989; Caldwell & Gilbert, 1990). There is often no systematic way in which people with SCI are integrated into their communities and the lack of a process to generalize newly learned skills to the home and community limits integration (Nelson, 1990). After listening to participants explain the importance of “getting out” and describe numerous constraints to their leisure participation in the community, strategies that utilize inclusive leisure services may be especially useful (Baker-Roth, McLaughlin, Weitzenkamp & Womeldorff, 1995; Dattilo, 1994).

Results of this study support the importance of including the perceptions of people with SCI when attempting to understand the relevance of leisure and social relationships to their integration into the community. By using such perceptions social contacts were identified as being important in facilitating community integration. It was clear from the data that leisure can be a context for the establishment and, perhaps the maintenance and development of such social contacts. TR specialists are encouraged to consider strategies to overcome limitations associated with rehabilitation environments by continuously planning for participants’ integration into the community. TR services can be designed to enhance the social support of people with SCI in ways that facilitate their return to the community.
References


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