Abstract

Title: ‘It’s just everyone understands’: How adults with an Acquired Brain Injury navigate stigma to create meaningful relationships in their communities.

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Background: Individuals with an Acquired Brain Injury (ABI), a leading cause of disability, are particularly vulnerable to mental health difficulties and frequently experience stigma. This places them at high risk of social exclusion. Social relations are a key indicator of quality of life after an ABI yet current literature fails to identify successful strategies to navigate stigma.

Objectives: 1.) To discover what factors enhance relationship maintenance and formation post ABI. 2.) To understand how positive relationships promote wellness by acting as a buffer to the effects of stigmatisation.

Methods: Semi-structured interviews with two male participants were completed and transcribed. An Interpretive Phenomenological Analysis (IPA) was conducted. Analysis of an initial descriptive layer of what participant is saying is enriched by an additional layer of the deeper interpretative work of the researcher. The themes emerged from this commentary.

Results: IPA produced three themes. ‘Everyday interactions’ outlined the stigma experienced in daily encounters which led to avoidance strategies. ‘Re-negotiating relationships’ emphasised the complexity of maintaining pre-morbid relationships. ‘The shared experience’ revealed that engagement with others with a similar disability experience, a shared understanding, was the principal strategy to managing stigma.

Conclusions: The findings suggest the continuing prevalence of stigma towards individuals with an ABI in society. Occupational therapists working in community settings are encouraged to consider that clients with an ABI have the opportunity to access disability specific spaces which are a huge protective factor in terms of their mental health.

Keywords: Stigma, acquired brain injury, relationships, community, shared experience
Introduction

Acquired Brain Injury (ABI) is one of the leading causes of disability worldwide (Gean and Fischbein 2010). Medical advances and intensive rehabilitation programmes are enabling more people to return to live within their community (Dinsmore 2013; Hyder et al 2007). This article investigates how adults with an ABI navigate stigma to create meaningful relationships in their communities. This research seeks to illuminate how individuals overcome stigma and the subsequent effects on wellbeing. It aims to discover what factors influence relationship maintenance and formation post ABI and to understand how positive relationships promote wellness by acting as a buffer to the effects of stigmatisation.

A concise literature review situates the research, providing an introduction to the concept of stigma and highlighting the importance of relationships. Subsequently, particular barriers to relationship growth for this population group are addressed. The methodological process and justification for the chosen analytical approach, Interpretive Phenomenological Analysis (IPA), is addressed. The findings section reveals the three themes that emerged from the IPA and a discussion centres on the theme of ‘the shared experience’.

Relationships and participation are core social determinants of health and key indicators of quality of life after an ABI (Dijkers 2004). These concepts are firmly within the domain of occupational therapy and this research will be of particular interest to occupational Therapists working with individuals with an ABI in community settings.
Literature Review

Stigma and ABI

The concept of stigma relates that anything outside the norm in society is considered deviant, giving the person with the negative attribute a tainted or ‘spoiled’ identity. Stigmatization of an individual strips a person of their humanity and results in rejection and isolation from society. Individuals with a disability are at particular risk of stigmatization. Goffman (1963) distinguished between the discredited, where the impairment is clearly visible, or the discreditable, in that the impairment is not immediately apparent. ABI is a discreditable, ‘hidden disability’ as there are typical no markers that indicates someone has had an ABI (Link and Phelan 2001) re-appraise Goffman’s work and postulate that stigma is the result of power dynamics in social interactions. They argue that stigma occurs as a result of labelling, stereotyping, separation, status loss and discrimination. This framework is situated well within the current literature as prejudice and stigma of people with an ABI arise primarily from the misconceptions and ignorance from others about their injury (Thornicroft 2007; McClure 2011).

Due to the lack of awareness about ABI and the invisibility of the injury the label of ‘normality’ is often applied (Gelech 2011; Nochi 1998). The perception of normality results in pressure to conform to others high expectations. Problems that frequently emerge include difficulty in emotional regulation being associated as bad temperament, and fatigue being misconstrued as laziness. Others can misinterpret memory or problem solving difficulties as having a learning disability. Lack of balance and slurred speech can be mistaken with substance abuse (McLennan 2010; Linden et al 2005). It is clear that these factors frequently lead to avoidance due to fear of embarrassment. The abnormal character traits produce stigma as a result of what Goffman (1963) refers to as ‘blemishes of character’.

If individuals with an ABI receive any form of benefits or leniency questions may be raised regarding their legitimacy (Yates 2003). However, disclosure may lead to assumptions that they are incapable and others have the power to reduce their opportunities in society as a whole. Individuals face a difficult balancing act of retaining a sense of self and pride while attempting to access services or accommodations that will enhance their quality of life (Karlovitz and McColl 1999; McColl et al 1998). According to the National Disability Authority (2011), it is individuals with a cognitive or invisible disability that make people most uncomfortable, reinforcing the social challenges for people with an ABI.


**Relationship importance and strains post ABI**

It has been established that stigma leads to diminished social networks (Carter 2004). Depending on what part of the brain is affected, personality changes can occur. This can increase stress in relationships and can lead to the loss of pre-injury friendships (Nolan 2006; Douglas 2013; Sander and Struchen 2011). Marriage breakdown is also a common occurrence (Burridge 2007; Wood and Yurdakul 1997). Many people with an ABI experience loneliness and yearn for more social supports. They are aware of the loss of self in the eyes of others, and due to status and role loss many people with an ABI are unable to fulfil roles that provide meaning and identity (Nochi 1998; Carter 2004; Simpson *et al* 2005).

People who experience an ABI are at high risk of experiencing anxiety, low self-esteem and depression (Bombardier *et al* 2010; Kreutzer *et al* 2001). Combined with complex psycho-social adjustment, social supports are of paramount importance (Yates 2003). Social ties offer empathy, coping and stress-buffering, resiliency and contribute to wellbeing (Thoits 2011; Steptoe 2008, Callaghan and Morrissey 2007). Furthermore how a person values their health partly depends on their perception of social support and that motivates the person in active participation (Isaksson *et al* 2007). Increased quality of social relationships fosters increased efficacy of rehabilitation programmes following an ABI (Jones *et al* 2011; Tomberg *et al* 2005).

**Limitations in Knowledge**

In an attempt to increase social supports for people with an ABI, trial mentoring programmes were set up but these had minimal impact on enhancing social support and increasing social network size (Hibbard *et al* 2002; Struchen *et al* 2011). Online social networking among individuals has also been highlighted as a potential solution to increase social networks, yet the depth and authenticity of those interactions may be questioned (Tsaousides 2011). Despite the abundant evidence base for the importance of meaningful relationships to people with an ABI there remains substantial gaps in knowledge as to how relationships can be successfully promoted. ABI affects about 10,000 people annually in Ireland and it deserves increased research attention (Hyder *et al* 2007).
Methodology

Method of Inquiry

Congruent with the ethos of the research question which seeks to generate new knowledge, a qualitative methodology is utilised (Creswell 2009). The paradigm surrounding this study is critical theory. Critical theory challenges that what is perceived to be natural and ‘real’ in society is actually created and shaped by social, political and cultural forces and actively seeks to promote change (Flick 2008). This research is part of a larger project, ‘Building Real Communities’, which is investigating the experience of stigma among disability groups in Ireland.

Interpretive Phenomenological Analysis

This research was analysed through an interpretive phenomenological analysis (IPA). IPA is most effectively utilised when the research question presents substantial issues of significant consequence for the individual (Smith et al 2009). Therefore IPA is a good fit for the purpose of this research. IPA requires a double hermeneutic, a dual interpretation of understanding what the participant is trying to make sense of, and the researcher subsequently making sense of the participants interpretation. IPA has its origins in psychology, but it is increasingly utilised among researchers in the health sciences. Cronin-Davis et al (2009) argue that IPA is compatible with research in occupational therapy as it seeks to explore the individual’s subjective meanings and experiences and understand the world from their viewpoint.

Participants

Smith and Eatough (2006) advise that for high quality IPA research a very small sample must be gathered. The focus is on getting in-depth analysis and quality must not be sacrificed for quantity. Smith et al (2009) recommends a sample size of three for a student project. Ideally this was the target sample size of this research; however in this instance two participants were recruited. In terms of demographics both participants were Irish males in middle adulthood, neither were working and both were living in an urban area with their wives.
Purposive sampling was necessary for this study as participants were required to have had lived experienced of the phenomenological issue in question (Bickman and Rog 2009). The participants were recruited through an organisation that assists people living with an ABI. The inclusion criteria were any adult aged 18-65 who had an ABI, the cause of the injury was not relevant to the study.

Ethics

Ethical approval was obtained from the University of Limerick- reference EHS11-35. Key ethical principles as outlined by Silverman (2013) were addressed. Pseudonyms were given and identifying information was omitted from the findings to confirm anonymity. A series of measures was taking to assure confidentiality, including having the data password protected. To address any psychological distress following the interviews, participants were given a list of contacts for support organisations. The purpose of the research was clearly explained to the participants and a brief cognitive quiz was completed to ensure informed consent prior to beginning the interview. Potential fatigue of participants was recognised and it was emphasised that the interview could pause at any time (Paterson and Scott-Findlay 2002).

Data collection

The data was gathered through semi-structured interviews, the most appropriate strategy when using IPA (Brocki and Wearden 2006). This option afforded the flexibility for participants to express their opinion while allowing consistency to make sure that the same topics are covered in both interviews. In particular, face to face, one-on-one interviews were completed. The interviews were audio-taped and transcribed (Stein et al 2013).

Data Analysis

Analysis was consistent with the IPA approach outlined by its founder in Smith et al (2009). The first steps involved with several close readings of the transcripts, moving from
empathetic readings to more critical readings to understand the essence of what the participant was saying, looking at the transcript line by line but also as a whole.

The next stage involved a two stage data process. An initial descriptive layer of what the participant is saying is noted. This is followed by a second layer, where the researcher attempts to make sense of the participant’s interpretation. This dual interpretation of descriptive and conceptual comments combines to make a ‘commentary’ from which initial themes emerge. A template was used in Microsoft Word which had three columns, the commentary was noted in the left hand margin and right hand margin was used for emergent themes. The centre margin contained the transcript page and line number.

Finally, the initial themes were grouped together and refined. A cross-check between the two transcripts produced the final master themes. The process is similar to thematic analysis in that it generates themes to discuss the findings, but IPA attempts to provide a more nuanced interpretation (Brocki and Wearden 2006).

Reflexivity

Reflexivity is acknowledged in completing this research. Most notably, prior to analysis, the researcher spent eight weeks on placement at ABI Ireland as part of practice education. Exposure to the population group has increased personal insights and confidence that the findings from these participants may be representative of the issues and feelings expressed by others with an ABI. Reflexivity was addressed by completing a reflective commentary in the form of analytical memos.

Trustworthiness

Qualitative research must strive to be trustworthy (Shenton 2004). IPA research does not seek to claim transferability but seeks to confirm finding amongst wider literature. Similarly, credibility cannot be guaranteed but was attempted, as the researcher attended regular meetings with the co-author of this research to discuss the research process. Fellow students also provided peer scrutiny for the data analysis. Dependability was gained as the interview schedule was adapted in a format suitable for people with cognitive difficulties and the questions were objective. Confirmability was attained by the systematic analytical
methodology in which the findings can be directly linked back to the transcript. Field-notes were completed after interview and participants cross-checked a summary of the interview sent to them.
Findings

IPA resulted in the emergence of three master themes. ‘Everyday interactions’ describes the experience of stigma experienced from everyday encounters which restricts participation in community spaces. ‘Re-negotiating relationships’ outlines the complexity in maintaining pre-morbid relationships. ‘The shared experience’ revealed that engagement with others with a similar disability experience is a successful barrier against the effects of stigma.

Everyday Interactions

As a result of discrimination experienced, the participants believe that ‘ordinary people’ don’t have a good understanding of their disability. They have learned to navigate the social sphere by approaching new people with hesitation. Graham provides an example of how misconceptions from strangers have impacted on his pleasure in life:

‘Like I won’t go near a pub, to go for a drink, something that I would have done prior to my injury, because I’d be, they’d be thinking that I’m drunk the minute I go into the pub and I wouldn’t have drink in me.’

The fear of embarrassment emerged very strongly and, as in this instance, the participants expressed avoidance to social situations as their principle strategy to overcome stigma.

The following extract from Graham encapsulates the sense of sadness and shame that was felt by both participants:

‘Since the accident I have tinnitus and sometimes I raise my voice, a little bit too much, and the person behind the counter accused me of being abusive to him and there was loads of other people standing behind me, listening to him actually say that.’

This demonstrates how even very minimal interactions in the public domain can have a significant impact on the participant’s self-esteem and desire to engage in society. The misunderstanding and misconceptions about how they present to the world was a constant source of exasperation. John recalled:
‘Taking myself for example if you stood me in a line of ten people you’d never know that I’d suffered a brain injury or that’s there’s anything wrong with me you know and they’re just looking at that, you’re grand.’

Both Men had arrived at a position whereby participating in the social world was filled with negative connotations and was perceived to be a risk for distressing experiences.

Re-negotiating relationships

Both participants expressed an internal conflict between wanting to be treated the same as before their ABI, as ‘normal’; and wanting people to understand and recognise their deficits. The participants sought for family and close friends to be flexible to accept them as there are now, taking into consideration their new limitations. However they are not always given extra accommodations from friends. This quote from John explores:

‘They were all sympathetic after I had the brain injury and in fairness to them they all called up to see how I was you know, but after that then its kinda back to normal I dunno you’re not treated differently.’

There is a sense of disappointment here that was echoed by both men, that others don’t appreciate their everyday struggles and they are perceived to be able to ‘just get on with it’. They verbalised frustration that their friends or wider family don’t see the side effects, that they don’t really understand. They explain how their wives are present at their most vulnerable times and only they truly know what it is like to live with an ABI as they share that very intimate, private space. John stated:

‘They think I’m back to normal they think right you got through this but they don’t see say what my family or my wife would see you know, they don’t know if I don’t go to sleep.’

Their immediate families have been successful in achieving the balance between their desired amount of independence and provision of support where necessary. Their preference is to be given independence to do things themselves knowing they have the option to stop and seek assistance as John explains:
‘They’re trying not to be singling me out, you can’t do that, you’re not allowed do that, they let me do as much as I can do but if I can’t do they are not jumping down my back.’

They perceive that others should acknowledge their difficulties without disempowering them, thus achieving a successful relationship.

**The shared experience**

Being surrounded by others with the same disability experience afforded security and familiarity in a relaxing, non-threatening environment as the participants feel that everyone understands their physical and behavioural peculiarities. There was an escape from the pressure to conform to social expectations; there was a space to just ‘do’, as Graham explains when referring to a disability organisation to which he attends:

‘I’m very conscious of the way that I actually walk now and the way that I actually speak now you know and... that’s why it’s great coming to a place like here.’

The shared space reduced feelings of isolation, providing a sense of belonging and acceptance for their new self. This also provided assurance and validation of their experience which created an element of relief. When speaking of an organisation to which he attends for people with an ABI, John reported:

‘I have the utmost respect for everyone, I mean I thought when I was coming in here Jesus I was the only one that had the brain haemorrhage or that you know.’

The shared experience was deemed extremely important, personally, socially and mentally. Both described how their friendships with others with an ABI had the power to lessen their anxieties and increase their mood. Graham states:

‘Because we’re all in the same boat, you know we all have brain injuries and, you can have so much, it’s a very good anti-depressant for me.’

The shared experience is deeply meaningful for the participants and provides fun and enjoyment.
Discussion

The importance of the shared experience in the findings was particularly significant and warrants the bulk of the discussion. The themes of ‘everyday interactions’ and ‘renegotiating relationships’, which were largely consistent with initial expectations, will be afforded a brief mention. This section will also address the limitations of the study and the implications for practice.

The findings from ‘everyday interactions’ highlights the detrimental consequences of stigma which strongly correlates with the literature reviewed, in particular McLennan (2010) and Linden et al (2005). The experience of stigma from everyday encounters led to avoidance strategies and to a loss of meaningful occupations, reaffirming the pertinence of the social model of disability for Occupational Therapists (Shakespeare 2006). The findings suggest a continuing lack of public awareness about ABI despite various educational campaigns by charity organisations including an annual ‘Brain Awareness Week’ organised by the Neurological Association of Ireland (NAI 2014). A solution is not readily available but Valente and Patchareeya (2013) outlines that components of successful awareness campaigns include the regular frequency of the message, the use of multi-media and government agencies, community groups and educational institutions working together. All campaigns should have measures of evaluation to test the impact and efficacy.

The theme ‘renegotiating relationships’ accurately reflected the literature in describing the difficulty in returning to pre-morbid relationships. The expectation that friends and family hoped relationships would ‘go back to normal’ echoes the findings of Gelech (2011) and Nochi (1998). As previously outlined many people with an ABI have to manage behavioural-emotional symptoms making it extremely difficult to adapt to the changes in relationship status. Family and friends can struggle to achieve the balance between offering their loved one autonomy and support (Wood and Yurdakul1997). This issue will be touched on again when implications for practice are considered.

The shared experience emerged strongly in the findings and is affirmed in the literature for various disability groups. People with disabilities often share common needs with each other which create a sense of a shared social identity, creating a space where people are relaxed and feel safe (Salmon 2013). Specifically, as ABI is an acquired disability, individuals can share in the biographical disruption in which they may be coming to terms with identity formation and struggling with loss of independence (Bury 1982). Peer support provides individuals with
a source of strength and information, to learn and inspire one another (Mullins and Preyde 2013). This resonates with the findings, in that there is an insular, protective effect of the shared experience, akin to a sense of respite, away from the experience of stigmatisation where individuals can flourish.

Dovidio et al (2001), through a reflection of his studies, argues that a common group identity has the power to reduce the effects of stigmatisation. Rebeiro and Cook (1999) state that some individuals with mental health difficulties, rather than prescription of therapy, require only an opportunity of a safe social space in which they can engage in meaningful participation. They discuss a ‘just right’ social environment in which participants could become actualized as individuals. When connecting with others who share the experience of stigma, there is a potential for a greater sense of belonging.

This notion of the shared experience is not new, in fact the history of disability studies outlines that people with disabilities have often grouped together to create a personal resistance to oppression (McDonald et al 2007). There is a continuing desire and need for self-authored spaces, as exemplified by two organisations in Ireland. ‘The Blue Tea Pot Company’ is a theatre especially for people with an intellectual disability, which was created to be ‘a place of creative identity’ in which members can grow and excel (The Blue Tea Pot Company 2014). The Irish Wheelchair Association (IWA) ‘Resource and Outreach Service’ was created with the aim to increase social participation and for people with mobility difficulties, with over 2000 people availing of this service each week (IWA 2014). In client-led research about what keeps people with a disability well, the main results included stress relieving activities, security and safety, pleasure, social connectedness and meaningful engagement (Hammel et al 2008; Faulkner 2000). Groups that offer the shared experience have the potential to match all these needs for people.

Limitations

The researcher recognises limitations in the study, most notably the small sample size, and the fact that only one interview with participants from one geographical location was conducted. IPA focuses on the individual and does not claim transferability but the findings have been discussed in relation to wider literature. Furthermore, as the symptoms and experiences of brain injury are so varied and unique it is a particularly difficult population
group in which to attempt to generalise findings. IPA is frequently criticised to be vulnerable to researcher bias, yet the strategies outlined in the methodology have sought to address this issue. Finally, as participants were recruited through an ABI specific organisation, they may have been more likely to emphasise the importance of the shared experience.

**Implications for Occupational Therapy Practice**

In respect of the limitations, the researcher does not attempt to offer staunch recommendations but rather raises some critical questions and considerations, outlining three areas for reflection for clinical practice in community settings.

**Current challenges of practice**

The effects of the moratorium on staffing and cutbacks to resources on service provision in the Republic of Ireland have yet to be documented in the literature. The College of Occupational Therapists (COT 2011), in a consultation paper to the UK Government, warned of the impact of further cuts on a decline in the quality of services. They outline that as a result of reduced budgets it is more difficult to provide a person-centred service with higher support needs prioritised and clients with lower needs at risk of losing out. There is a risk that clinicians are limited to intervening on a very basic ‘survival’ level. Clinicians are encouraged to reflect on how much time is spent on issues related to social determinants of health, in realising clients ability to fully reach their potential, to reach that stage of ‘becoming’ and ‘belonging’ as outlined by Wilcock (1999).

The British Society of Rehabilitation Medicine (2003) utilises the Slinky Model of Rehabilitation as a framework when working with individuals with an ABI. This three stage process involves individuals transiting from ‘acute care’, to ‘reduced disability’ to ‘enhanced participation’ level. The HSE (2013) outlines the scope of practice priorities for occupational therapists in community care to include functional assessments and reports, environmental adaptations and provision of equipment, aids and seating (HSE 2013). It may be questioned if therapists in the community are being increasing confined to reaching only the ‘reduced disability’ stage for clients.
Challenging values

In light of the discussion, therapists may need to re-consider their interpretation of concepts of inclusion and community re-integration when working with this population. While the UN Charter for the Rights of Persons with a Disability has yet to be ratified in Ireland, occupational therapists are encouraged to lead by its principles, including promoting the right for full and effective participation for all (UN 2007). The principles are reflective of OT philosophy and values, however as Gray and Hahn (1997) report, significant stigma reduction can take at least a generation and clients need to be supported in current realities. Previous social spaces may no longer be inviting for clients due to stigma and therefore may be at risk of occupational deprivation. Occupational therapists have a role in liaising with community groups and being aware of community resources so that they can empower clients to consider specific avenues to spend time with others with a similar disability experience for support and occupational engagement (Gordon 2004; Kielhofner 2005).

Creation of an ABI specific social skills group

The theme ‘re-negotiating relationships’ outlined the difficult process of re-framing and managing pre-existing relationships. During acute care, the occupational therapist has a role in educating families about the symptoms of ABI, including possible communication and social difficulties (Golisk 2009). However there should equally be a role to educate patients, not just on their condition, but to empower them and give them strategies to assist in the re-negotiation of relationships once home to manage this transition. Therefore it might be useful, once individuals return to their community, to facilitate a small group that focuses on social skills. The group would centre on practical communication strategies, particularly role plays and practising assertiveness skills, to assist in recovery and longer-term health promotion. This could include role plays, and providing skills that will assist in articulation of needs.
Conclusion

Summary

This research has provided a narrow lens by which to understand how adults with an ABI navigate stigma to maintain and develop meaningful relationships. A review of the literature established an unequivocal link between social connectedness and wellbeing, and highlighted the prevalence of stigma for people with an ABI. The research sought to discover the participant’s strategies in overcoming stigma so that the interviewees’ experiential knowledge can complement therapists’ clinical knowledge to increase efficacy when working with this client group.

Following a semi-structured interview with two male participants, and a subsequent interpretive phenomenological analysis of these transcripts, synopses of the three master themes were outlined and illuminated with verbatim quotes. ‘Everyday interactions’ revealed that stigma in everyday encounters restricts participation as continuous discrimination leads to fear of embarrassment and avoidance of community spaces. This raised a discussion point that there is a need for increased, measurable ABI awareness campaigns to promote understanding which may lead to greater acceptance. ‘Re-negotiating relationships’ outlined the complexity in managing pre-morbid relationships as friends and extended family struggled, in the participant’s view, to accept their new self. In light of this information, there is a possibility of creating a specific ABI occupational therapy led social skills group in the community once individuals return home. It would focus on skills such as assertiveness to assist individuals express their desired levels of assistance to create more harmonious relationships.

The opportunity to form relationships with others with a similar disability experience to mitigate the effects of stigma and improve wellbeing emerged strongly. The credibility of this significant finding was enhanced through a discussion of the numerous positive benefits of the shared experience which were outlined in connection to other disability groups. The evidence was complemented by examples of active disability groups in the Irish context.

The research encourages clinicians to be mindful of attitudinal and environmental barriers that may limit their client’s full and effective participation in society and to consider alternative strategies could be put in place to improve social functioning. It is important to reflect that the principle of inclusion may not always equate with re-integrating individuals...
with an ABI into the mainstream, but offering a new social space, therefore knowledge of community resources and groups is emphasised. There are currently no statistics available on the impact of cutbacks to occupational therapy services in the community but there may be less time afforded to clients who do not have high priority physical needs.

Revisiting the aims

The research set out with two aims, to discover what factors enhance relationship maintenance and formation post ABI; and to understand how positive relationships promote wellness by counteracting the repercussions of stigma. It was revealed that the factors for optimal relationship growth were empowerment and opportunities for independence within a supportive and empathetic environment, in which people have a good understanding of the symptoms of ABI. Wellness was promoted by a feeling of security and acceptance that enabled the participants to just ‘be’ and ‘do’ while also becoming and belonging. The participants rejected active participation in the public domain and therefore meaningful occupational engagement in this environment would be limited. Therapists need to understand the meaning clients attach to particular situations so they can support that client in therapeutic engagement. The research question was sufficiently answered; however there is wide scope for further research.

Further research

Primarily, this study could be revised with the inclusion of a greater number of participants which could strengthen the themes and increase the credibility of the findings. A study, in partnership with one of the ABI specific organisations, would be beneficial to embark on a more in-depth investigation. This may involve facilitation of focus groups to discover if particular occupations in that shared space are more likely to promote friendship development and increase feelings of self-worth. It may also be conducive to interview and assess individuals entering the organisation so as to measure over time any increase in health-related quality of life and determine if duration or frequency of exposure to the shared experience is significant. An increased evidence base will give weight to occupational therapists justification for attending to social determinants of health as an integral part of practice.
Reference List


Health Service Executive (2013) ‘Role of the Primary Care Occupational Therapist’ available: http://www.hse.ie/eng/services/list/2/PrimaryCare/pcteams/dublinsouthpcts/dunlaoghaireglasthulepct/ot.html, [accessed 12th April 2014].


