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Postinjury Marriage to Spinal Cord Injured Men:
Women’s Perspectives on Making a Commitment

by

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Abstract

The experiences of 8 able-bodied women in making postinjury marital commitments to men with a spinal cord injury (SCI) were explored. Using grounded theory methodology, the data was organized into 7 major categories (themes) which were discovered to be important factors influencing relationship progression: partner’s characteristics; personal characteristics; openness/receptivity; coupling; relationship functions; relationships with others; and societal attitudes and awareness. These interrelated factors were organized and presented as a Dynamic Model of Relationship Development within the context of physical disability. This model highlights the role of individual factors and external social forces on relationship development, thereby making it distinctive when compared to existing models of courtship.

Participants revealed: an openness to a relationship with a partner with SCI; experience with disability; flexibility regarding role performance; acceptance of disability and need for assistance; an attitude aimed at fostering partner’s independence; and resiliency when faced with social disapproval.
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Chapter 1

INTRODUCTION

It is difficult to imagine many experiences more devastating than sustaining a spinal cord injury (SCI) which leaves a legacy of permanent paralysis. Traumatic spinal cord injury brings life as the individual has known it to a dramatic and crashing halt and places enormous stress, both physical and psychological, on the newly disabled person as he/she begins the arduous and daunting process of adaption and adjustment.

It is estimated that up to 85% of SCIs occur in males, the majority of them being young and single. Approximately 60% of these injuries occur to individuals between the ages of 16 and 30 years (Gutierrez, Young, & Vulpe, 1993; Trieschmann, 1988). With the preponderance of SCI occurring in men, and given the perspective and objectives of this paper, reference to the injured person as male and his significant other as female will be generally adopted throughout this paper. To enhance appreciation for the far-reaching effects of SCI, a very brief summary of the physical and psychosocial implications of SCI will follow.

The physical consequences of SCI are extensive. SCI can produce symptoms which are either temporary or permanent. Physical impairment may be complete (total sensory/motor loss) or incomplete (some nonreflexive sensory/motor functioning) below the level of injury. The location and extent of neurological injury determines the degree of physical impairment. It is important to note that the skeletal level of injury does not always directly correspond to the extent of spinal nerve damage from swelling or bruising above or below the bony fracture. With that caveat, cervical injuries (C1 to C8) result in quadriplegia, which entails paralysis in both upper and lower extremities. At C6, the potential for independent living exists and at C7, it is probable. Thoracic (T1 to T12),
lumbar (L1 to L5), and sacral (S1 to S5) injuries result in paraplegia, paralysis in the lower extremities (Trieschmann, 1988).

To varying degrees, individuals with SCI are challenged in virtually every sphere of their lives by motor impairment, sensory impairment, bladder and bowel dysfunction, and compromised sexual functioning. As well, potential organic problems associated with SCI include concomitant brain injury, body temperature disruption, compromised respiratory function, pain, spasticity, urinary tract infections, pressure sores and other medical consequences, such as hypotension and autonomic dysreflexia: a sudden, severe increase in blood pressure which can be life-threatening (Gutierrez, et al. 1993; Trieschmann, 1988).

During the acute phase of SCI injury, medical management of the physical trauma and mastery of new techniques to perform the activities of daily living are the focus of rehabilitation. As Trieschmann (1988) asserts, the psychosocial issues of living with a disability, which are paramount to long-term adjustment, are typically inadequately addressed in acute medical rehabilitation programs. Our present understanding of both the short-term and long-term psychosocial consequences of SCI is tentative and based largely on clinical impressions and personal testimony, rather than controlled scientific research (Craig, Hancock, Dickson, Martin, & Chang, 1990).

Discharge from a rehabilitation setting marks a return to the community and a dramatically altered lifestyle. The immediate impact of SCI on individuals' lives varies with level of injury and other demographic variables; however, immediate challenges to be faced include: architectural barriers, increased dependence on others, delay of age-appropriate developmental tasks, inability to fulfill former roles (i.e. vocation), reduced employment prospects, restriction from formerly enjoyed leisure activities, altered sexual identity and body image, social devaluation, and disrupted interpersonal relationships.
Considering the breadth of obstacles a person with SCI must face, it is not surprising that many authors have described psychosocial adjustment to SCI as an ongoing developmental process (i.e. Trieschmann, 1988; Oliver, Zarb, Silver, Moore, & Salisbury, 1988; Whalley Hammell, 1992). Although relatively high levels of life satisfaction and personal well-being appear to be achieved by many individuals with SCI (Carlson, 1979; Crewe & Krause, 1990; DeVivo, Richards, Stover, & Go, 1991; Eisenberg & Saltz, 1991; Schulz & Decker, 1985), poor adjustment and psychological morbidity are also suggested by higher rates of suicide, depression, anxiety, self-neglect and substance abuse as compared to the general population (Craig, Hancock & Dickson, 1994; Hancock, Craig, Dickson, Chang & Martin, 1993; DeVivo, Black, Richards, & Stover, 1991; Heinemann & Hawkins, 1995; Heinemann, Mamott, & Schnoll, 1990; Whalley Hammell, 1992).

Permanent SCI results in a chronic condition with significant medical and psychosocial consequences, impacting virtually every area of an individual’s life. Among the many questions confronting the newly injured person are concerns about the impact of their disability on their present or future intimate relationships. Common inquiries advanced within clinical settings, include: Will my spouse/girlfriend still love me? Will I be able to have sex? Will I ever have a family? What kind of woman could ever want someone like me? (Allden, 1992; Neumann, 1979; 1991). In a rare look at men’s experiences and concerns about sexual relationships and marriage, Yoshida (1994) articulated the fears many men experience regarding initiating relationships. A quote from one of her respondents illuminates the difficulties men with SCI may encounter.

Like I know because I have discussed it with a lot of people that I...Just lots of people I have known over the years. And there is lots of fears and fears of...like a lot of people in chairs are afraid to get involved with like an AB [able-bodied
woman], because sooner or later the woman will um, will um, abandon them. Or stay with them and cheat. And um, so a lot of them avoid because of that.

Unfortunately, it is difficult to address these queries and concerns from the extant literature. At present, the interpersonal impact of SCI on pre-existing relationships and the potential barriers to forging new postinjury unions are not well understood. One potential indicator of interpersonal adjustment is marital status. Recent investigations of marital status for persons with SCI indicate that they are less likely to marry and more likely to divorce, at least in the short term (DeVivo & Fine, 1985; DeVivo, Hawkins, Richards, & Go, 1995; Brown & Giesy, 1986). These findings suggest that the sequelae of SCI, in combination with its stigma inducing properties, make it more challenging for persons to contract a first marriage, maintain existing marriages, or to remarry after divorce or widowhood (Brown & Giesy, 1986). Whether one is attempting to sustain a marriage or forge a new one, it seems reasonable to assume that the pervasive consequences of SCI have, or will have, a significant impact on not only the injured person, but also the noninjured partner.

The literature is practically silent when it comes to the perspectives of nondisabled mates, leading at least one author to refer to the spouses of persons with SCI as “the forgotten others” (Neumann, 1979; 1991). As a result, primarily anecdotal writings and speculations inform us about the nature of their experience. Considering that the vast majority of individuals with SCI are men, most of whom were young and single at the time of injury, it seems particularly pertinent to understand the experiences of women who have chosen to become romantically partnered to men with SCI.

It is the objective of the present study to explore, articulate, and theoretically conceptualize women’s perspectives on making a marital commitment to a male partner who has sustained a permanent SCI. Chapter 2 will provide a review of the literature on
intimate/marital relationships and SCI, as well as develop the rationale for this project and the guiding research questions.
Chapter 2

LITERATURE REVIEW

In contrast to extensive medical research on the physical dimensions of SCI, the literature is relatively sparse regarding the subjective experience of persons with SCI as they attempt to cope with the implications of a traumatic injury of this magnitude. To date, the psychological literature has primarily focused on patients' acute grief responses to injury, and coping and adjustment to the physical and psychosocial sequelae of SCI (Laskiwski & Morse, 1993). In particular, the qualitative aspects of significant interpersonal relationships after SCI have received limited attention. Although it is recognized that the demands of SCI place immense strain on others as well, particularly the immediate family (McGowan & Roth, 1987; Oliver, et al. 1988; Steinglass, Temple, Lisman, & Reiss, 1982; Trieschmann, 1988; Versluys, 1980), few attempts have been made to enhance our understanding of the adjustments significant others must make to their loved one's severe physical disability.

The primary focus of this literature review is on SCI in the context of the most intimate of all adult relationships, the union between spouses. In general, disability and marriage is a surprisingly neglected topic in the literature. A review of pertinent findings will be briefly summarized below, initially focusing on research relating to a variety of disabilities in the context of marriage, followed by presentation of the sparse literature which is specific to SCI and marriage.

Summary of Research

Disability and Marital Relations

Many of the early writings which focused on disability and marriage have addressed the social barriers to developing intimate relationships. In his classic work, Goffman (1963) thoroughly explored and described the dehumanizing effect of
stigmatized physical disability, concluding that perceptible bodily disfigurement likely contributed to the narrowing of courtship opportunities.

Miller and Morgan (1980) described social conditioning from an early age for young people with cerebral palsy to anticipate a nonsexual role in life. The authors reported a study in which 72 couples, where one or both partners had cerebral palsy, were interviewed about marriage and sexuality. A tendency to marry later in life was found, however, no specifics were provided. While one-third of the sample reported positive parental responses to their decision to marry, another one-third of the respondents' parents were opposed to the union. Many of the couples responded to negative attitudes by becoming more determined to marry.

Individuals with cerebral palsy married to an able-bodied person were underrepresented in the sample; however, based on their data, Miller and Morgan (1980) concluded these relationships may be more challenging than when both partners have a disability. It is unfortunate the authors did not provide specifics as to how the latter relationships are more difficult.

Hahn (1981) identified and commented on the social difficulties confronting men and women with a disability in their efforts to establish sexual and/or marital relationships. He argues there are strong theoretical reasons to believe that "...the effects of stigmatization may be so powerful that they may pose a seemingly insurmountable obstacle to love and marriage" (p. 223). Hahn's review discovered strong evidence of an unwillingness to enter into close personal or intimate relationships with someone with a visible disability. This finding echoes a conclusion by Safilios-Rothschild (1970, as cited in Hahn, 1981), that the likelihood a nondisabled individual will accept a disabled person as an eligible marital partner is very small.

The above authors published their works over 15 years ago and social awareness
of, and sensitivity to, disability issues appears to have improved with advocacy efforts by persons with disabilities, and others. Despite progress, there is considerable evidence to suggest that the social perceptions of persons with disability remain as more than mere vestiges of historical discrimination (i.e. Anderson & Antonak, 1992; Artinian, 1990; Braithwaite, 1991; Yoshida, 1994).

A number of authors have also addressed disability and marriage with a focus on marital relations and adjustment issues. Nagi and Clark (1964) compared the characteristics of post-polio couples who remained married and those who separated or divorced, and found a greater proportion of married couples had higher levels of education, were employed in professional or managerial capacities, and enjoyed higher income levels. The authors hypothesized that socioeconomic variables may be important factors in marital stability.

Skipper, Fink, and Hellenbeck (1968) found little could be predicted about women with disabilities’ or their husbands’ marital satisfaction from knowledge of their physical mobility, which emphasizes the difficulty in establishing direct associations between physical and psychological factors.

Carpenter (1974) examined role allocation in families where the husbands were disabled and found that men did more household tasks when their wives were employed; however, the degree of disability severity affected the extent of their participation. This study appears to have assumed that participation in household tasks represented a change in role, perhaps reflecting a more stereotypical expectation for gender roles prevalent at the time.

In her investigation of the impact of a variety of physical disabilities on the communicative characteristics of married couples, Thompson (1981) found wives of men with a disability perceived more autonomy and separateness within their relationship than
a nondisabled comparison group. This investigator also concluded that acquired disability had more negative effects on predisability marriages, as compared to postdisability marriages. Overall, the negative impact of the disability was attributed to pragmatic limitations, as opposed to psychological or emotional issues.

In a more recent investigation, Rodgers and Calder (1990) discovered marital adjustment was significantly related to emotional adjustment and not to level of disability for men and women with multiple sclerosis. The authors also found that when marriages were viewed as being less well-adjusted, problems were often blamed on the chronic illness, perhaps inappropriately. Although a positive marriage was found to be an important resource for persons with multiple sclerosis, the investigators concluded the potential for marital difficulties was significant. When compared to a normative sample, couples where one partner had multiple sclerosis were found to be significantly less well-adjusted.

Artinian (1990) explored the experience of young dialysis patients in forging and maintaining marital relationships. Renal failure represents a hidden disability as its effects are not visually perceptible and typically requires disclosure to be socially recognized; however, many of the issues dialysis patients face parallel the experience of more visible disabilities. The major process Artinian discovered was the necessity to progressively bend normative expectations for marriage. Specifically, successful relationships demonstrated flexibility about expectations for: a) the selection of a marital partner, b) involvement in physical care, and c) marital role performance. After finding a partner who will look beyond the disability, participants described the discouragement they often received from family members and friends. Couples deciding to marry negotiated sharing responsibility for the dialysis patient's treatment regime. Striking a balance in marital role performance was found to be important, particularly in ensuring that expectations for the
dialysis patient’s contribution were neither too low or too high. Overall, Artinian found that as time progressed in the development of a committed relationship, the predominancy of renal failure and dialysis receded to where it was viewed as a constraint that needed to be accommodated.

Parker (1993) focused on the impact of acquired disability after marriage on couples’ sexual relations as well as the nature and meaning of marriage within the relationship. The author also identified factors which might predispose marriages to fail after one of the partners becomes disabled. Parker found open communication about sexual difficulties, and in some cases having a sense of humour about them, were important. When intercourse became impossible, noncoital forms of physical intimacy (for example, kissing and cuddling) often served to maintain closeness. Couples in Parker’s sample described some negative impact on their lives as a result of the partner’s disability; however, they also described their relationships as closer or strengthened by the experience. Caregiving spouses tended to admire how their spouses dealt with their various impairments and/or pain. A theme of reciprocity and duty also emerged. Many caregivers considered that if the situation were reversed, their spouse would have looked after them. For other caregivers, a sense of obligation for a partner who had been a good mate was described.

Caregiving partners in Parker’s (1993) sample often attempted to boost their disabled spouses’ self-esteem. Spouses with impairment expressed sadness or guilt at the burden they represented to caregivers, particularly women. Parker suggested that women, who are socialized to be “givers rather than receivers” (p. 575) may have more difficulty when their husbands take on a caregiver role.

Parker (1993) also identified five factors which may affect the quality and stability of marital relationships; specifically, the quality of marriage before onset of disability
notions of duty, severity of the spouse's impairments, time (since onset of disability) and practical considerations.

In a recent theoretical paper, Rolland (1994) addressed the impact of chronic illness and disability (including SCI) on couples' pre-existing relationships, highlighting the need to rebalance skews which may occur in the relationship as a result of one partner's condition. Depending on the nature of the condition, the impact of chronic illness/disability may be mild, intermittent, or, as in the case of a severe disability such as SCI, may impinge on the couple on a daily basis. Rolland emphasizes that strong communication skills are essential to overcoming the challenges of chronic disorders as maintaining intimacy requires the inclusion, not avoidance, of issues of disability and threatened loss. Extraordinary focus on the affected partner, the stress of long-term caregiving and dependency, balancing togetherness and separateness, life cycle disruptions, and altered sexuality may act to disrupt a previously balanced, mutual relationship.

In sum, the general literature on disability and marriage reflects the limited state of our knowledge about the interpersonal consequences of impairment. It appears individuals with a disability experience difficulties initiating romantic relationships, in large part because of the considerable social stigma that exists. When marriages are contracted the couple may be faced with extra challenges, such as disapproval from family and/or impairment related stressors. Higher socioeconomic status and emotional adjustment appear to be associated with increased marital adjustment. Despite the increased demands which are associated with disability, it appears that with open, sensitive communication patterns the potential for increased intimacy and relationship satisfaction also exists.

**SCI and Marital Relations**

Studies of SCI and marriage have primarily investigated marital status, spousal
adjustment, sexuality, marital adjustment, and compared preinjury versus postinjury marriages. More recently, exploration into courtship after SCI has begun. These areas are reviewed sequentially below, followed by a brief discussion of the influence of societal attitudes on mating and marriage.

**Marital Status**

As noted above, investigations of marital relationships and SCI are scarce. Early empirical work focused on marital status and stability rates, both of which are relatively gross indices of marital outcomes and cannot be taken as reliable indicators of the qualitative aspects of intimate relationships (Abrams, 1981). Although divorce can be presumed to represent unsatisfactory marital relations, many unhappy marriages continue unterminated for a variety of reasons including financial considerations, religious convictions, children, etc. What marriage and divorce rates do provide is an indication of the social impact of SCI on the most intimate of all relationships.

A review of the extant investigations of marriage and divorce rates for individuals with SCI reveals inconsistent findings. Early studies suggested good reason for optimism with reports of equivalent marriage and divorce rates for both preinjury and postinjury unions, as compared to the general population (Abrams, 1981; Guttman, 1964; El Ghatit & Hanson, 1975; El Ghatit & Hanson, 1976). El Ghatit and Hanson (1975) found that marriages where the husband was continuously employed postinjury had the lowest rate of divorce, suggesting income stability may be an important factor in maintaining stability in a marriage.

In contrast, more recent investigators have noted a substantial short-term effect on marriage rates and marital stability (Brown & Giesy, 1986; DeVivo & Fine, 1985; DeVivo, et al. 1995) with persons with SCI significantly less likely to marry and more likely to divorce as compared to expected rates for the general population. The latter
findings are consistent with clinical evidence that not only can disability impose considerable strain on pre-existing relationships, but it may constitute a challenging barrier to forging intimate relationships in the future (i.e. DeLoach & Greer, 1981; Hahn, 1981; Lemon, 1993; Oliver, et al. 1988; Vash, 1981; Wright, 1983). Although the long term effect of SCI on marital status is not clear, it appears that after a period of adjustment to SCI, the divorce rate begins to decline towards the normal rate expected for the general population (DeVivo, et al. 1991; DeVivo & Richards, 1992).

**Spousal Adjustment**

The justifiable focus on stabilizing and caring for an injured person during the acute stages of SCI may result in a lack of attention on the nondisabled partner who is also experiencing the devastation and trauma. Hart (1981) repeatedly interviewed the significant others (spouses, girlfriend and mothers) of seven men and women over the 40 day period following SCI injury. She discovered partners (and mothers) expressed the following needs: to feel adequately informed; to feel helpful to the injured person; to cope with home and other family responsibilities; for emotional support; to express feelings; and to feel that their loved one was receiving good quality of care.

In a rare investigation, Vargo (1984) provided evidence of the profound physical, psychological, affective, social upheavals, and pressures experienced by nondisabled women when their husbands sustained a traumatic SCI after marriage. The author interviewed 10 women across a range of time postinjury (2.5 months to 10 years) providing insight into the process of spousal adjustment.

During the acute phase of injury, women reported the paramount importance of emotional and instrumental support from others, their tendency to assume the role of protector for her partner, the need to control the physical and emotional environment, assuming responsibility for physical care of their spouses, recurring feelings of pressure,
from the workload, and, occasionally, feeling unappreciated. Particularly distressing to the informants were the unsolicited comments from medical staff regarding the expectation of a marital breakdown. As well, the women felt their emotional experience was often marginalized by hospital staff.

Despite the tremendous upheaval to their lives, many women in Vargo's sample also spoke of the traumatic experience as a time of personal growth, positive changes, and a renewed sense of commitment which enhanced the couples' closeness. When the acute phase of their husbands' injuries had passed, reconstruction of the women's lives and relationships included dramatic changes to lifestyle, altered or clarified personal values, and intrapersonal changes (Vargo, 1984).

Kester, Rothblum, Lobato, & Milhous (1988) investigated long-term spousal adjustment to a male partner's SCI (range: 2 to 12 years postinjury) and found stress-related, adverse health consequences for women as a result of being married to or living with a partner who had sustained a SCI. Consistent with Vargo's (1984) findings, noninjured spouses also reported positive changes in their lives including increased closeness with their partners and families, and changes in personal values (for example, appreciating life and the importance of each day). Overall, spouses of partners with SCI did not differ significantly from a matched comparison group in terms of life satisfaction or level of social activity. Kester, et al.'s (1988) findings suggest that while long-term adjustment to the consequences of living with a partner who has a SCI may be successful, it is also stressful and chronic, with potentially significant medical and psychosocial consequences for spouses.

A limitation of the Kester, et al. (1988) study, recognized by the authors, was the confounding of the experimental group and socioeconomic status. Poorer health outcomes in the spouses of partners with SCI could have been attributable to their
significantly lower socioeconomic status. On another point, it is also unclear from the investigators' report how many marriages/involvements took place before or after the partner's SCI injury, although both conditions were included in the sample. As will be discussed in greater detail below, there may be fundamental differences in the nature of marital commitments made before and after injury; however, this does not appear to have been a recognized factor in the study design.

Although limited in number, these ground-breaking studies suggest that the emotional and physical toll of SCI can be tremendous for spouses of partners with SCI, though, the experience is not without positive aspects.

**Sexuality**

As Trieschmann (1988) reminds us, it is important to distinguish between sexuality, sexual drive and sex acts. Sexuality is considered here as the expression of sexual drive through a wide range of sexual behaviours, not only sexual intercourse. It is beyond the scope of this paper to provide an exhaustive review of sexual functioning for this has been an area of considerable interest, particularly in the medical literature. If any aspect of interpersonal functioning after SCI has received attention, it has been the area of sexuality. Unfortunately there exists a striking lack of corroborating data from spouses or intimate partners. Furthermore, it is only recently that authors have directed attention to the quality of sexual experience, rather than a focus on the functional aspects of sexuality in newly injured, hospitalized men (Willmuth, 1987). The reader is referred to Willmuth (1987) for a more thorough review of sexuality after SCI. This survey of the literature will highlight the psychosocial aspects of altered sexual functioning.

Early research in the area of sexuality focused primarily on the physiology of the sexual response, however, recently the psychosocial aspects of sexual adjustment after SCI have begun to receive attention (Willmuth, 1987). The impact of altered sexual
functioning can deleteriously affect the injured person's self-concept and sense of personal worth, particularly amongst men. Although adjustment to altered functioning is significant for women with SCI, they experience relatively less impaired genital function to perform sexually and, with improved acute care management, are increasingly capable of conception, pregnancy and delivery (Verduyn, 1991).

The loss of ability to achieve psychogenic erection, ejaculation, along with low fertility after SCI, and a diminished sense of personal attractiveness, can be devastating to self-worth. For many men, the physical sequelae of SCI is emasculating in a culture which places high value on sexual performance (Drench, 1992). Finding a partner who is willing to experiment with sexual activities may be difficult because of embarrassment, self-consciousness or a devalued sexual identity. It appears that the difficulties experienced by individuals with SCI (or any disability) are not just the direct consequence of their disability, but they occur in the context of interaction with the social world. Social perceptions of persons with a disability as nonsexual, impotent, or the notion that sexual behaviour without intercourse is inferior, are frequently shared by the person with an acquired disability (Pearson & Klook, 1989; Wada & Brodwin, 1975). Unfortunately, it appears that many rehabilitation programs provide superficial, if any, sexual and/or marital counselling (Drench, 1992; Miller, 1988; Pearson & Klook, 1989; Tepper, 1992). Although our understanding remains tentative, it appears that sexual adjustment may follow overall adjustment to SCI (Kettl, et al. 1991).

Pearson and Klook (1989) interviewed 10 paraplegic men and found many of their respondents shared the view that they were unattractive to the opposite sex and asexual because of their disability. An emphasis on the centrality of sexual penetration was evident as well as an attitude that experimentation was not worthwhile because there was no solution to their physical problems. The sample was of Chinese origin and the authors
suggest that fundamentally conservative sexual attitudes may have exacerbated the respondents' attitudes.

There exists a dearth of investigations of female sexuality after SCI, perhaps because these injuries occur less often in women. Kettl, et al. (1991) reported women with SCI were socially and sexually less active after injury. The participants rated sex as being less important to them and they were generally less satisfied than before their injury. Despite personal difficulties, most women felt they satisfied their sexual partners and only 15% reported their injury had led to the dissolution of a relationship. The authors concluded that the biggest change for participants was not in the frequency or quality of sexual activity, but rather a diminished body image and reduced sense of attractiveness to others.

Linton (1990) compared 118 paraplegic and quadriplegic men's locus of control and sexual satisfaction, discovering evidence that the latter may be dependent on the active shaping of one's sexual life. Romeo, Wanlass, and Arenas (1993) explored the differences in psychosocial functioning of quadriplegic and paraplegic men, as well as compared the men with SCI to able-bodied men. The authors found no significant differences between quadriplegic and paraplegic men, suggesting the powerful influence of psychological and social factors rather than biological influences on psychosocial functioning. When compared to able-bodied men, men with SCI had greater problems with body image; however, they were comparable across sexual drive and satisfaction.

In a rare investigation of intimate relationships from the perspective of the female partner, Neumann (1979) found on average the women were somewhat sexually inexperienced. The 20 respondents indicated physical attractiveness of their partner was important to them, and they very clearly considered their partners with SCI to be attractive. Neumann speculated that sexual inexperience led to a de-emphasis on the
sexual aspects of relationships.

The extant literature suggests that sexuality is a significant problem for most individuals with SCI; however, it appears there has been minimal support from health professionals and rehabilitation programs in the area of sexual education (Miller, 1987; Tepper, 1992; Trieschmann, 1988). As well, the general lack of research involving intimate partners severely limits our capacity to understand their feelings and attitudes. A partner’s response is a critical element in the sexual fate of individuals with SCI (Althof & Levine, 1993). At the present time, we have very limited information about how difficult it may be for single individuals with SCI to initiate intimacy with new partners and/or develop meaningful long-term relationships. There is evidence to suggest SCI may be a significant interference to the development of intimacy (Bozzacco, 1993; Yoshida, 1994).

Marital Adjustment

As noted, marriage and divorce rates reveal little about the qualitative factors within marital relationships such as satisfaction, communication patterns, or social life; nor do they inform us about the individuals who create the relationship (Neumann, 1991). Investigations of marital adjustment/satisfaction have primarily compared preinjury and postinjury unions and these studies will be discussed in the following section. What follows is a discussion of two investigations which looked at marital adjustment alone.

David, Gur, and Rozin (1977-78) interviewed 16 Israeli women who had married partners with SCI postinjury. The authors appeared to focus more on sexuality and conception in their interview method rather than on marital adjustment; however, they reported high levels of dissatisfaction, primarily associated with the women’s premarital naivete about their future husband’s sexual functioning and unmet expectations to bear children. According to David, et al. there is an extremely high value placed on family and having children within the Israeli culture. It seems likely that this cultural expectation,
coupled with a lack of accurate information about the reproductive consequences of their intended husband’s physical limitations, played an important role in the women’s disillusionment and dissatisfaction in their marriage.

Urey and Henggeler (1987) compared the characteristics of couples who were successfully adapting to SCI and those who were not. As well, the relationship between positive marital adjustment in couples with SCI and the positive adjustment of able-bodied couples was examined. Consistent with research on differences between distressed and nondistressed able-bodied couples, partners with SCI who were satisfied with their marriages demonstrated greater frequencies of instrumental and affective positive behaviours and sexual satisfaction, as compared to couples with SCI who experienced less marital satisfaction. Urey and Henggeler also found that distressed SCI marriages engaged in significantly fewer leisure and social activities than their nondistressed counterparts, both able-bodied and couples with SCI.

Overall, Urey and Henggeler (1987) reported similar processes between couples with SCI and able-bodied couples; although, some important distinctions were noted. As compared to able-bodied couples, husbands with SCI were found to be less sensitive to their wife’s sexual preferences and indicated less pleasure from sexual activity, leading the authors to hypothesize that sexuality may play a less important role in the lives of couples with SCI.

The above studies are far from definitive in the area of marital adjustment and should be considered within the context of the discussion which follows. A number of investigations of marital adjustment have focused on the comparison of preinjury and postinjury marriages.

**Preinjury versus Postinjury Marriages**

Although marital satisfaction is reported in both preinjury and postinjury marriages
(Kester, et al. 1988; Simmons & Ball, 1984; Neumann, 1991), some evidence indicates that postinjury marriages are generally more satisfying (Crewe, Athelstan, & Krumberger, 1979; Crewe & Krause, 1988; Schulz, Tompkins, Wood, & Decker, 1987; Simmons & Ball, 1984;). This finding is consistent with Deyoe's (1972) conclusion of greater marital stability in marriages which occur after injury.

Crewe, et al. (1979) found that, despite comparable levels of spinal lesion, injured persons (85% were men) in preinjury marriages were less motivated for independence and received a greater level of assistance from their spouses. Furthermore, persons with SCI in postinjury marriages were found to have better psychosocial adjustment and were more likely to be employed. Postinjury marriages were assessed by psychologists to be happier than preinjury marriages, and an overall trend for better sexual adjustment was also found. Preinjury and postinjury marriages were not found to be significantly different in terms of social life or life satisfaction.

In another direct comparison of preinjury and postinjury unions, Simmons and Ball (1984) found that both wives and husbands with SCI were significantly more inner-directed (a tendency to react according to an internalized set of goals or values) and had better marital adjustment than preinjury marriages. The authors emphasized overall marital adjustment for both groups was high.

In a study which focused on determinants of primary caregiver well-being, Schulz, et al. (1987) compared spouses who had assumed that role during or after marriage. Although the two groups did not differ on overall psychological well-being, significant differences were found in those who married their partner's postinjury. These partners were happier in their current stage of life and felt more hopeful about the future. As well, caregiving spouses who married after injury considered their partner's disability to be less a limitation than those already married at the time of injury.
Crewe and Krause (1988) also compared persons with SCI (83% men) in preinjury and postinjury marriages, using life satisfaction as an outcome measure. Individuals with SCI in preinjury and postinjury marriages were not significantly different on medical variables such as hospitalizations, nonroutine physician visits, sitting tolerance, etc. The two groups did differ significantly on a number of variables. Those individuals with postinjury marriages had higher educational achievement and were far more likely to be working. They also reported greater satisfaction with their sexual lives, living arrangements, social lives, emotional adjustment, sense of control over their lives, and general health.

Postinjury marriages have been hypothesized to be more successful unions for a variety of reasons. Marriage after disability avoids the trauma and emotional distress associated with the acute stage of injury (Vash, 1981). As the disability is a recognized factor in the relationship from the outset, adjustment, role changes, and issues of loss are likely not as preeminent. Furthermore, new partners, by making a presumably free choice, may be more likely to avoid feeling trapped and burdened within the relationship (Crewe, et al. 1979). Postinjury couples are not faced with unlearning entrenched patterns of relating and may evidence greater role flexibility to improvise ways of interacting where no social scripts exist to act as a guide to behaviour (Neumann, 1991). Greater physical independence and self-reliance may develop when the individual with a SCI is single at the time of injury. Crewe et al. (1979) found in marriages contracted preinjury, disabled partners were more likely to receive extra help with self-care and daily activities, potentially discouraging achievable levels of independence and placing further burden on caregiving spouses. Given that persons with SCI are more likely to be employed in postinjury relationships (Crewe, et al. 1979; El Ghatit & Hanson, 1975), it is also possible that greater financial stability and access to resources enhances marital satisfaction and
adjustment. As well, employment and/or productivity has been found to be significantly associated with better psychosocial adjustment in persons with SCI (Krause, 1990) which could be hypothesized to contribute to marital adjustment.

Another possibility is that decisions to marry postinjury are arrived at more thoughtfully than marriages in general because of the recognized challenge of living with a disability. It could be that individuals who were able to attract new partners after SCI may have unique characteristics, such as superior social skills, motivation, self-esteem and/or intelligence, than the disabled population as a whole, and these qualities might contribute to more successful unions (Crewe, et al. 1979).

Some authors have suggested that able-bodied spouses in postinjury marriages may have unique qualities or personal values which contribute to the success of these relationships, such as, independence, maturity, and strong communication skills. These personal characteristics may facilitate their willingness to pursue intimate involvement with a person with SCI (Crewe, et al. 1988). Simmons and Ball (1984) compared preinjury and postinjury relationships and found that for able-bodied wives married after SCI only inner-directedness scores were significantly associated with marital adjustment, suggesting the overall better functioning of postinjury unions may be particularly dependent on self-actualizing characteristics. Neumann (1980, as cited in Neumann, 1991) speculated that higher levels of inner-directedness may increase the likelihood of selecting a SCI mate because of an ability to resist external pressures and the opinions of others in determining that the potential satisfaction within the relationship outweighs the obvious physical challenges.

Postinjury Courtship

Although there is increasing evidence that postinjury marriages are generally more satisfying, at present we know very little about the process leading to postinjury marriage.
In her exploratory study, Yoshida (1994) advanced the perspectives of 28 men with SCI in meeting and deciding about the future potential of others for a long term relationship. The author identified the single most critical question participants asked themselves was “Can the person deal with the life of someone in a chair?” (p. 184). The five major considerations participants described in considering the viability of a relationship with a prospective other were: 1) acceptance of the person with SCI; 2) awareness and assistance with accessibility; 3) altered divisions of labour; 4) comfort with sexuality; and 5) long term plans, such as having children, aging with a disability, caregiving involvement.

**The Influence of Societal Attitudes**

Courtship and marriage in the context of disability is likely influenced by societal attitudes towards persons with disabilities. Pervasive universal themes (archetypes) have been described across societies which characterize persons with disabilities variously as heroic, as saintly, or as worthless, as demonic, as fool (Neufeldt, 1984). It seems intuitive that individuals who choose to marry a person with a disability may be characterized in similar fashion. Historically, social ideals for marriages have not included a partner who is severely physically disabled. The reactions of others, including family and friends of both partners, and professionals, may be very protective and negative towards the union (DeLoach & Greer, 1981).

Goffman (1963) has thoroughly described the stigma associated with perceptible disability. Hahn (1981), who is disabled by polio, offered a personal case-study based on his own experience, suggesting only 5% of the nondisabled population may be receptive to a close relationship with person with a disability. Vash (1981) echoes Hahn’s sentiments commenting that a “…sizable proportion of the field of potential lovers will classify you peremptorily as noneligible for courtship consideration because of the functional and/or aesthetic liabilities you [a person with a disability] present” (p. 75).
In her overview of research on social attitudes towards persons with disabilities, DeLoach (1994) points out that diversity in individuals appears to elicit feelings of discomfort and discriminating behaviours, rather than an appreciation for difference. In particular, DeLoach reminds us that persons with disabilities are more readily accepted as co-workers and casual friends than as potential dating or marriage partners. This author comments that unless an individual can successfully negotiate the initial stage of a relationship wherein personal appearance is important, it is probable that a desired relationship will not develop. Also problematic in forging new relationships are the myths and generally unenlightened social views of sexual functioning for persons with a disability, such as reduced sexual desire or inability to have sex.

In light of prevailing social attitudes, it may be difficult to comprehend why an able-bodied individual would choose to marry someone with a permanent and significant physical impairment, such as SCI. The social stigma associated with physical disability, in particular, represents a barrier against sexual relationships with disabled persons which, for some nondisabled persons, may approach the level of taboo (Hahn, 1981). It seems choosing to marry a partner with many physical limitations, who may require considerable day-to-day assistance, can inspire concern, suspicion and/or disapproval from others; reinforcing the social devaluation of persons with a disability, as reflected in the following anecdotal writing.

DeLoach & Greer (1981) described a typology of individuals who are unusually attracted to disabled people; however, no data was provided to support their descriptors. These authors acknowledge but do not describe "...those valued individuals who relate well to everyone, disabled or not" (p. 95). Rather, attention is directed towards the walking wounded who are persons so deeply hurt in a previous relationship that they seek to enter a partnership with persons unlikely to emotionally harm them. The would-be-
dictators are very insecure individuals who need to dominate others and seek relationships with a disabled individual to fulfil a need to feel superior. Unsolicited missionaries underestimate the quality of life for disabled persons and seek to save them, most often at a spiritual level. The gallant gesturers consider themselves to be doing the person with a disability a favour, typically discount them as a sexual being and consider the relationship an opportunity for self-congratulation. It is most unfortunate that, considering the sparse literature dedicated to the spouses of disabled individuals, such a negative impression of the motivations of able-bodied partners is implied. On a more positive note, Guttman (1964), based on his clinical experience, suggested that the motivation to marry a person with SCI, in the majority of cases, appears to be love and affection, although he too cautions against self-serving motives on the part of an able-bodied partner.

Summary

The literature reviewed suggests that our understanding of the impact of SCI on both preinjury and postinjury marriages remains in its infancy. It appears that individuals with SCI are significantly less likely to marry and more likely to divorce as compared to expected rates for the general population. The impact of SCI on pre-existing marriages can exact a substantial emotional and physical toll on both the injured partner, and their spouses. Concerns about sexual performance and sexual identity, as well as perceptions of persons with disability as asexual may interfere with the development of new relationships and the maintenance of existing unions. Although empirical evidence gathered to date suggests that postinjury marriages are, in general, more satisfying than preinjury marriages, the perspectives of women who choose to marry men with a SCI have not been articulated.

At the present time we can only speculate about the experiences, issues, processes, motivations, and characteristics of able-bodied women who chose to enter a committed,
intimate relationship with a man with SCI. The writer is unaware of any published study which has specifically explored this substantive area and as such, there is only silence in response to the question of newly injured persons - what kind of woman/man could possibly find someone like me attractive? (Neumann, 1979). The images and implicit assumptions we hold about able-bodied partners are derived from a combination of clinical impressions, anecdotal evidence, personal testimony and societal attitudes towards disabilities in general.

**Purpose of Research**

The goal of this research is to develop a theoretical model describing the process by which able-bodied women decide to marry a spinal cord injured partner, and identify the issues and factors which are salient in making that commitment. The research questions which guide this project are very broad, and consistent with the goal of retrospectively exploring the participants' perspective and experience in making a marital commitment to an individual who has sustained a SCI.

Specifically, the initial research questions which drive this project are as follows:

1. What are the processes through which able-bodied women decide to make a marital commitment to a partner who has been spinal cord injured?
2. What are the specific issues, psychosocial factors, fears, challenges and sources of optimism which are salient in making this decision?

A discussion of the pertinent methodological considerations in designing this project is presented in Chapter 3.
Chapter 3

METHODOLOGICAL CONSIDERATIONS

Introduction

As previously stated, our present understanding of the impact of SCI on both preinjury and postinjury marriages remains in its infancy. Investigations of marital relationships and SCI are scarce and, to date, studies have relied heavily on quantitative approaches (i.e. Crewe & Krause, 1988; DeVivo, et al. 1995; DeVivo & Fine, 1985; Simmons & Ball, 1984) which have provided frequency data, primarily on changes in marital status (marriage and divorce) and preinjury versus postinjury marital satisfaction/adjustment. The writer is unaware of any published study which has specifically addressed able-bodied women's experiences in meeting, developing romantic relationships, and marrying men with SCI.

As this substantive area of study is essentially uncharted, the salient variables have yet to be identified so as to permit a theory testing approach. Therefore, an inductive methodology was sought which permitted the derivation of personal meaning, patterns, themes, and categories of analysis from the informants, as opposed to imposing the preconceived ideas of the researcher (Patton, 1990). Furthermore, as it was anticipated that the population of interest would be relatively small and challenging to recruit, a qualitative, exploratory design was desirable to maximize the richness of the data collected. Specifically, this research project employed a grounded theory approach.

Grounded Theory

Grounded theory was developed to provide a rigorous and systematic approach to qualitative research which would also encourage the researcher's creativity, an essential feature in the discovery and development of new insights into an area of study (Glaser & Strauss, 1967; Strauss & Corbin, 1990). The intent of a grounded theory study is to
comprehend the concerns, actions, and behaviours of a substantive group and explain those patterns at a higher level of abstraction - a theory (Chenitz, 1986). This inductive methodology is designed to develop explanatory theory about social and psychological phenomenon and has the potential to make its greatest contribution in areas where little research has been done (Chenitz & Swanson, 1986; Strauss & Corbin, 1990).

The grounded theory approach, with its reliance on the inductive examination of data for theory generation, requires that researchers remain close to their data. Data collection and analysis are conducted concurrently, guiding subsequent theoretical sampling which is focused on development of the emerging theory (Rennie, Phillips & Quartaro, 1988). The primary techniques employed in the grounded theory approach to data analysis are coding and the constant comparative method.

**Coding**

During the coding process the data is condensed, labelled, categorized, conceptualized at a more abstract level, and rearranged by making connections between the categories. Grounded theory analysis uses three major types of coding: open coding, axial coding, and selective coding.

During open coding, data is broken down, examined, compared, conceptualized and categorized. At this stage, codes range from simple descriptive labels to more general abstract conceptual categories (Charmaz, 1983). By making comparisons and asking questions of the data (what is this?; what does this represent?) concepts that appear to pertain to the same phenomena are tentatively grouped and represent a category. With the development of categories, other concepts may be recognized as properties/subcategories of emerging categories. The process of open coding therefore leads not only to the discovery of categories, but also to the discovery of their properties and dimensions.

Axial coding represents the procedures which rearrange the data by making
connections between categories and their respective subcategories. This is accomplished by focusing on the causal conditions which lead to the phenomenon, the context, the action/interactional strategies by which a phenomenon occurs and the consequences of these strategies. The model which guides systematic thinking about the data is as follows:

\[
\text{CAUSAL CONDITIONS } \Rightarrow \text{ PHENOMENON } \Rightarrow \\
\text{CONTEXT } \Rightarrow \text{ INTERVENING CONDITIONS } \Rightarrow \\
\text{ACTION/INTERACTION STRATEGIES } \Rightarrow \text{ CONSEQUENCES}
\]

Selective coding refers to the process of determining the core category (the central phenomenon) and systematically relating it to other major categories. At this integration stage of the analysis a story line describing the core category is explicated, subsidiary categories are integrated, the relationships are validated against the data and further refinement of the categories is completed. It is important to recognize that the various modes of coding do not necessarily occur in stages, and particularly during open and axial coding, researchers will typically alternate between the various analytic procedures (Strauss & Corbin, 1990).

**Constant Comparative Method**

The discovery mode of grounded theory involves the systematic categorization of data while resisting theorizing until patterns emerge during the coding process (Rennie, et al. 1988). For example, after two interviews have been completed and initial substantive coding of concepts and themes is completed, the two narratives are then compared to identify similarities and differences. Similar codes are subsequently grouped together under higher order, relatively more abstract concepts - categories. Categories continue to emerge and evolve as more data is collected and analyzed. The patterns and connections between the categories (theoretical codes) form initial hypotheses about the relationship between categories which are then tested against the data and/or guide subsequent data collection, a process referred to as theoretical sampling. In this fashion, the grounded
theory researcher alternates between inductive data collection and analysis and deductive hypothesis testing and verification, often relying on feedback from informants to validate findings (Huberman & Miles, 1994).

Data collection continues until the categories are saturated and one core category is discovered which best conceptualizes how a phenomenon is processed (Chenitz & Swanson, 1986). Theoretical saturation is deemed to have occurred when no new or relevant data is emerging regarding a category and the relationships between the categories are established and validated (Glaser, 1992; Strauss & Corbin, 1990). The discovery of a core category is an essential feature of a quality grounded theory and is at the heart of the integration process (Strauss & Corbin, 1990). This process leads to the development of a grounded theory.

A vital part of data analysis is memoing. Memos are ongoing, conceptual notes which the researcher uses to document ideas and conceptual thinking about the data - the analytic process. In earlier stages of the research they guide data collection. By reading, rereading and sorting them, memos aid in the discovery, integration and organization of categories around a core category, indicate where further clarification is necessary, and facilitate the development of theory (Strauss & Corbin, 1990).

**Theoretical Sensitivity**

A very important concept within the grounded theory approach is the theoretical sensitivity. This term refers to the personal qualities of the researcher and reflects his/her level of knowledge and insight, ability to understand and give meaning to the data, and the capacity to recognize pertinence (Glaser, 1992; Strauss & Corbin, 1990). In qualitative methodology, the creditibility of research findings rely heavily on the skill, sensitivity and integrity of the researcher (Patton, 1990).

As an able-bodied woman married postinjury to a quadriplegic man, the researcher
has direct personal experience with the substantive focus of this study. By living the experience, the potential for increased theoretical sensitivity to the domain was considered to be a possible benefit. As well, it was hoped that shared experiences would facilitate the development of rapport with participants and enhance the richness of the data obtained. While the researcher’s personal experience was considered an asset, it had the potential to bias what was significant and meaningful to the participants, as they told their stories from their own perspective (Corbin, 1986). This issue was monitored in a number of ways: (1) by politely declining to discuss the researcher’s personal experience with participants until all data had been collected; (2) by making explicit preconceptions and assumptions about potential findings in a journal prior to the commencement of data collection; and (3) as required through the ongoing process of memoing, which is an integral part of the grounded theory method.

Although the researcher has had previous experience with qualitative analysis, a potential weakness was deemed to be a lack of experience with grounded theory methodology. Extensive reading and regular consultation with the investigator’s supervisor and other researchers conducting grounded theory studies was a means of compensating for this identified deficiency. The researcher’s clinical experience with interviewing was considered an asset which could improve the quality of data collected.

**Contentious Issues in Grounded Theory**

Qualitative methodologies have been the subject of considerable debate and criticism, particularly when inappropriately evaluated against the canons of hypothetico-deductive methods - random assignment of participants, large numbers of participants, hypothesis testing, experimental control and statistical analysis (Rennie, et al. 1988). It is well beyond the scope of this paper to address the long-standing scientific debate over how to best study and understand our social world. Both qualitative and quantitative
approaches have inherent strengths and weaknesses. These methodologies represent different approaches which may be more or less appropriate for different types of research questions (Patton, 1990).

Qualitative methods in general, and grounded theory specifically, are oriented toward exploration, discovery and use an inductive logic to guide research design (Patton, 1990). An important benefit of the approach is that it facilitates access to areas of human experience which often are difficult to address with traditional research methods (Rennie, et al. 1988). Qualitative methods permit the use of data which does not lend itself easily to quantification (Corbin, 1986).

Until recently, there have been few generally agreed upon canons for the conduct of qualitative research. Huberman and Miles (1994) suggest there is a lack of consensus for establishing criteria by which qualitative findings are to be considered plausible or convincing. The particularly contentious issues of theoretical sampling and sample size, and threats to the credibility of findings will be briefly addressed below. It is recognized that many of these criticisms are levied against qualitative approaches in general; however, they will be discussed here from a grounded theory perspective.

Theoretical Sampling and Sample Size

Generally, qualitative research designs focus in depth on relatively small samples which have been selected purposefully as information-rich cases for study (Patton, 1990). In contrast to the quantitative investigator who randomly selects cases and seeks population representativeness, the grounded researcher searches out initial participants specifically because they are knowledgeable about the phenomena of interest, seeking the representativeness of concepts. Guided by the iterative process of data collection and analysis, further sampling is theory driven to elaborate, refine and/or test the validity of emerging categories and their relationships (Chenitz & Swanson, 1986). Patton (1990)
argues that "random probability samples cannot accomplish what in-depth, purposeful samples accomplish, and vice versa" (p. 185).

At the outset, the grounded theorist cannot specifically state the number of participants required to reach saturation, the point at which no new information is forthcoming from data collection, although this generally occurs after the analysis of between five to ten protocols (Glaser & Strauss, 1967; Rennie, et al. 1988).

**Threats to Credibility of Findings**

Validity and reliability are critical issues in evaluating the integrity of any research findings; however, measuring grounded theory results against positivistic canons developed specifically within quantitative paradigms is misguided (Strauss & Corbin, 1990.) The approximate analogs to quantitative measures of reliability and validity are typically conceptualized as adequacy of evidence and credibility of the research (Chenitz & Swanson, 1986).

Ultimately, the credibility of the emergent grounded theory is its plausibility as an explanation; its comprehensiveness in accounting for the data, its grounding in appropriate procedures which inductively link the theory to the data, and its utility via generated hypotheses and the suggestion of new directions for future inquiries. Threats to the credibility of grounded theory have commonly focused on subjectivity, the validity of verbal reports as data and its generalizability (Glaser, 1978; May, 1986; Rennie, et al. 1988).

**Subjectivity.** Grounded theory methods are commonly criticized as too subjective and therefore, axiomatically, unreliable and invalid. It is increasingly acknowledged that conventional methods of controlling subjectivity (formal operationalism, experimental designs, quantified measurement, interpersonal distance from participants, etc.) cannot fully protect against bias, but may merely obscure it (Patton, 1990; Rennie, et al. 1988).
The grounded analyst supports his/her theory with adequate documentation of the emergent categories, justified by evidence from the data to aid the reader in assessing the credibility of reported conclusions (Glaser & Strauss, 1967). It has been suggested that the best test of grounded theory's integrity and ability to explicate the lived experience and fit is the reaction of the individuals under study (May, 1986).

**Verbal Reports as Data.** Concerns about the veracity of informants' verbal reports can be another source of scepticism. Clearly, verbal reports rely on access to conscious material, and retrospective accounts are highly dependent on recall. The absence of criteria with which to validate “truth” could be viewed as problematic; however, grounded theory is rooted in the symbolic interactionist tradition which is interested in understanding the inner or experiential aspects of human behaviour. Grounded theorists strive to understand the world from their participant's perspective - seeking to know the individual's construction of meaning for events in their lives (Chenitz & Swanson, 1986).

Philosophical beliefs about the nature of truth influence a reader's reception of research findings. The notion that a singular material truth awaits discovery and validation is more closely associated with logical positivistic paradigms. Naturalistic approaches accept the idea of multiple realities and the relativity of truth, which is viewed as ultimately context specific. Qualitative researchers strive for fairness and balance in the treatment of multiple perspectives, and truth is interpreted to mean reasonably accurate and believable data rather than true data in an absolute sense (Patton, 1990). The discovery of similar experiences across a number of different participants, by means of the constant comparative method, increases the credibility of informants' individual accounts (Rennie, et al. 1988).

**Generalizability.** Grounded analyses typically involve a relatively small number of specifically selected informants, raising questions as to the generalizability of any emerging
theory. As stated, the goal of sampling is to develop an understanding of the conditions under which the phenomena occurs and how, where, and why it occurs. While generalizability in a conventional sense is not the goal of grounded analyses sampling techniques, through replication of findings across a small number of participants, the researcher gains insight into a commonly experienced phenomenon. The grounded researcher, in seeking to develop substantive theory, strives for a powerful, meaningful explanation for a specific set of circumstances or situations, which may or may not be generalizable to other settings (Huberman & Miles, 1994; Rennie, et al. 1988; Strauss & Corbin, 1990). Verification and extended generalizability is left to subsequent studies within the grounded theory paradigm (Rennie, et al. 1988).

Strategies employed to maximize the credibility of the present research are addressed in Chapter 4.
Chapter 4

DESIGN OF THE STUDY

Purpose of Research

The primary goal of this study was to explore, articulate, and theoretically conceptualize the processes through which able-bodied women decide to make a marital commitment to a male partner who has previously sustained a permanent spinal cord injury. A simultaneous objective of this project was to specify the issues and factors which were salient to the women in making this decision.

As discussed in Chapter 3, the grounded theory methodology was used in this exploratory research. The population of interest was women who had made a postinjury marital commitment to a male partner with paraplegia or quadriplegia as the result of a SCI. It was the researcher's intention to sample participants until no new information was forthcoming, a point referred to as saturation. It was anticipated that a minimum of 5 or 6 participants would be required.

Participant Recruitment and Selection

Initial Contact

Female participants were actively recruited with the assistance of the Canadian Paraplegic Association (Alberta)(CPA). All participants were required to meet the following criteria for inclusion in the study:

- over 18 years of age;
- made a postinjury marital commitment to a male with a spinal cord injury which resulted in permanent disability (paraplegia or quadriplegia);
- able-bodied and free of any life-threatening medical condition at the time of their marital commitment (as determined by self-report); and
- willingness to participate in the study.
The participant's current marital status was not a criterion for participation and, therefore, individuals who were divorced or who did not follow through with their commitment to marry would have been included if any had been located. As the method of recruitment was through registered CPA members (predominately injured partners - in this case, male), it was perhaps not surprising that such cases were not identified. It is unlikely that men would refer their former romantic partners to a researcher and therefore the opportunity to talk to women involved in terminated relationships was undoubtedly very reduced.

Participants were recruited in two ways: by a letter from CPA inviting them to participate and by an advertisement in Spinal Columns (Spring, 1996), a tri-annual publication of CPA. CPA staff identified 15 Calgary members whom they were aware had married subsequent to their spinal cord injury, and an initial recruitment letter along with an "Information for Participants" sheet detailing the study, was forwarded to these prospective participants (see Appendixes A and B). The recruitment letter was followed up by a telephone contact from CPA staff at which time permission was requested to provide the researcher with their name and telephone number. This recruitment strategy was designed to ensure that participants would feel free to decline participation in the study, should they wish to do so.

Of the identified 15 prospective participants, CPA was unable to contact five individuals. Another two did not meet the study criteria; two declined; leaving six who agreed to have their name forwarded to the researcher.

Two additional participants contacted the researcher directly as a result of the Spinal Columns advertisement and volunteered to participate, bringing the total number of informants in this project to eight.

A description of pertinent participant demographic information is provided in
Table 1. The selection of participants resulted in a balanced representation of:

- employed and unemployed partners;
- paraplegic and quadriplegic partners;
- women who were caregivers and noncaregivers to their partners.

**Pre-interview Contact**

After referral from CPA, a pre-interview telephone contact was made by the researcher to answer any questions potential participants might have and to invite involvement in the study. All contacts were advised that each participant in the study would be interviewed twice, with the initial interview expected to last between 1 and 2 hours. The second interview was described as an opportunity to clarify and elaborate on the information obtained during the first meeting, and could also be used to address issues identified during interviews with other participants. It was estimated that the total time commitment for the two interviews would be between 2 and 4 hours.

All individuals contacted by the researcher volunteered to participate in the project, and a mutually convenient time and location for the first interview was negotiated. Six participants were interviewed at the University of Calgary, while the other 2 participants requested the interviews be conducted in their respective homes.

**Instruments**

**Interview Guide**

An interview guide with broad, general, open-ended questions and probes was developed to elaborate the personal narratives of the participants' experiences in making a marital commitment to a partner with a SCI (see Appendix C). The interview included questions focused on relationship history; impact of the partner's disability on the relationship; social attitudes; personal concerns; the decision-making process; and sources of confidence in ultimately deciding to make a marital commitment. Participants were also
Table 1

Participants' Demographic Information

<table>
<thead>
<tr>
<th>Participant</th>
<th>Age (at 4/30/96)</th>
<th>Length of Marriage (at 4/30/96)</th>
<th>Current Occupation</th>
<th>Lived together prior to Marriage</th>
<th>Previous marriage (self)</th>
<th>Husband employed</th>
<th>Husband's Level of SCI</th>
<th>Provide daily care</th>
<th>Children</th>
</tr>
</thead>
<tbody>
<tr>
<td>Penelope</td>
<td>43 yr. 1 mo.</td>
<td>7 yr. 8 mo.</td>
<td>Licensed Practical Nurse</td>
<td>Yes (1.0 yr.)</td>
<td>Yes (1)</td>
<td>No</td>
<td>C 5-6</td>
<td>Yes (P/T)</td>
<td>No</td>
</tr>
<tr>
<td>Sara</td>
<td>37 yr. 8 mo.</td>
<td>9 yr. 10 mo.</td>
<td>Physiotherapist (P/T) Homemaker</td>
<td>Yes (2.0 yr.)</td>
<td>Yes (1)</td>
<td>No</td>
<td>C 5-6</td>
<td>Yes (P/T)</td>
<td>Yes (2)</td>
</tr>
<tr>
<td>Karen</td>
<td>32 yr. 6 mo.</td>
<td>7 yr. 6 mo.</td>
<td>Homemaker (former Program Co-Ordinator)</td>
<td>No</td>
<td>No</td>
<td>Yes (P/T)</td>
<td>C 5-6</td>
<td>No</td>
<td>Yes (2)</td>
</tr>
<tr>
<td>Lisa</td>
<td>28 yr. 0 mo.</td>
<td>0 yr. 11 mo.</td>
<td>Cook/Housekeeper</td>
<td>Yes (2.5 yr.)</td>
<td>No</td>
<td>No</td>
<td>T 12</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>Emily</td>
<td>40 yr. 11 mo.</td>
<td>1 yr. 11 mo.</td>
<td>Occupational Therapist Semi-Prof. Singer</td>
<td>Yes (4.5 yr.)</td>
<td>Yes (2)</td>
<td>Yes (Self)</td>
<td>T 4-5</td>
<td>Yes (P/T)</td>
<td>Yes (2)*</td>
</tr>
<tr>
<td>Janice</td>
<td>23 yr. 11 mo.</td>
<td>1 yr. 4 mo.</td>
<td>Music Teacher</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>T 12</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>Donna</td>
<td>30 yr. 8 mo.</td>
<td>2 yr. 7 mo.</td>
<td>Student</td>
<td>Yes (1.5 yr.)</td>
<td>No</td>
<td>Yes (P/T)</td>
<td>T 6</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>Ann</td>
<td>39 yr. 3 mo.</td>
<td>1 yr. 10 mo.</td>
<td>Homemaker (former Nurse)</td>
<td>Yes (3.5 yr.)</td>
<td>Yes (1)</td>
<td>Yes (P/T)</td>
<td>C 6</td>
<td>Yes (P/T)</td>
<td>Yes (1)*</td>
</tr>
<tr>
<td>Mean</td>
<td>34 yr. 6 mo.</td>
<td>4 yr. 4 mo.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

F/T = full-time
P/T = part-time
* children from previous marriage
encouraged to discuss any relevant issues which were not specifically raised by the investigator.

All participants were asked essentially similar questions during the first interview, however, the semi-structured nature of the guide allowed for discretion in seeking additional information and/or following leads introduced by the interviewees.

Data Recording and Transcription

With each participant's consent, all individual interviews (initial and follow-up) were audio taped, the tapes were duplicated for safekeeping, and transcribed verbatim by a paid research assistant. All transcriptions were checked back to the original audio tape by the researcher and maintained in password protected computer files. Printed copies of transcriptions were maintained in a secured location in the researcher's home office.

The focus group meeting was also audio taped; however, consistent with Strauss and Corbin's (1990) recommendation, verbatim transcription was very selective. After listening to the audio tapes, only those sentences or passages which specifically refined and/or expanded the emergent theory were transcribed and included in the analysis.

Two principal strategies were used to protect the participant's identities. Pseudonyms for both the women and their partners were substituted in the transcription process and are used throughout this report. A single list of the proper names of all participants and their corresponding pseudonyms was maintained in a password protected computer file in the researcher's home office.

Procedure

Interview Rehearsal

A female colleague was recruited to allow the researcher to become comfortable with the procedure and to field test the questions developed for the semi-structured interview. Although the researcher has clinical experience with interviewing techniques, it
was deemed important to identify any potential difficulties with comprehension from the interviewee's perspective. The pilot interview was conducted and evaluated prior to interviewing study participants.

Feedback from the pilot interviewee suggested the Interview Guide was coherent and flowed in a logical manner. Only two minor changes were made to the interview protocol. Firstly, a final, broad question was added (Item 15) inviting informants to share any relevant information which the interviewer had not specifically inquired about. Secondly, as the initial plan to use pseudonyms during the interview process proved to be awkward and unnatural, it was decided to use proper names during the interviews and substitute pseudonyms during the transcription of audio tapes.

**Initial interview**

All participants were interviewed by the researcher. The first interview began by clarifying any queries from participants, obtaining written consent to participate in the study (see Appendix D) and collecting demographic information (see Appendix E). It was explained to all participants that while the researcher would be more than willing to discuss her own experience, she would reserve revealing any personal details until after both interviews had been completed. This caveat was emphasized to preserve rapport and avoid entering into a two-way discussion and/or influencing the responses of the participants.

The length of the initial interviews ranged from 45 minutes to 2 hours 20 minutes, with an average duration of 1 hour 42 minutes.

**Follow-up Interview**

After the first interviews had been conducted and resulting transcriptions analysed, participants were recontacted to review and verify the researcher's summary and test emergent themes and issues against the participants’ experience. During the follow-up
interview, questions specific to the participant were also advanced to clarify and fill in gaps of understanding.

An omission in the original interview guide was identified during the analytic process; namely the personal meaning attached to the decision to cohabitate (for those who did) and make a marital commitment. During follow-up interviews all informants were asked to elaborate on the personal significance and meaning of living together and/or marrying their partner.

Data Analysis

The ambition in using the grounded theory method is to generate abstract concepts and describe their relationship to each other in a manner which will explain and account for the variation in behaviour with a substantive area of interest (Glaser, 1992). To accomplish this goal, data collection and analysis occur concurrently in an iterative, nonlinear manner. As stated earlier, the various modes of coding do not necessarily occur in discrete stages of data analysis; rather they can occur within a single coding session.

Variability in the choice of analytic units can be found across grounded theorists. While Glaser (1978) recommended line by line analysis, this researcher coded meaning units conveyed by the informants as suggested by Rennie, et al. (1988). For example the phrase "...I would find myself like going to work early to go to ICU to see how he, how he'd been through the night, and then I'd find myself sort of staying a little late after work going to ICU to see how he had done all day kind of thing" was considered to represent a meaning unit and during open coding was descriptively labelled as seeking contact.

The first few interviews were coded in a relatively descriptive fashion, with terms for concepts and categories often directly reflective of the informant's discourse. Employing the comparative method of analysis, similarities and differences in the personal narratives of the informants were identified. Similar concepts were grouped to develop
categories and each unit of analysis was assigned to as many categories as seemed appropriate. As the analysis proceeded, more abstract, higher-order categories were derived from the grouping and regrouping of existing concepts, categories and dimensions. Data collection continued until no new information was obtained in the interviewing process. Saturation of codes and categories was deemed to have occurred when coding no longer resulted in the further development of categories and their properties.

Categories and labelled phenomena were rearranged throughout the data analysis by making comparisons between the data, asking ongoing questions of the data, and generating hypotheses about possible relationships between identified categories. These provisional hypotheses were subsequently tested both against the data and with participants during the follow-up interviews. In this way, data analysis moved between inductive and deductive thinking in a constant interplay between proposing and checking statements of relationship (Strauss & Corbin, 1990).

Triangulation and Theory Validation

To strengthen the research design, a number of validation procedures were established and followed. As a check on the conceptual field of the primary investigator, the researcher’s supervisor inspected a subset of the interview transcriptions and data coding to provide an independent examination of the categorizing process. In this way, concerns, over-interpretations, or inconsistencies would have been identified and discussed if they had been found to exist.

The integrity of the data was enhanced by inviting feedback from informants on at least two occasions. As stated, detailed summaries of the initial interview were negotiated with each participant. This data verification process confirmed that the researcher’s account of the interview accurately reflected informants’ meaning and perceptions.
Participants were asked to verify the content of the researcher's summary statements and to correct any misconceptions or inaccuracies. These summaries are presented in Chapter 5.

As previously stated, during the second interview, the researcher sought to go beyond mere elaboration of previous points raised, but also tested emergent categories, properties, and tentative hypotheses about their relationships to each other.

To validate the emerging theory, all informants were invited to participate in a focus group meeting at the researcher's home when the preliminary data analysis was completed. Two of the participants declined to attend to ensure their continued anonymity, while 2 informants did not attend for reasons unknown to the investigator. In total, 4 of the 8 participants attended the presentation of preliminary data analysis results and emergent theory. Participants were given the opportunity to have input and provide feedback on the plausibility, explanatory power and fit of the researcher's findings.

A final audit on the findings of this investigation relates to the fashion in which the extant literature is used in a grounded theory methodology. A complete review of all relevant research beforehand is not considered essential, rather the literature is used to sensitize the researcher to concepts and gaps in knowledge. After data collection and analysis is completed, an entirely different body of literature may be sought to link emergent theory to existing research and theory. In this way, the extant literature can act as a supplementary source of validation of findings and/or establish differences from published literature (Strauss & Corbin, 1990).
Chapter 5

PARTICIPANTS

Introduction

To ensure the validity of the researcher's interpretive summaries of the initial interview, each participant was provided with the opportunity to elaborate on issues and/or correct, if necessary, the researcher's succinct description of the major issues and themes which emerged during the semi-structured interview. These mutually agreed-upon summaries are reproduced here to give the reader a better understanding of the women who participated in this investigation. As indicated earlier (see Chapter 4), pseudonyms have been used throughout this report to protect the identity of the participants and their spouses.

Negotiated Summaries

**Penelope**

Penelope is a 43 year-old licensed practical nurse. Her 35 year-old husband, Kent, was injured in 1978 and is a C5/6 quadriplegic. Kent is not employed, however, he receives an honorarium for his participation in a local injury prevention program. This is Penelope's second marriage and Kent's first marriage. They have been married for over 7 years and do not have any children. Penelope describes herself as a mothering/nurturing type of person and thinks that may be why she chose to enter the nursing profession.

Penelope met Kent met in the summer of 1987 when he was admitted to a local hospital where she was employed in a spinal cord rehabilitation unit. Although she was living with a blind man at the time, Penelope was very attracted to Kent and the couple bonded during his hospital stay. She found this somewhat puzzling as she described Kent as "scrawny and unhealthy" and generally unconcerned about his appearance or health. For professional reasons, Penelope restrained her feelings and actions; however, after Kent
was released from hospital their relationship very quickly developed and she left her previous partner. Penelope and Kent began living together in the Fall of 1987, became engaged in February, 1988 and were married in August of 1988.

Penelope reports she had no hesitation about becoming romantically involved with Kent and was well aware of the work involved, both as a result of her professional experience and because very early in the relationship she took primary responsibility for providing Kent's care. Although Kent required assistance and she admitted caregiving can be physically exhausting, Penelope described her partner as very independent. Penelope wonders if she would ever enter a relationship with someone who was totally dependent on her. [The couple presently has an attendant who provides home care to Kent on the days Penelope is working, providing her with considerable relief from caregiving responsibilities.]

Penelope considered her relationship with Kent to be more open, honest and trusting than any previous relationship she had been involved in and she attributes this to "the way Kent is". The couple communicated well from the beginning and Penelope chose to be more outspoken and assertive in this relationship than she had been in her previous marriage. Penelope describes Kent as very supportive and encouraging and this has helped to build her self-esteem, something she reports has always been a problem for her.

Kent's disability has required that Penelope adjust to restrictions on some activities due to accessibility issues. This can be a source of arguments for the couple as Penelope often chooses not to go places where they will have to be dependent on others to negotiate stairs, etc., whereas Kent is more easy going about these matters. Penelope has also come to accept the need for planning and the loss of spontaneity in the couple's activities.

Perhaps the biggest consideration for Penelope in deciding to marry Kent was the
consequent loss of his funding (A.I.S.H.) upon marriage. Penelope always assumed that she would be the wage-earner in the family and, although she recognized there would be financial challenges for the couple living only on her income, she claims the issue was not a priority in deciding to marry. The couple agreed prior to marriage not to have children, in part because of Penelope's disappointment with attempts to conceive during her previous marriage and her subsequent unwillingness to go through that process again. As well, the couple mutually agreed it would be too difficult a lifestyle for Penelope to assist Kent, look after a child, as well as be the wage-earner in the family.

Penelope describes herself as someone who does not think too much about the future although she wondered about their age difference and what might happen as she got older and found it more difficult to help Kent with transfers and his other physical needs. Penelope decided to marry Kent quite quickly. Penelope had confidence in her relationship with Kent and felt she was doing the right thing as she did not have any reservations about marrying, nor did she foresee any problems for the couple which they could not handle based on their relationship to that point.

Kent's parents welcomed Penelope to the family and continue to be very supportive both instrumentally and emotionally. Penelope hypothesizes that Kent's parents may have been somewhat relieved by their marriage as they had been primarily responsible for providing care and assistance to their son since his injury. Penelope's parents live in Ontario and did not meet Kent until the wedding. Although at one point her mother inquired about the extent of Kent's physical limitations, in general, her family did not express any concerns about the marriage. Penelope did not consider her family's reaction had any influence on her decision to marry Kent.

Lisa

Lisa is a 28 year-old cook/housekeeper in a seniors' lodge. Her 27 year-old
husband, Steve, was injured in 1991 and is a T-12 paraplegic. Steve is currently seeking employment. This is the first marriage for both Lisa and Steve. The couple have been married for 1 year and do not have any children. Lisa reports Steve was her first and only boyfriend.

Lisa met Steve through a mutual friend in late 1992 and instantly liked him. The relationship progressed very quickly and Lisa characterized it as a mutual love at first sight experience. Within a month they began dating and approximately one month later the couple moved in together. From the very beginning, talking has been and continues to be a very important part of the couple's relationship.

Lisa emphatically states she had absolutely no hesitations about becoming romantically involved with Steve, although he was apparently initially concerned about her reactions to his disability. Lisa had no previous, direct experience with physical disability; however, she attributes her willingness to "look past the chair" to her upbringing which taught her to accept people for who they are. As well, Lisa states she was overweight when she met Steve and she appreciated his ability to overlook that.

Lisa describes Steve as very independent and "...could do everything but walk". She was impressed by and respected Steve's determination to live a full life and persevere to overcome the obstacles which face any individual living in a wheelchair. Lisa occasionally helped Steve overcome physical barriers (i.e. stairs) and admits to experiencing frustrations with people's rudeness in social settings and general lack of awareness and intention to make the environment accessible to all.

Both Lisa's and Steve's families readily supported their relationship. They became engaged within the first year of their relationship and another year later they were married. Lisa trusted her "gut feeling" that Steve was the man she wanted to marry and remained unconcerned about any challenges which Steve's disability might present in the future.
Lisa felt assured that Steve would always be good to her and she was confident they would continue to be honest with each other and communicate well. Honesty and open communication represented two critical elements in a good marriage for Lisa.

Sara

Sara is a 37 year-old physiotherapist. Her 40 year-old husband Jack was injured in 1980 and is a C5/6 quadriplegic. Jack is not employed. This is Jack's first marriage and Sara's second. The couple have been married for almost 10 years and have two young boys together, aged 6 and 4 years.

Sara met Jack in January of 1982 when she was working at the extended care hospital where he was residing. Sara was married at the time and it was not until about a year later, when she became separated from her first husband, that the relationship evolved into a romantic one. At that time, Jack began coming out of the hospital on weekends to spend time with Sara and then in 1984 they went on a holiday to Hawaii together. In April, 1984, Sara and Jack began living together and approximately 2 years later, in June, 1986, they were married.

Although Sara did not have any prior experience dating someone with a disability, she states she did not have any hesitations or concerns about becoming involved with Jack. From the very beginning of their relationship Sara performed caregiving duties for Jack; however, it was very important to her that he was romantically interested in her and that they were together for that reason, rather than the convenience of her providing nursing care and his dependence on her. Sara reports she ultimately felt confident that Jack cared for her and, knowing that, she accepted the caregiving responsibilities as something that just had to be done. Sara believes her occupational training was useful in
familiarizing her with techniques to deal with the physical demands of caregiving.

Sara felt respected by Jack and found him to be very kind and caring towards her. She reports she left a very physically, emotionally, and verbally abusive first marriage to a man she had been involved with since the age of 14 years, and "...couldn't believe that someone [Jack] could be this nice to you...". Sara states she and Jack cared for each other very deeply and genuinely enjoyed, and continue to enjoy, each other's company. She describes them as "thinking alike". Jack emphasizes good communication and Sara states she has improved tremendously in this area of their relationship. Sara describes herself as gaining more self-confidence and independence in her relationship with Jack, primarily because of his encouragement, trust, respect and love.

Sara advised she has had to adjust to some restriction of activities and a slower pace of life with Jack; however, she accepted this and suggests "...it didn't stop us going places and doing things", such as enjoying outdoor walks, travelling and socializing with Jack's large family. Sara also had to adjust to Jack's occasional periods of poor health which sometimes required her to attend events or go places alone. She encourages Jack to take full responsibility for his health. Rather than assuming responsibility for Jack's physiotherapy she suggests he redirect his health concerns to the medical profession. In general, Sara admits she tries to encourage and support Jack's attitudinal and physical independence as much as possible.

The couple's decision to marry was made quite quickly. After living together for approximately 2 years, Sara had complete confidence in the relationship and readily committed to Jack's spontaneous proposal that they marry on a couple of days' notice.

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1The couple now have an attendant who provides daily home care and this helps to separate caregiving from their personal relationship, as well as relieve Sara of primary responsibility for Jack's care.
Sara reported she would not have married Jack unless she was convinced that it would be a successful union. At the time they decided to marry, Sara and Jack both presumed they would not have any children, and that was acceptable to both of them. Sara claims it was not important to her whether the couple was legally married or not; however, this was a significant issue for Jack.

At the time Sara became involved with Jack, her parents were living in Scotland. Initially Sara's mother expressed some concern about her involvement with Jack and asked Sara if she was "...sure you're not just taking your work home with you?". After Sara's parents had an opportunity to meet Jack and they were assured their daughter was happy, they were supportive of the relationship. Sara reports Jack's family welcomed her into their family from the beginning and fully support her relationship with their son.

Ann

Ann is a 39 year-old nurse who has retired very recently to be a full-time wife, mother and homemaker. Her 31 year-old husband, Peter, was injured in a sporting accident in 1982 and is a C6 quadriplegic. He is employed full-time as an electrical engineer. This is Peter's first marriage. Ann was previously married and she has a 9 year-old son from that relationship who resides with her and Peter. Ann and Peter have been married for almost 3 years.

In March of 1989, Ann met Peter at a social gathering and agreed to accompany him on a future business trip to provide caregiving services. Peter wanted to get to know Ann before they travelled together and a date was arranged. Despite Ann's poor first impression of Peter, he persisted in seeking contact with her and she changed her opinion about him as she got to know him better. In February, 1990 Ann and Peter began living together. Approximately 3 years later, in June, 1993, they were married.

Ann reports considerable direct experience with disability. Her grandmother was a
paraplegic and had been a very accomplished, independent woman. As well, Ann attended an integrated public school and had numerous classmates who were in wheelchairs. In her occupational role as a nurse, Ann worked in a spinal-neuro rehabilitation clinic and was well aware of the challenges facing individuals with SCI. Ann states she did not have hesitations about dating Peter because she has "...never seen a difference between" persons with a disability and able-bodied people. Her only criterion for dating someone in a wheelchair was that they were working or occupied in some kind of productive activity, such as volunteering.

From Ann's perspective, the couple shared many interests, values and goals for the future, as well as genuinely enjoying each other's company. She describes her partner as her "soulmate" and "best friend" - a man of great fortitude and optimism, who sets and accomplishes goals in his life. Ann spoke admiringly of Peter's unstoppable, independent attitude and adjustment to his SCI. Ann claims she has never "considered him disabled" and if she "thought he was disabled then [she] wouldn't live with him". Ann believes she and Peter have a good relationship and life together, which is based on strong team work and mutual nurturance.

Although Ann recognizes she went into the relationship with a clear idea of the caregiving demands that she was accepting, she admits she was not prepared for "how much of my life I had to give up for him" and how exhausting it would be to take primary responsibility for most of the tasks of daily living. During the first year of their relationship, Ann reports the couple fought primarily about issues associated with providing his care and his parents, and at a critical point decided to enter counselling. Through therapy, the couple were able to learn how to fight constructively and their relationship improved dramatically. Peter and Ann have developed many strategies to minimize the impact of caregiving tasks on her time. These approaches have been
innovative, solution-focused, and creatively targeted on the goal of maximizing Peter’s independence.

Ann supports, promotes and, in some cases, insists on Peter being independent whenever and wherever it is reasonably possible. She researches equipment and strategies that facilitate Peter’s independence, and has always searched for ways to overcome physical challenges and barriers. If Peter struggles to accomplish a task and/or it is not time efficient to expect him to do something, then Ann willingly helps him.

Ann finds her philosophy and actions have been, and continue to be, a source of conflict with her mother-in-law. According to Ann, Peter's mother prefers helping her son as much as possible, which Ann feels takes away from Peter's dignity and ultimately fosters dependency. In general, Ann feels Peter's parents have never approved of her or trusted her motivations, and they have never fully accepted her as the recipient of their son's affections. Ann reports they have been an interfering influence in her relationship with Peter and were "the only reason we didn't get married earlier". Over time and with the help of counselling, Peter was able to align his loyalties and commitment to Ann with the result that his parents have become a less disruptive force in the couple's relationship.

Although Ann's parents expressed some initial concerns about their daughter's involvement with someone in a wheelchair, after meeting Peter their fears were allayed. They subsequently welcomed him to the family and approved of the relationship. Similarly, Ann reports some of her friends voiced initial reservations about her choice of mate (particularly as she had been involved in a previous "awful marriage"), feeling she deserved a supportive, independent partner. Over time friends and both sides of the family, with the exception of Peter's mother, have been supportive of the couple's relationship and enthusiastic in their endorsement of the union.

Making a lifetime commitment to marriage was critical to Peter and ultimately
became a criterion for him continuing in the relationship. For Ann, as a divorced woman, marriage was less important and did not guarantee that anyone would live "happily ever after"; however, she agreed to marry Peter because it was so important to him to make a formal commitment. Because of the quality of their relationship, their love and affection for each other, and Peter's demonstrated character, Ann expected their marriage would be successful. The couple had developed strong, open communication with each other and had effectively resolved contentious issues between them. Humour plays an important role in their relationship and has been an effective coping strategy which appears to have enhanced the quality of their life together.

Ann described Peter as "such a good parent". He and her son have formed a strong, mutual, emotional bond with each other. Ann reports Peter prioritizes family life over career and has continually demonstrated his desire to always work on the relationship. This commitment is very important to Ann and not something she has personally experienced or witnessed in other relationships. For medical reasons, Ann is not able to have more children and the couple never planned to have a larger family.

Ann's main concern in making a long term commitment to Peter was his prognosis for a long life. Although he maintains a very healthy lifestyle, because of her nursing background Ann was very cognizant of the longer term health risks associated with SCI, admitting this has periodically concerned her. Financial considerations were never an issue for Ann or Peter. Ann is independently wealthy and Peter has an excellent job and is able to provide a good income for the family.

Karen

Karen is a 32 year-old full-time wife, mother and homemaker. Her 32 year-old husband, David, was injured in a sporting accident in 1982 and is a C5/6 quadriplegic. He is employed full-time as an engineer. This is both Karen and David's first marriage and the
couple have a 6 year-old son and 4 year-old daughter together. Karen and David have been married for over 7 years.

Karen knew David prior to his injury as they attended the same high school; however, they went their separate ways after graduation in 1981. In May of 1985, Karen started attending the same church as David. Karen was concerned about how David would react to her because she had known him preinjury. She avoided talking to him initially because she did not want to pull "...scars off old wounds". Eventually, David approached her and over the next two years a friendship developed. As the relationship evolved and Karen got to know David better, she recognized she was developing very strong feelings for him, which she confessed to him. Karen reports David was initially hesitant to fully trust her interest in him; however, with time, the relationship evolved into a romantic one. David gained confidence in Karen's love for him and eventually disclosed reciprocal feelings for her. In April, 1988 he proposed to Karen and the couple were married in October, 1988.

Prior to her involvement with David, Karen had direct experience volunteering/working with persons with developmental delay. Before disclosing to David that she was romantically interested in him, Karen contacted the C.P.A. to educate herself about the implications of SCI. After researching SCI and exploring the potential difficulties a couple might face when one of the partners had a SCI injury, Karen predicted she would be capable of meeting the challenges associated with David's disability. Her education about the sequelae of SCI was expanded by discussions with David and through his demonstration and explanation of physical aids to daily living. Coincidentally, in 1987 Rick Hansen was doing his worldwide Man in Motion Tour and Karen followed his romance with Amanda, a physiotherapist on his support team, with particular interest. She felt inspired by their story.
From Karen's perspective, she and David shared many interests, activities, personal values and future goals. It was very important to Karen that they had unity in their spiritual life, particularly as she knew she wanted to raise a family. Karen described David as a "pretty special guy" whose personal strengths, and the positive attitude with which he faced challenges each day, were inspiring to her. Karen reports that, from a very early age, she had a clear idea of the kind of person she wanted to marry. David clearly met all her criteria and after their first date Karen claimed she knew this was the man she wanted to marry, "wheelchair or not". Aside from sharing her spiritual beliefs, David was motivated, goal-oriented, of good character, with tremendous internal strength, and an excellent sense of humour. Karen also felt David had the qualities to be a good father and had the financial capability to support their shared desire that Karen be a full-time mother when their children were young. (Although Karen knew that David was unable to father children, the couple had agreed they would adopt.) When Karen went through a particularly difficult time emotionally, David clearly demonstrated his support and love for Karen. She reports she was very much in love with David and looked forward to building a life and family with him.

Karen and David did not live together prior to marriage. While they were dating David always had an attendant and she was not involved in providing any assistance with his self-care activities. However, about a month before their marriage, an incident occurred when it became necessary for her to provide emergency assistance to David. Although it was "no big deal" to Karen at the time, shortly thereafter she experienced concerns about her ability to handle David's disability. Although she felt unwavering in her love for David, she wondered if she was up to the challenges she might face. Through prayer and a returning faith in her personal ability to handle adversity and challenge, as she
had in the past, Karen's reservations about marrying David passed².

Karen describes David as having a very independent attitude towards his disability and reports he believes the best way to break through social attitudinal barriers is by demonstrating capability - a credo he adheres to daily.

Karen reports she has had very strained relations with her significant family members (her mother and grandmother - she never knew her father), who she described as troubled individuals. They reacted very negatively to her relationship with David. Although they professed to like David personally, the family expressed concern that Karen was taking on "just another project you're gonna give up tomorrow" and that it was pity that Karen was confusing altruism for something else. Neither Karen's mother nor grandmother attended Karen and David's wedding. Although Karen is saddened by her mother and grandmother's reactions to her marriage, with the help of individual counselling she has come to terms with what she considers her family-of-origin problems. Karen claims her family's negative reactions did not influence her decision to marry David in any way. David had become Karen's new priority and family. In contrast, David's family was very supportive and lovingly accepted Karen, approving of their relationship wholeheartedly.

Some of the couple's friends "had a hard time" with Karen and David's relationship. Karen became aware that some people were concerned she was marrying David for philanthropic reasons. In other instances, vague negative reactions were communicated very indirectly through other friends, innuendo, or via social withdrawal. Because these reactions were covert, Karen never fully understood these friends' concerns

²Karen advised that despite her thorough exploration of SCI, she found the first year of marriage very difficult as she adjusted to the realities of living with a partner with a severe physical disability.
about the couple's decision to marry. She also experienced social attitudes from casual acquaintances which seemed to either deify her and David, or pity them based on inaccurate assumptions about their quality of life.

Making a marital commitment was very important to both David and Karen, and she would not have considered beginning a life together without marriage. Karen's primary concern when marrying David was whether or not the couple would be able to adopt children and how she would manage without David's assistance in providing care for newborns. She recognized that there would be some restriction of their activities as a result of David's disability, however, she felt she had accepted those consequences. Financial issues were not a concern for the couple as David's injury was fully pensionable and he receives an excellent disability annuity. Furthermore, with his professional training David is able to generate a good income.

**Donna**

Donna is a 31 year-old full time student. Her 36 year-old husband, Tim, was injured in 1980 and is a T-6 paraplegic. He is employed full-time in marketing/sales. This is both Donna's and Tim's first marriage and they do not presently have any children, although they plan to have a family in the future.

In January, 1991 Donna met Tim through her roommate when she offered Tim and his friend, who was also paraplegic, a place to stay while they were skiing in the Kanaskis area. Donna had not had any previous experience with someone who used a wheelchair for mobility and claims she did not know what to expect when they arrived. She was very surprised by how independent Tim and his friend were, getting themselves in and out of her trailer and up and down the ski hill. Initially, Donna did not like Tim; however, as she got to know him better through group activities, her first impression changed and a friendship developed. Approximately 4 months later Tim and Donna began to date and in
April, 1992 Donna moved into Tim's home. The decision to live together was influenced by pragmatic reasons, a growing emotional closeness and the notion to "try it". Tim and Donna lived together for approximately 18 months until they were married in September, 1993.

As stated, Donna had very limited experience with disability. She learned about the physical consequences of SCI by talking with Tim and by observing him in the course of his daily activities. Donna described Tim as very independent and self-sufficient, and as not requiring any physical assistance from her or a professional caregiver, to perform activities of daily living. Donna very definitely promoted Tim's ongoing independence. She considered him very capable of looking after himself, as he had clearly demonstrated over the years prior to meeting her. Although the couple continue to help each other in a variety of ways, Donna made it evident she "...didn't want to be somebody's mom."

Donna reports she did not have any hesitations or concerns about becoming romantically involved with Tim and she found the practical impact of his disability on their life together to be fairly minimal. She does not feel the couple's activities were restricted to any great extent by Tim's disability. The couple share a love of outdoor activities and they enjoyed skiing, biking and hiking together. According to Donna, Tim is very adventurous and willing to try anything. For example, he was the first paraplegic in Canada to skydive!

Donna describes her relationship with Tim as the first serious relationship she had been involved in. Her previous relationships were enjoyable but were "never really heading anywhere". Donna found Tim to be very mature, sensible, emotionally strong, kind, considerate and caring. From her perspective, the couple were very compatible and had successfully resolved issues which had arisen between them. They shared mutual goals, including raising a family, and were equally supportive of each other's independent
goals. By living together, Donna felt confident the couple would not be faced with any "surprises". Prior to marriage, Donna and Tim attended couple counselling which helped them to learn to communicate effectively and to resolve conflicts in a constructive way.

Donna's parents and family liked Tim very much and approved of her relationship with him, neither expressing nor demonstrating any concerns to her. Donna has a very close relationship with her family and describes them as always supportive of her right to make her own choices in life, providing their unconditional love. Although Donna considers that Tim's parents regarded her as very "different", they supported their son's happiness and seemed to accept her as Tim's choice in a partner. Donna's and Tim's friends endorsed their relationship and, overall, the couple enjoyed a positive response from the people who were important to them.

Donna describes her decision to marry Tim as a gradual, evolving one. The couple developed long term goals together, which included the assumption that one day they would be married. They often discussed plans within the context of "when we're married". When Tim proposed to her Donna immediately accepted without hesitation. She considers herself a strong, independent, self-reliant woman; and, although she had every confidence in her relationship with Tim, she knew that she would never remain in an unhappy relationship. In view of the foregoing, Donna reports she was not apprehensive at all about making a marital commitment to Tim.

Janice

Janice is a 24 year-old self-employed music teacher. Her 27 year-old husband, Karl, was injured in a vehicle accident in 1989 and is a T-12 paraplegic. Karl has not been employed since his accident. This is both Janice and Karl's first marriage and the couple do not presently have any children.

Janice met Karl in July, 1988 while they were performing with their respective
dance groups. The couple had been dating and Janice described their relationship as "fairly serious" at the time of Karl's accident. Janice reports she loved Karl very much and after his injury "...it didn't matter to me [her] whether he had the use of his legs or not", although clearly the couple had numerous adjustments to face. Karl attempted to give Janice the opportunity and freedom to end their relationship; however, Janice was committed to the relationship and chose to stay. Prior to Karl's accident, Janice reports no direct experience with persons with a disability. Janice learned first-hand about the sequelae of SCI by sharing in Karl's traumatic experience. She was actively involved in all aspects of Karl's rehabilitation program, arriving at the hospital early each morning to spend the day with him. Janice insisted on learning how to provide assistance with self-care activities such as bowel treatments, showers, etc. After Karl was discharged from the hospital Janice described his adjustment to his disability as poor. Janice reports that "for the first couple of years he really felt sorry for himself" and was unmotivated, depending on her and his parents to do everything for him. Janice found Karl's mental attitude and lack of personal goals more difficult to accept than his physical disability and in April, 1993 she left the relationship. At that time Janice knew that she desired a life partner, not someone to look after. She states she had lost hope that the Karl she had once known would reemerge and assume responsibility for his life.

According to Janice, after they broke up, Karl became active in wheelchair sports and returned to school. When they ran into each other approximately 9 months later, Janice noticed a tremendous change in Karl's attitude and personal independence. Janice felt Karl was "back together" and the couple resumed their relationship essentially where they had left off. They became engaged in February, 1994 and were married in December, 1994.

From Janice's perspective, she and Karl shared many interests, friends and future
goals together. During the time they were apart, even though she dated, Janice remained very emotionally attached to Karl and found he was always on her mind. When the couple were reunited in December, 1993, Janice considered that they had developed a strong, stable relationship, had tremendous love and affection for each other, and with all they had been through together they "finally understood each other". She reports they were very compatible and had very open communication with each other. Janice admired Karl's courage in struggling to overcome his traumatic injury, acquired disability, and initial bitterness over his circumstances. She described Karl as very considerate and nurturing of her during the year prior to their marriage.

Janice reports her biggest concern about making a marital commitment to Karl again was that he might relapse into dependency on her; however, she saw no evidence of this former pattern. Janice and Karl did not live together prior to marriage. Before the couple married Janice insisted that he move out of his parents' home and live on his own to establish his personal independence. According to Janice, during that time Karl tried to do as much as he could on his own to ensure that she would not be burdened by his disability. As Karl demonstrated an improved attitude, Janice gained confidence that their union would be a successful one. As well, Janice describes herself as a very physically and emotionally strong person and she felt confident that she could handle any issues that the couple might have to face in the future because of Karl's disability.

Prior to marriage, the couple planned to have children in the future and discussed the various options available to them. Janice planned to continue teaching music and Karl aspired to start his own computer business.

\[3\]

\[3\]At present, Janice is concerned that her greatest fear prior to marrying Karl has materialized. During their marriage his attitude has once again deteriorated. She feels she has to pressure Karl to do anything and describes him as angry and resentful. She currently considers the future of their relationship to be at risk.
Although early in his rehabilitation Janice provided assistance with Karl's daily self-care activities, he was able to achieve a relatively high level of physical independence, assuming full responsibility for his own care without any help from Janice or an attendant. Janice stresses that the physical demands on her because of Karl's disability are fairly minimal, however, she recognized that if the couple had children and/or owned a house, her domestic responsibilities would increase significantly.

Janice states that her mother was initially very concerned about her relationship with Karl because she was so young when they became involved. By the time the couple planned to marry, Janice described her family as very supportive. She states they recognized that Karl "was very able" and did not represent a burden to Janice. In contrast, Janice had a more strained relationship with her future in-laws, particularly Karl's mother. She considers that Karl's parents have fostered dependency in their son and they resented Janice's attempts to promote Karl's independence and self-sufficiency. Janice is aware that her in-laws have questioned her motivations for remaining in the relationship and reports her mother-in-law has speculated that it was because of a possible financial settlement in the future from Karl's pending legal action in connection with his injury. She has coped with this distrust by distancing herself from her in-laws.

A number of Janice's and Karl's friends and acquaintances appeared surprised by their decision to marry. Janice felt that some people felt sorry for her, characterized her as heroic because of her commitment to Karl, and in some cases expressed concern and gave her unsolicited warnings about the choice she was making. Janice attributed the reaction from others to their general lack of understanding of Karl's disability and a minimization of his capabilities. Although these social responses to her impending marriage were upsetting, she chose to ignore such unsupportive comments and attitudes.

At the time of their marriage Janice and Karl's financial future was uncertain. The
couple planned to live in his government-subsidized, modest apartment and expected that they would share joint responsibility for their financial future. Janice recognized that financial pressures could be an ongoing challenge for the couple. As stated, Karl has instigated legal action in connection with his accident, however, the outcome was and remains unknown.

**Emily**

Emily is a 41 year-old occupational therapist/semi-professional singer. Her 43 year-old husband, Roger, was injured in 1981 and is a T5/6 paraplegic. He is self-employed in a variety of capacities. Roger is a musician; provides verbal transcription and braille production services; and conducts seminars and workshops on sensitivity training and disability awareness at the national, provincial and civic levels. Roger is also an active volunteer and is involved on several boards and task forces. This is Emily's third marriage and she shares custody of her two children, a 12 year-old son and a 9 year-old daughter, with her second husband. Roger was previously married and has two daughters, aged 19 years and 16 years, who do not reside with him. The couple have been married for 2 years.

In May, 1989 Emily met Roger when they performed together in a musical band. She states she was married at the time and was not consciously looking for another relationship. Emily describes being powerfully attracted to Roger ("...like a lightening bolt...") and very inspired by his positive attitude, directness and accomplishments. She described him as extremely good-looking, with a good personality, evident self-confidence, and strong self-determination. Emily quickly recognized that she was developing strong feelings for Roger and, despite his reticence, she persisted in seeking contact with him, within a week of their first meeting. The couple entered into a discreet relationship for approximately 3 months until Emily and her then husband mutually
decided to end their marriage. In January, 1990 Emily and Roger began living together and approximately 4 1/2 years later, in May, 1994, they were married.

Emily reports experience with disability through her professional role as an occupational therapist. Her work has been primarily focused on mental health, cognitive impairment and long-term care. Emily's son also has special needs. He was diagnosed a severe hemophiliac at birth, requiring careful daily monitoring and contributing considerable daily concern and stress to Emily. Despite the aforementioned experience with disability, Emily had to educate herself about the physical consequences of SCI, which she did with Roger's help. Although Emily admits she was surprised to find herself in a relationship with someone with a disability, she did not find the implications of Roger's injury were overwhelming for her.

Emily reports her hesitations about becoming involved with Roger were largely influenced by her feelings of guilt for terminating her pre-existing (second) marriage and the resultant break-up of her children's family. Emily faced financial sacrifices to leave her marriage for a less certain financial future with Roger. She felt very much "in love" and was optimistic that she and Roger could "conquer anything". "Nothing seemed impossible" if they were together, particularly in view of the adversity that Roger had already faced and overcome as a result of his injury and acquired disability. Emily stated she considered being with Roger "was to be the next phase in her life of greater strength, personal control, and risk-taking."

From Emily's perspective, the couple shared many interests and goals, especially a passion for music and performing. She described Roger as strong, gentle, sensitive, attentive, humorous and very affectionate and "he was just everything that I wasn't used to - that I hadn't known". Emily admired Roger's independent spirit. She was not certain she would have become involved with him if he had been more dependent on her or others.
From very early in their relationship Emily has provided care and assistance with some of Roger's activities of daily living. She accepted caregiving as a part of being with Roger and although she admits it is hard at times, the couple has successfully managed this aspect of their lives.

Most of Emily's friends, and her father and sister (her mother is deceased) disapproved of the relationship with Roger. Much of their concern related to the dissolution of Emily's second marriage, although she sensed others wondered "why would she want him", apparently puzzled as to why she would "deliberately choose to have such a hard life", giving up the comforts of an "upper-middle class life". Rather than a personal dislike for Roger, Emily felt the stigma associated with disability, his dissimilar religious background and more modest potential as a financial provider formed the basis for her family's disapproval. Emily's father and sister did not attend the couple's wedding. Although their reaction saddened and angered her, Emily was not overly influenced by her family's lack of support for her relationship with Roger. Emily reports her children were very receptive to Roger and "they love him to bits". In contrast to her family's reaction, Roger's parents and siblings were very pleased about the couple's relationship and somewhat relieved that he had finally found love and happiness with a partner.

Emily described her partnership with Roger as having a very strong, mutual, emotional bond and devoted attachment to each other. She also pointed out that the relationship has been, and continues to be very volatile. The couple have experienced tumultuous periods in their relationship and in the past have temporarily separated and sought counselling to resolve their problems. Despite their arguments, Emily stated she could not imagine life without Roger. Although Emily and Roger felt very committed to each other while they were living together, it became important for both of them to marry and formally affirm themselves as a couple. As well, it was critical to Emily that her
children felt reassured they were members of a stable family unit with her and Roger.

While the couple considered having a child together, Emily would have to undergo genetic testing in view of her special needs child and, together with the physical challenges of conception, they decided against having a larger family.

Emily expressed some concerns about the future with Roger, including possible health problems and/or greater dependency and ongoing financial pressures. She was very aware of the daily inconveniences associated with caregiving, bowel accidents, etc.; however, after living together for over 4 years she states she accepted these consequences. Marrying Roger "felt right" because of their strong love and attachment to each other and all the challenges they had overcome together.
Chapter 6
RESULTS

Introduction

Data analysis proceeded in a step-wise fashion as detailed in Chapter 4. The first three interview transcriptions were coded, assigning concepts and labels to meaning units. Preliminary categories were discovered via the comparative method. At this time, the researcher's supervisor provided an independent check on the coding procedure which confirmed the primary investigator's conceptualization and labelling of the narratives. Data collection and analysis proceeded in an iterative manner until all 8 participants had been interviewed twice.

Initial coding of the transcripts resulted in a total of 221 concepts and labels, which were sorted, organized and reorganized into higher order categories and subcategories representing consistent themes across the participants' narratives.

Seven major categories emerged from the data analysis and are presented below in an order designed to approximate the chronological course of the relationship and the theoretical model developed from the data (presented in Chapter 7). This discrete, linear presentation is recognized as artificial for the relationship between emergent categories is presumed to be dynamic and interactive.

1. Partner's Characteristics
2. Personal Characteristics
3. Openness/Receptivity
4. Coupling
5. Relationship Functions
6. Relationships with Others
7. Societal Attitudes and Awareness
An elaboration of these emergent categories and their subcategories (properties) will follow. To avoid an unwieldy presentation for the reader, the writer has attempted to be judicious in the selection of examples from the personal narratives to illustrate the categories. Therefore, only those passages considered particularly illustrative of the relevant concepts are rendered here.

It is important to emphasize that the space dedicated to each category (and its subcategories) is not necessarily representative of its relative significance in the proposed developmental model (presented in Chapter 7). Rather, the emphasis on certain categories and subcategories is likely reflective of the research questions asked and the participants' descriptions of issues and factors which were salient in their personal experience.

Major Categories of the Analysis

Partner's Characteristics

The category designated partner's characteristics reflects qualities and attributes which participants ascribed to their future mates. Participants used many positive adjectives to describe their partner and explain their attraction to him. The category of partner's characteristics primarily emerged from the following concepts: adjustment to disability/fortitude; autonomy; loving/trustworthiness; maturity/responsibility; and idiographic qualities. These subcategories are discussed separately below.

Adjustment to Disability/Fortitude

The theme of positive adjustment to disability was reiterated across the narratives and appeared to be a critical factor in the development of the couple's relationship. The majority of participants (n = 7/8, 88%) described their partners as demonstrating good adjustment to SCI, as well as an evident determination to overcome the challenges imposed by their disability. A sampling of representative comments from the data are presented below to illustrate this subcategory.
Ann: “There isn’t a day that he has been in this wheelchair that he said ‘woe is me.’ He got into that wheelchair and he said ‘you know something, there’s a reason for this’...it’s his attitude that nothing will stop me...he’s very, very strong, very focused you know, he’s a good example for anybody...for anybody to wake up after breaking their neck and say, okay, let’s get a tutor in here, I refuse not to graduate with my class...He graduated high school with all his classmates, he went on to university with all his friends. He didn’t skip a beat...D’you know, it’s this, it’s his attitude that nothing will stop me...You know, and it won’t....”

Karen: “...and he just couldn’t wait to get out of rehab and, you know, when he saw some of the guys going upstairs to the fourth floor solarium, smoking drugs and stuff, he said...‘it’s so sad...I just want to get out and get to university and on with my life. You know, I got plans here’....”

Penelope: “...I know he hates being in a chair, but it’s the way it is and nothing’s going to change that so I think that’s how he gets on with things. He doesn’t let it stop him from doing the things he wants to do. I don’t know if resigned is the right word, I think it’s just, maybe coping is better...I think everybody, whether able-bodied or not has, you know ‘woe is me’ kind of days, but his are so few and far between that I don’t think it really affects his day to day living....”

Lisa: “...he wasn’t giving in, letting this damper his life in any way...before I even met him...he had dealt with it pretty much...so that’s what I think attracted me to him, cause he was so stubborn that he wasn’t gonna let anything get in his [way], well like this is the way life goes, deal with it and carry on you know....”

Emily: “...he is so internally strong, he seemed to me then so clear thinking, he had such a good attitude, a good perspective...that’s what I saw...he was so positive and that’s what I remember...I kind of got to see him in action and I thought this is even more
amazing...then I remember feeling, kind of watching him do all his things you know and then, you know, then you go through kind of an admiration thing and then the admiration thing turned into attraction...he had gotten into a good space, things were going very well, I know he had been through a lot. If I had met him in a different space and time you know, years before, I don't know. I'm not sure that anything would have happened...I think if I had met him in one of his down times...then I'm not sure that I would have, could have been that giving...that open hearted or open minded."

In contrast to the other participants, Janice's experience was somewhat unique. Not only was she romantically involved with her partner prior to his SCI, but she left him specifically because of his inability to adjust to his injury, his lack of personal motivation, and his increasing dependence upon her. Janice felt the relationship was simply not viable unless Karl became more independent. Her comments below emphasize, from a negative perspective, the significant role the partner's adjustment to disability appeared to play in the development of a romantic relationship.

Janice: "...he was just so upset and, just feeling sorry for himself...You know when you're laying in a bed and, you don't care...he always called himself a cripple...I associate it completely with the accident...for the first couple of years he really felt sorry for himself and, that was, that was harder than accepting the injury really...."

Janice and her partner were subsequently reunited after she noticed a tremendous improvement in his attitude and adjustment to his injury. As evidenced in her comments below, she experienced a returning optimism about their future together as a couple.

"...when I got back together with him, it was like I had a new Karl - like one that was, you know, kind of back together...in that year he got into wheelchair tennis, he got into the basketball team, he started skiing...he even started back at school...I loved his courage to move on and do other things."
Autonomy

The subcategory of autonomy emerged as a very major theme in the participants’ descriptions of their partners. In this context, autonomy refers to an attitudinal stance of independence, self-direction, and self-sufficiency, to the extent it is physically possible.

In general, the data reflected the well established relationship between the level of injury, severity of physical disability, and ultimate potential for physical independence. Level of injury was not found to be clearly associated with the partner’s employment status, level of activity, or degree of autonomy.

Examples from the participants’ comments are provided below.

Ann: “...he does as much as he can for himself...they [her parents] were assured because of his independence...if he was asking me to do everything, they wouldn’t have been so assured....”

Janice: “…he would normally insist on doing a lot of things...on his own, or at least try it on his own so that I wouldn’t have to be burdened...he was very independent, like he can go downstairs on his own...He goes up and down the escalator, like he’s not, it’s not like I have a lot to do with it....”

Karen: “…he’s in the mind set where it’s like, I’m me, I’ve got this and this and this strength, accept me as a person, don’t give me any special little treats, or any sort of special help in getting a job or doing whatever. Let me do it the way everyone else does it, the way the rest of the population does it cause I’m no different from anybody else. I just happen to get around in a wheelchair, but...don’t treat me any differently....”

Lisa: “...he could do everything but walk...[he] does everything himself. You know, like there’s the odd thing, like if we get to a place that’s got stairs, you know, I have to lift him...he’s the type of person, he won’t ask for help unless he desperately needs it - so I mean like if it’s a wicked hill like this [demonstrates angle]...you could hear him
starting to grunt and groan and that was it, it was like ‘Oh, stay out of his way!’...you can see the determination on his face like ‘You’re not going to beat me!’...he’ll push up there you know until he can’t push no more...he’s stubborn...he likes that he can do everything himself....”

Donna: “And he wouldn’t let me help him up [after falling off a ski-lift] so people are looking at me like, oh isn’t she just a cold person. She’s not helping him. Of course he doesn’t want that help...I mean he had been independent for years...he didn’t require anything like that from me...he tried everything...he wasn’t trying to rely on me for anything, he was already his own person....”

Emily: “...he had kept himself in good shape too so he had enough physical strength to manage the demands, so he wasn’t dependent on me, which was good...he was totally, totally independent, which I thought was amazing...if he had been more dependent on me, I’m really not sure, I don’t know what I would have done...Roger will mow the lawn himself...push, wheel, push, wheel, and he can do that for a few hours....”

Penelope: “Always deep down inside I’m thinking about the other person, you know, what he or she may think, or is that right what I’m doing kind of thing, and I think his whole ‘I really don’t care’ attitude kind of attracted me...I just take for granted that, you know, when he gets up for the day and I say ‘Do you have anything to do today’? Oh yeah, I have to go with so and so and do a speak [speech], you know like he’s made all the arrangements to get there and come back and I know, you know, if he’s hungry he’ll eat, if he’s thirsty he’ll drink!”

Loving/Trustworthiness

Many participants mentioned their partner’s kind and gentle manner, which encouraged them to entrust themselves to these men. For some of the participants, compared to past relationships, this was a very new experience to have faith in their
partner’s benevolent intentions.

Sara: “I [found] him kind and caring...I come from a very abusive relationship. Couldn’t believe that someone could be this nice to you and actually like you because you’re you....to have a trust in me that I had never seen before, that if I went for an afternoon, that he wouldn’t question me as to where I’d been and what I’d done or who I’d been with....”

Janice: “He was always very considerate. I was always the first priority....he had so much compassion and cared, he cared for me....”

Emily: “…he was gentle, he was sensitive, he was so affectionate, he was warm, he was funny, he, he listened, he was just everything that I wasn’t used to, that I hadn’t known.”

Donna: “…[he was] all the good things you look for in someone I guess. You know, kind, considerate, caring.”

Karen: “…his steadfastness...his love for me...and the way that he would really help me...he wasn’t being frivolous about it, he was very pained about what I would tell him and stuff....”

Lisa: “…he’s you know, kind of loving and caring and, you know, he listens to what I have to say you know, and he takes what I have to say as my opinion and doesn’t say ‘You’re wrong’ and so he listens to me and...respects me...I knew he’d always treat me well, you know that was I think the biggest one, yeah. That he would never do anything to hurt me, and vice versa....”

Maturity/Responsibility

A number of participants identified their partner’s stable and mature nature as important characteristics.

Emily: “…he’s kind of the responsible one, that everyone looked to and I could
tell, I knew that he was the responsible one, the organizer, the level-headed, more clear thinking one of the group. You know, didn’t drink at that time....so he was like the dependable [one]....”

Donna: “That [his maturity] was a large part of it...he was at that point in his life where...he knew what he wanted, he was pretty stable...Some guys are just out for a good time....”

Ann: “Like a lot of times I find that women will improve but men kind of stay stagnant, and but he’ll always read self-help books...for him it’s not like oh that’s a sissy thing, a, you know, girl thing. Like he’ll always work on the relationship as well.....”

Idiographic Qualities

Participants also described their partners in ways that were unique and specific to their mate. A few examples are provided below.

Donna: “He was willing to try anything. And if it didn’t work, well, it didn’t work...he did skydiving...he was in the newspapers and everything. He was the first one, the first paraplegic in Canada maybe...that went, it was a tandem jump...And he’s quite intelligent too.”

Karen: “...he basically has a really incredible sense of humour, I think it just, you know, just got him through so much....”

Ann: “...my husband’s a very optimistic person, I mean nothing is pessimistic in his life, you know.”

Lisa: “...he was just so easy to talk to....”

Personal Characteristics

The category personal characteristics refers to the participants’ attributes, attitudes, and behaviours. Throughout the interviews, the women showed a clear tendency to attribute relationship satisfaction to the qualities of their partner and their
developing bond, as opposed to their own characteristics. Bierhoff (1991) has referred to this trend as a consumer attitude towards intimate relationships, reflecting an emphasis on relationship benefits rather than personal contributions. As a result, this category is less developed than others.

This deficit is perhaps not surprising considering this study has attempted to understand women's perspectives and from that vantage point there appears to be an inherent tendency to survey those things which are external to the self. Participants were disinclined to describe themselves and therefore the researcher's impressions and interpretations are acknowledged as more influential within this category, with less reliance on the direct verbal data.

This category is presented in its currently under-developed state as theoretically it appears an important factor within the commitment model developed in this project. Furthermore, the extant literature highlights the significance of personal characteristics within theories of attraction (Hendrick & Hendrick, 1992).

As a group, the participants could be described as mature women who were open-minded, assertive, autonomous, and resourceful. The women's average age at marriage was 30 years, and as stated, half of the sample had been married previously (N = 4/8, 50%). The women's overall maturity was reflected in their openness to a relationship with someone with a severe physical disability. As well, participants appeared to make realistic assessments of the obligations associated with marriage to a partner with SCI. Typically they willingly chose to accept those additional responsibilities with confidence. Illustrative comments are provided below.

Janice: "I'm a very strong person and I knew that whatever issue came up, that if he couldn't deal with it, I would deal with it...I realized what he has to do to survive. And, um, if I was committed to him, what I'd have to do...what I'd have to also go
through to...for the two of us to survive as a unit.”

Karen: “But I thought, but I thought well, I’ve met challenges before in my life, and I’ve dealt with them. I’ll just deal with this too...you know I have to sort of, you know [gasp], to share my thoughts with you and right now, sit down, you know, I have to tell you this [laugh].”

Ann: “A lot of times, like a lot of times I would like to have just taken off or, you know, like go away for two days or whatever but, the commitment’s there to come back and help him...or whatever, even if, no matter how mad I am....”

Lisa: “Well, probably my honesty [gave her confidence]. And I knew that I could look past his chair....”

Participants’ assertiveness and sense of autonomy were demonstrated through their promotion of their partner’s independence (discussed in greater detail elsewhere), their decisiveness, and their own independent attitudes. A sampling of participant comments is presented.

Emily: “I have to rely so much on myself....”

Karen: “You have to do a lot on your own...Like David bought me a power drill for my birthday...I mean you’re very independent...I don’t feel sorry for David. I get mad at him, I tell him off...you know, he’s being a jerk, he gets it...[If] they’d [family] have cut us off that’d been A-okay by me. I still would have married David...they can’t accept it, too bad, so sad....!”

Donna: “...I’m able to look after myself...I wasn’t going to become someone that he had to look after....”

Janice: “Um, I’m very domineering too so, so I knew that whatever came up I would be able to handle it. I’m not this uh, wimpy small little person that would need help with every little issue that came up.”
Ann: [when she felt her partner had mistreated her on their first date Ann said to him]...but don't ever think you'll get away treating me like this again!"

Penelope: “they [friends/family] knew I was gonna do what I was gonna do regardless...I’ve always kind of done things in my life. That’s maybe in the back of my mind, I worry about what my parents think, but to the extent where it would stop me if I thought, you know they might be upset or something. I never, I never lived my life that way.”

**Openness/Receptivity**

A striking willingness to enter into a dating/romantic relationship with someone with a SCI was discovered across all the participants interviewed, reflected in the category designated openness/receptivity. This open-mindedness to a romantic relationship was demonstrated by the vast majority of women (N = 7/8, 88%) who did not express any hesitation and/or immediate concerns about becoming involved with someone with a severe physical disability. Whatever social barriers to developing intimate relationships may exist for persons with disability, they were not apparent in this investigation. Overall, the participants described personal experience with disability; personal values and beliefs; and, in some cases, a pre-existing relationship; which may partially explain their openness/receptivity to enter into a romantic relationship. It is important to point out that these properties of openness/receptivity are not necessarily mutually exclusive.

**Experience with Disability**

More than half the participants had considerable experience with persons with a disability (N = 5/8, 63%), primarily through their occupational roles in health care settings (N = 4/8, 50%). Two of the women (Penelope and Ann) worked as nurses in the spinal care units of local hospitals. Another two participants (Sara and Emily) are occupational therapists, with experience working with a variety of physical and/or mental disabilities.
For a number of years, one of the informants (Karen) volunteered and eventually lived in a Christian community established for very profoundly mentally disabled people.

Three participants also had significant individuals in their lives who had physical disabilities. Ann's grandmother was a paraplegic and a very accomplished woman. Ann also has two very close friends with severe physical disabilities. Penelope lived common-law with a blind man prior to meeting her husband. Emily's son was born with severe hemophilia and requires special needs care.

Experience with disability is reflected in the comments of some of these participants.

Penelope: "...you know rehab is, that's all you have is disabled of some kind...when I lived in [province]...that's my first introduction to anybody with a severe disability...I met this fellow who was...a quadriplegic, but he was a high quad and could do nothing except for with his mouth and we became quite good friends...that was back in the 70s...I guess I've been around [disability] a long time, just never really thought about it...I knew what was involved and you know from working with these guys on the unit that...what I would have to do, if need be, you know and it's not even really like work."

Ann: "My grandmother was paraplegic. She broke her back when she was 25 years old...and she raised both of her sons...so to me, I've always been around disabled people, like I grew up in [state] and...we integrated kids early...we had kids in wheelchairs and stuff like that so I've never ever seen a difference between the two...there's one guy who's a paraplegic, and him and I are like best friends - we're like brothers and sisters and we see each other quite often...I worked for [hospital] for 8 years on the spinal neuro-rehab unit...I had a lot of confidence when I went into the relationship [with partner]. I had a lot of knowledge of what kind of care he'd require. I had a lot of you know, book smarts...Like I really knew what his expectations were. I really, I knew what a routine
was, I knew what a shower was, I know what positioning is...."

Sara: "I started working in hospitals when I was 17, the day after my 17th birthday I was a nursing attendant, waiting to get into physio school...Probably through my work, having known so many people in wheelchairs, and with different disabilities and known them as people, not just through disability...I used to take people home for supper from [extended care centre]...When I first came to [extended care centre] and I hadn't seen so many severely handicapped people, CPs [cerebral palsy] and epileptics, and I'd never seen quite so many all in one spot...I think that probably from my background in physio, I think that makes it easier to cope with the transfers...."

Emily: "...my first love was always general medicine, acute stuff and, you know, head injuries, brain injuries, orthopaedics, and burns...so we had placements in internship and, I mean for everything, we had pedes [orthopaedics] and burns, and been there, done that - seen it all so I knew kind of textbook sort of what to expect...and I saw Roger...I'd say but I'm an OT [occupational therapist] so I can handle this right, I'm an OT so then I kind of switch on my OT mind...and my little boy has special needs...."

Karen: "I worked, I lived in a [name] community which is...for very profoundly, mentally disabled people to get them out of institutions and into a family situation...so I ended up living in one of them for about 3, 2 or 3 months and I really enjoyed it...there are communities like that in Calgary and so I had been involved with that outfit as well, you know we lived with one fellow who's very profoundly mentally disabled and I just loved him...But prior to that I'd had quite a bit of exposure just to, to individuals living there in the homes."

Personal Values and Beliefs

Some participants described their openness in terms of personal values they held, their perspective on persons with disabilities, and a general attitude of openness towards
all individuals.

Lisa: "I never thought of it really as I went for more of what he was like, not, like his chair pretty much wasn't there, more the person. I was brought up that way. Look at the person inside, not the person outside...I was kind of brought up with you kind of accept people for, for who they are and kind of go with it...just cause they're in a chair doesn't mean they're any different, you know, they just, something on them doesn't work. It's as simple as that...."

Karen: "We all have limitations to one degree or another and we just look at our strengths and pursue those to as far as we can...you can be as disabled or not disabled as you want...you tie yourself up, just your own mental, your own lack of mental positive attitude I guess...you know and that all comes from the mind and you choose, you choose to be happy or you don't...."

Sara: "My mom came to visit one year and she said 'I don't know how you work in here with all these poor creatures - when you think of them as your friends', you know. All these 'poor creatures' think life is okay, just because they're really twisted doesn't mean to say that they think that life is bad, you know, they have a different idea of what a good life is."

Donna: "It's just an openness to everyone...that's how I was raised is that everyone's equal and you don't put them into different groups and no prejudice...."

Ann: " I don't consider him disabled, and I guess that's a big turning point in our whole relationship. If I'd, if I thought he was disabled, then I wouldn't live with him...and I wouldn't put up with him."

Pre-existing Relationship

For only one participant (Janice), the romantic relationship predated her partner's SCI. The trauma of SCI and the rehabilitation process was an experience the couple
shared. The existing emotional connection and Janice’s sense of obligation to her injured partner contributed to her willingness to continue in the relationship.

Janice: "...our relationship was fairly serious before his accident. And after his accident it was, it was still very strong...he kept saying you know, ‘don't feel like you have to stay, you know, you can leave, you're free to leave.’ But that's not, that wasn't my intention at all actually...I loved him very much and it didn't matter to me whether he had the use of his legs or not. Like there were, there were other young people in the same room as him that had a girlfriend and never came back. So you know, he kind of thought that I'd make that same choice...I think it was just that we had such a strong relationship that, you know, this was just something that can be dealt with...and I felt obligated, well I have to stay, you know I've stayed this long and you know, what are people gonna think...."

In other situations, the romantic relationship evolved from a seemingly platonic connection in a rather subtle fashion. This gradual development of romantic interest provided the opportunity for the participants to get to know the partner and become comfortable with his disability.

Donna: "I'm thinking there's a different kind of acceptance, and you go from, first instant when you first see the person as, here's a person in a wheelchair. Well, okay, this is a human being. I accept this person as a human being. Then you go on to the next stage and you get to know them and, this is an individual. Okay I accept this person now as Tim [partner], as a person, not just some human being. And then you go on and now I accept this person as Tim in a wheelchair...but unless you can change that level of acceptance then it, then the relationship can't continue on...You can accept him as a friend but then you have to accept him as something more...It was no big fireworks and, like you read in the books and stuff: It wasn't that, it was just, it just slowly went along and it
[was] like a snowball getting bigger and bigger and you don't really notice it at first".

Karen: "...we sort of slowly began this, this friendship...and by that point I had actually I guess been much more comfortable with the wheelchair and the disability...And then, and then after I got to know him as a person and his personality and his interests and the things that we liked in common, it was, I was, I sort of felt very strongly towards him...."

Coupling

The category designated coupling refers to the process by which the participant and her partner come to define themselves as a couple with a long term commitment to each other, operationally defined in this study as marital commitment. This process represents the core category which has emerged from this investigation. The major subcategories of coupling were: connecting, discovery/creating intimacy, interpersonal challenges, disability-related challenges, coping/problem solving strategies, evaluation/commitment, cohabitation, and accommodation to disability. These eight conceptual aspects of coupling are discussed separately below.

Connecting

The subcategory of connecting refers to the process leading up to the participants beginning an exclusive dating relationship. Generally, at this time the social world comes to recognize these two individuals as a couple. As the participants connected with their partners there was usually some recognition and, in some cases, disclosure of strong feelings for each other.

Connecting emerged from concepts and labels such as meeting, attraction, seeking contact, becoming available, acceptance of partner's disability, friendship and dating, and recognition/disclosure of feelings.

The informants described meeting their partners in three primary ways: through the
participant’s occupational role ($N = 4/8, 50\%$); through common activities ($N = 2/8, 25\%$); or by introduction through friends ($N = 2/8, 25\%$).

For many participants the initial connection with their partner was romantic in nature ($N = 5/8, 62\%$). For others ($N = 3/8, 38\%$) the development of a romantic union took place over time, evolving from a friendship.

For two participants, connecting meant overcoming a poor first impression of their partner. If not for the partner’s persistence in seeking contact, the couple may never have connected.

A sampling of the participants’ comments supporting the development of this subcategory follows.

Emily: “...there definitely was something, whether it was soul mate attraction, you know physicality...mystique, intrigue...we were obviously attracted to each other...very, very, very powerful. It was very powerful...and he looked so good...and this was really important...I think what it was was passion, I’m sure that’s what it was when we met...it was love, it was just, it was just simple, it was, it was almost immediate...then at the end of the evening... [she thought] there’s something happening here and I don’t know what this is...and I don’t know why, and I don’t know what I’m supposed to do with it, but I can’t stop thinking about him...can I live without it - and I couldn’t. I think he could have, it was...definitely more me pursuing him...until I had decided what I was going to do, we couldn’t be seen in public and, it wouldn’t be fair to my husband.”

Lisa: “I liked him the minute I saw him...I was just out and bought him...it was there and it wasn’t going away so, yeah, and he was the same with me, he knew right off the bat too...he asked me if I loved him, I said yeah, and then I asked him and he said yeah, so that was pretty much how it started...that was about maybe two weeks [after meeting] or something like that....”
Penelope: “...I don’t know, something just sort of clicked...kind of made a bond I suppose - started a bond...I just sort of found him attractive...he ended up having surgery while, while on our unit...and I would find myself going to work early to go to ICU [intensive care unit] to see how he’d been through the night and then I’d find myself sort of staying a little late after work, going to ICU...that just sort of snowballed...it [declaring feelings for each other] was, I would say almost from the start, kind of I believe while he was still in hospital it was kind of an unspoken kind of attraction...I was in a relationship at the time that was sort of touchy...I ended up...leaving that relationship [with common-law boyfriend]...the relationship with Kent progressed....”

Ann: “...I think the first time he took me out ...it was the worst date I’d ever had in my entire life......[and then] he kept on calling me and asking me to go out with him and I said I’m not looking to date anybody...so about every 2 weeks he’d call me up and ask, say, ‘well, can I take you out to dinner?’...yeah, he was pursuing me...he bothered me enough that I said ‘okay I’ll go on a second date with you’...And I thought...you’re not the jerk I thought you were....like the chemistry was there you know....”

Donna: “...they [friends] would come out to go skiing and we just got to be friends - hung around together...the reason we didn’t start going out when I first met him was not the wheelchair, it’s cause I just couldn’t stand him [laugh]. He bugged me, followed me, you know, it seemed every time I turned around he was right there...but it, you know, started to grow on me, I guess...sometimes your first impression of people just...it doesn’t turn out...to be what the real person is...I think four months after that...We just started going out together by ourselves.”

Karen: “...then eventually we sort of slowly began this friendship...and then one night David phoned me up and my roommate [whom he was dating] was out and he said ‘well do you want to come?’ And I said ‘sure’...so we went out and...I went oh this is an
interesting fellow...I sort of felt very strong towards him. I don’t think he did towards me...I was quite keen...and I told him this...I know I blew him away and he still talks about it...."

Sara: “I was married [when she met Jack]...after I got divorced [about a year later]...we started spending weekends together, we went to Hawaii...and then we moved in together.”

Janice: “...my friend kind of got us together cause I was kind of interested in him...a couple of weeks after we started dating...Within the first two months, it really started to develop...our relationship was fairly serious before his accident...when I was 18 we were gonna get married, and his accident happened I think when I was just turned 17.”

**Discovery/Creating Intimacy**

The subcategory of *discovery/creating intimacy* refers to a process of mutual exploration which is marked by close association and increasing familiarity. After connecting and the commencement of dating, the participants described coming to know and understand more about their partner and the developing relationship. Informants generally found evidence of mutuality based on the positive discoveries they made. The concepts of commonality; compatibility; open communication; respect; sexuality; shared values and goals; and trust represented important properties of discovery/creating intimacy. Narrative passages from the participants exemplifying this subcategory are provided below.

Ann: “...we’re both very independent people, we just [got] along well, like we...we both think on the same level...we communicate so well and we’re so in synch with each other, we have so many common beliefs...and common goals...we would always, we’ll always talk...we both had the same moral beliefs and...it is rare to find somebody in their, he was what 24, when we met...who’s career isn’t number one in their life...who thinks
family is more important...."

Penelope: "...I found out that he was from the same area where I grew up, you know, within a few miles radius...I don't know it was kind of, it was very comfortable from the start...open, honest, never you know kept any secrets...he's very trusting of me...."

Janice: "...we had a very open relationship...we knew everything about each other. There were no secrets, we could talk to each other about anything, say anything to each other...we just, we knew each other, we were comfortable with each other...you could just do anything around each other and it wouldn't surprise the other person...we had a lot of the same interests...we were two peas in a pod, we got along together...I don't think we even argued once."

Lisa: "...we'd get up at like 10:00 in the morning and we'd talk 'til 3:00 in the afternoon...so we kind of, we opened up a lot...right from the beginning...we've always been able to talk to each other, which I think is everything...so we got to know each other really well...we talk about everything...he listens to what I have to say...and respects me, yeah. So I think that was the biggest one...we always talked about being together, about being married and having kids and living in a nice house....both of us have always wanted a family...we're a lot alike in a lot of ways...."

Emily: "...we had so much in common...we talked, like I say, the cell phone, we got rid of the phone [laugh] after cause there was...so much to talk about...that’s [performing] our one passionate, together work...and the trust was a very big thing...I must have trusted him an awful lot and I did...not totally dependent but we’re...I want to say like synchronicity...it [sexuality] was a very big part...in fact it, probably it was bigger than most of the other parts to begin with...."

Sara: "He's [Jack] really big on communication so we have to talk everything out
so, which helps....lots of conversations, lots of openness, finding out about each other...."  
Karen: "...then he talked to me more openly about his disability in time...completely from how he felt, experiences he had...and of course our spiritual, our faith life is very similar as well...."

Donna: "...we were getting closer and closer...it just seemed we worked into having long term goals...It was no big fireworks and, like you read in books and stuff. It wasn’t that...it just slowly went along...it took a while to get comfortable enough with each other to talk about it [sexuality]...."

Evaluation/Commitment

The subcategory of evaluation/commitment refers to the ongoing processes by which the participants appraised their partner, the relationship and, in some cases, themselves, within the context of increasing their investment in the union and in making an long-term, emotional commitment to their mate. Many participants were quite conscious of, and explicit about, their contemplations and criteria for involvement, continuation in their relationships, and ultimately marriage. For others, evaluation and commitment was more tacit, gradual, and/or intuitively based.

As stated earlier, commitment was operationally defined in this study as marriage; however, it quickly became apparent there was considerable diversity across participants as to when their long-term intention to remain with their partner was formed. Based on this narrative data, marriage cannot be considered an accurate indicator of commitment, rather it is better considered as an outcome of commitment.

Half the participants did not consider the formality of marriage had personal significance for them. Most of these women (N = 3/4, 75%) had been previously married and this may explain, in part, their ambivalence about remarriage. It is important to emphasize that the reduced momentousness of marriage does not suggest participants
necessarily minimized the significance of being committed to a long term relationship with their partner.

The concepts which comprised the category of evaluation/commitment were: criteria for involvement; attachment; relationship history; self-evaluation; comparison to previous romantic relationships; personal significance of marriage; and relationship progression. Examples from the personal narratives should serve to illustrate these properties of evaluation/commitment.

Criteria for involvement. A number of participants described explicit criteria for initial or continuing involvement in the relationship.

Penelope: "...I had sort of said to myself you know well, um, if we're in this relationship for say six months and his ways aren't changed or he doesn't try and help himself, you know, stop the drinking or you know cut it way down and stop the drug abuse, then I was prepared and I told him that I would not remain in the relationship...I felt that you know there could be something there for the two of us if he was willing to maybe straighten out somewhat, and so I gave it a shot and it worked!"

Karen: "...I always dated with the idea that is this person, right from the word go, I always felt is this person marriage material? And if they weren't I thought why am I gonna waste my time? I don't want to waste his time, I'm not being fair to him, I'm not being honest...I had about five or six different sort of traits that I felt made up a good, a good husband and father...David fit almost every one of them."

Ann: "...I didn't date anybody from the [rehab unit where she worked]...because they need about a year to adjust to their disability anyway...I would never ever date anybody in a wheelchair that didn't work...my idea is not to sit at home and watch somebody sit on AISH [Assured Income for Severely Handicapped]...I don't have a problem it they volunteer for this if they do that, but you know, this nonproductive life,
it's just like, to me that's not normal...you know I'm going on with my life and I'm not staying with anybody who isn’t....”

Janice: “Well, before we got married, I insisted that he live on his own...He lived with his Mom and Dad...I wanted him to try and be a little bit independent....”

Lisa: “that [was] what I think I was looking for in a partner...honesty and communication were the top two. So, and we got that right off the bat so...I met the man I wanted to marry and chair, or no chair, that was it...He had all the qualifications I ever wanted....”

Attachment. For some participants the development of a strong attachment to their partner made a future without him difficult to imagine, clearly fuelling a sense of commitment.

Emily: “...I couldn’t imagine not being with him. I didn’t want to be without him....”

Ann: “...here’s my soul mate, here’s my, we’re best friends you know like we were, we were made to be on this earth together...I feel I would have been lost without him...we adore each other...we both feed each other very much....the thing is, we were just meant to be together....”

Janice: “...while we were apart [the couple broke up for 9 months] I constantly felt for him and thought of him. Like, he was always in my mind...I was too attached to him.”

Relationship history. Living together, resolving issues, and demonstrated compatibility were identified by participants as giving them confidence in making a commitment to their partner.

Donna: “Just the time we had spent together, and living together and going through everything together. I guess, and past problems came up, we were able to look after them, get through them, talk about them. We didn’t fight...not huge scraps where
we just could not come out...."

Sara: "Once you’ve lived together a couple of years I think that you know the problems...."

Janice: "The love that we had for each other and that we’ve stepped through it for so long. I mean, we separated for a year, and then got back together so that must mean something. You know how long can you keep dating [laugh]? I think that’s, that’s what we looked at too, is how long we’d been together and here we are back together again, well, why not get married?"

Penelope: "I think that’s maybe what made me think that everything was gonna be okay is because I think that’s how we started out and you know, didn’t create any real problems or I didn’t foresee any ways...."

**Self-evaluation**. Looking at one’s own capacity for commitment to the relationship was significant for some of the participants.

Karen: "...it was jitters to the point of...I was really thinking gee whiz...am I out of my mind...just the gravity of the situation of what I was undertaking, and what both of us were undertaking, you know, getting married. Part of it too, I realized could also have been just my fear of actually committing...[she worried about] just not having that tenacity to, to stick with it, you know, come what may, difficulties aside, just do it, you know....he [David] would always kind of drop hints to me...‘well Karen this is your life - do you want this?...this is me...you can walk any time’...And then I go home and I go oh man [laugh]. Can I really do this?...I remember thinking to myself, okay Karen, if David, if David was not in a wheelchair, how would you feel right now? Would you still marry him? And I go, in a New York minute. Okay, well now you got a little added challenge, will you still love him? And that’s what’s important...."

Emily: "...do I have enough, did I think I would have enough strength to deal with
everything and, accidents, and just stuff, just daily living, self care, crappy junky [laugh] that happens everyday...that was hard...."

Comparison to previous romantic relationship. With the exception of two participants who had not previously been romantically involved, all six remaining participants compared their current union with past relationships in the process of evaluation. In every case, these six women valued the qualities of their current mate and relationship beyond anything they had previously experienced.

Donna: “All of my other ones had, none of them was serious I guess. They were just for fun...I just knew they were never really heading anywhere. They were just um, yeah just having a good time...Compared to the other guys I’d gone out with, he was, he just seemed more mature. He had his feet on the ground, I guess.”

Penelope: “...I found in this relationship, prior to marriage and now, is that it’s much more honest than anything I’ve ever had with anybody who’s able-bodied....”

Emily: “...they weren’t bad marriages...I was looking for, that I had been through twice before and couldn’t find. I thought that maybe this third time...it was like a bolt of lightening from the sky - okay you’re gonna spend the rest of your life actually in love this time, and not for the convenience or because it’s the right thing to do...it felt like that was my last chance.”

Janice: [during the time she broke up with Karl] ”...I only dated him for about a month and a half...but I found myself constantly thinking of Karl and constantly comparing Karl to him....”

Karen: “...you’re [David is] every bit a whole a man compared to the, to the half-witted ding dongs I’ve dated...These guys have full use of their limbs but I wouldn’t be caught dead with them...most of these other guys I dated, they, most of them, some of them didn’t really have any sort of clear purpose and sense and, just all befuddled and they
go from, they would want to spend time with me, [rather] than time with whatever they should be doing and it would, it almost became suffocating....”

Ann: “...I was in an awful marriage...My first husband was my high school sweetheart...he was an alcoholic...he packed up his stuff and left...So he left me holding the bag, like being the responsible person...I had to support and do everything....”

Sara: “ I come from a very abusive relationship. Couldn’t believe that someone could be this nice to you...it was so nice to be away from my husband, my ex-husband was a pretty heavy drinker. And I didn’t miss any of that too much....”

**Personal significance of marriage.** As stated, half the participants were not highly motivated to marry. For these women, it was typically their partner’s desire to wed which led them to make a marital commitment. For the other participants, formalizing their pledge to each other was a significant and, for some, essential component of commitment.

Ann: “To me it [marriage] made no difference...the two of us had already made the commitment...We were living together and it was really important to him that he get married, and it wasn’t important to me, and yeah we kept that going back and forth...But it came down to, if we weren’t gonna get married, he was gonna leave the relationship because that, that was critical to him...you see, marriage to him is a commitment...and a lifetime commitment. Marriage to me is as long as we can tolerate it...I’m not in that fantasy, Cinderella, happily ever after mode....”

Donna: “I wasn’t scared to marry him. I guess I always thought that well, I’m able to look after myself. If I don’t like this I can just, I’m not dependent on him....”

Sara: “…it wasn’t important to me...I wasn’t too worried about ever being married again, or, so it was him that decided that it was time...I think he always wanted to get married....”

Penelope: “…I think if Kent hadn’t, not that he pushed the issue, but um, if it had
never been brought up I would have just as well have stayed living together and been just as happy, it wasn’t a big [deal] no, it wasn’t...being married or not is, to me, doesn’t really make a whole lot of difference, I mean you can be committed to somebody for 50 years of your life and, you know, have a common-law relationship....”

Karen: “…for me and for my husband, we see it as a divine calling, that is a vocation, that God has willed for us to be together...to marry and to build a life together...I mean I take this commitment very seriously, I don’t walk away from marriage unless the person’s beating me senseless or he drinks our money away, or something like that. Like I’m here for the long term....”

Emily: “And you know, we needed to make, both of us needed to make a very definite, I know Roger needed to make a commitment...So the commitment thing was important.”

Janice: “I think it [marriage] meant more to me than to him....”

Lisa: [explaining what marriage meant to her] “I guess being together forever, you know, with somebody that you love. Like I said I pretty much knew right from the beginning that he was who I was going to spend the rest of my life with....”

Relationship progression. This subcategory refers to the timing and process of making a marital commitment. The average length of time couples spent dating and/or living together prior to marriage was approximately 3 years. Most of the participants (N = 5/8, 63%) reported a formal engagement period (range: 6 months to 1 year) was a distinct feature of their courtship.

In this sample partners typically proposed (N = 6/8, 75%), and in these cases all participants reported immediately answering with an affirmative response. Sometimes the partner’s proposal was a surprise. In other cases, the couple had discussed the prospect of marriage in the future and therefore the question was not completely unexpected. In
either circumstance, the quick and spontaneous response of the participants suggests that the process of evaluation and commitment to their partner had already occurred and these women were clear about their intention to remain with their partner for the long term.

For the remaining two participants, the decision to marry was a more debated, mutual decision-making process. In both these instances, the couples had lived together for a number of years (3-5 years) and the significance of marriage was the focus of discussion, not the level of emotional commitment and personal attachment to the partner.

A brief selection of relevant comments is provided below.

Sara: "...Jack said to me 'why don't we get married this weekend?' and I says 'okay, sure'. And I went to work and I came home and he said 'so how many people did you tell?' and I said 'you were serious?'...and he says 'yeah' so we went to the mall and got a wedding ring on the Friday night, got a license Saturday morning, called our friends who wouldn't believe us, they were over and we were married by 1:30!"

Penelope: "Mm, we hadn't really talked about it [marriage]. I hadn't really thought about it and then he asked me to, it was actually Valentine's Day of '88 that he asked me to marry him and I said yes...it was basically quick...When I look back on it, it all just seems so straightforward that, you know, no little glitches or anything to, to make me stop and wonder if I was doing the right thing or anything like that...if I had of had any reservations I probably would have said no."

Lisa: "...he was in his leg braces standing in the kitchen and he asked me and I said yes [laugh] so...I think it was Valentine's Day...when we officially got engaged...it was just so, you know, it was fast, like I knew it and that was it and he knew it...right from the beginning, so."

Donna: "We kept saying well when we're married we'll do this...and then finally one day he did, [he] asked me to marry him...but [before that] we never once said, sat
down and said okay, so we’re getting married...I didn’t know he was going to ask that very day....”

Janice: “Uh, he asked me actually. It wasn’t a surprise because we had talked about it. He had also proposed, I don’t think I mentioned it, before we broke up....”

Emily: “Yeah, and I don’t know why [get married] 5 years later?...we could have gone just fine not being married, and I know a lot of couples do, but, but there is a change...Not that there’s any guarantees....”

Ann: “...it came down to, if we weren’t gonna get married, he was gonna leave the relationship...because that, that was critical to him. It was like ‘I [Peter] would rather never be married and never date anybody than not be married’. So we came to a compromise and...so we did get married.”

Karen: “…I pretty much knew after the first date that I was gonna marry him...it just seemed to be clear and stronger in my own mind that, yes, you know, this...is where we’re headed...He was saying to me that um, he too sensed that you know, the more we spend time together, the more it’s going to be an inevitable process that we will get married. And he was happy about that...he asked me to marry him [it was a bit of a surprise]...But he didn’t tell me the process until after the fact....”

**Accommodation to Disability**

The subcategory of *accommodation to disability* refers to the participants’ adaption to the implications of their partner’s SCI. The women in this study described the process of acceptance and adjustment as ongoing, with impact waxing and waning over time.

In general, the greatest accommodation was required during the initial stages of affiliation; however, over the developmental course of the relationship, new challenges specific to disability continued to arise and adaption was required. A number of
participants indicated there were times when the additional responsibilities and caregiving demands associated with their partner’s disability felt difficult to cope with. Corrective action was often necessary to rebalance the relationship, and for these reasons, this subcategory overlaps with coping and problem-solving strategies, discussed below.

All participants at the focus group meeting agreed that they held atypical expectations for role performance within their relationships, an apparently important factor in accommodating their partner’s disability. Stereotypical gender roles were less adhered to, with many women reporting they developed new skills to perform “male” tasks. Although at times a number of participants admitted to feeling overwhelmed and somewhat unprepared for what was required of them, overall they have made the necessary adjustments and accept the added challenges of disability as an unavoidable part of life with their chosen mate.

Illustrative comments from the participants’ narratives describe the subcategory of accommodation to disability.

Ann: “...the really funny thing is I thought, oh I can handle this. I know what your [Peter] demands are. I know what your needs are. There’ll be no problems, it’ll be smooth. I mean, after [all] I’ve been in this field for, you know, 9 years or whatever. And I was shocked. There was a real eye-opener...So here I went into this relationship very confident, didn’t think I’d ever get burnt-out, didn’t think I’d ever get tired...And you know something, it’s hard...because it’s hard to always be that person...I say that to him all the time, I always say to him...’I can’t live like this...you can’t help me’... [but] it’s just part of our life...it’s not physical, it’s just time, managing time...for the first year when we were living together it was that he couldn’t coordinate with my activities....”

Sara: “It just seems that you go from one problem to the next...so it’s not just the disability, it’s all these regular problems...It’s just, there’s always something in everybody’s
Karen: "...it sort of got to the point where I didn’t even notice it anymore. It just, it’s just this is the way it is and it’s part of life but, living it can be a hard part of life at times...but, that’s the way it goes...It’s cute because David often said you know ‘I and my wheelchair are one’ [laugh] and I go ‘no, you’re not’. You know, and we’d always have this kind of ongoing debate and discussion about that and go, I accept you - disability - some days I don’t know [laugh]....”

Janice: "...everything kind of changed, you know he, got into, I guess the role of being a paraplegic and you know, it’s never gonna be the same as it was [before his accident].”

Sara: "...I don’t see myself as Jack’s caregiver, I see myself as his wife. So that stuff comes with it but I don’t, it doesn’t make any difference to me...in my first marriage we fought about who’s job it was to clean the house...now I cut the grass, I clean the house, I wash the vehicles and I don’t mind and there’s no fight about it.”

Penelope: "...and when it gets to the point where you’re doing more of the caregiving than the wife, that’s when, at least in my situation, that’s when I pull back and say ‘well enough for now...we gotta do something here.’ And then there may be more attendant care for a little while and then it’s okay. But I don’t think you can help but have that in this type of relationship. I really don’t...there’s gotta be times when you doing some of the things - and that’s the way it is....you don’t stop and say ‘no, I’m not doing that today’...it’s gotta be done and I’m the one to do it!”

Emily: “Sometimes it really is tough but we condition ourselves and accept it...the expectations are different...this situation is very different - you expect different things of yourselves....”

Lisa: "...I never paid any attention to whether this is accessible or anything until..."
I...started going out with him...you know so it's kind of been an eye-opener...I think it's harder on them [disabled person] than it is on us just to go out and do it...they have to sit there and go I can't do that anymore....”

**Interpersonal Challenges**

The category of *interpersonal challenges* refers to the tensions, problems, concerns, and conflicts that participants described as developing between themselves and their partner. These difficulties were not specifically related to disability. It seems reasonable to assume that all people in intimate relationships struggle with these types of interpersonal issues and environmental events from time to time. All participants described interpersonal challenges such as conflict, breaking-up, seeking mutual understanding, personal concerns, and/or partner’s concerns about the relationship.

Informants characterized the intensity of interpersonal conflict as ranging from minimal to quite volatile, at the extreme resulting in temporary separation. Illustrative comments are provided as follows:

Donna: “It went pretty well. Um, there were things that we had to get used to about each other ...just pick up your socks, don’t do this, don’t do that...we argue at first, we certainly do argue. Then I guess, you know, after you get the anger out, then you can come together and decide some way to solve the problem; discuss it, talk about it.”

Penelope: “I try and deal with it as best I can and, yeah, we have had arguments about it...all I say is all we can do is try and keep plugging along....”

Sara: “...So Jack would say this drives me crazy, that you can tell me before hand...Jack often doesn’t feel well...[he] is really quiet when he doesn’t feel well cause he doesn’t like to complain...So then I said, ‘well, why aren’t you talking to me?’ And so once we figured that out, then I’d say ‘okay I’ll leave you alone’....”

Karen: “...there was real distinct male female differences. Differences in
approaching things and that was one thing that I had a difficult time with...I didn’t really know how a man related to things - you know how they’re not as maybe verbal, communicative as we are. And I used to get absolutely frustrated to no end why he didn’t want to talk to me about different things, when I was ready to talk to him....”

Janice: “...we broke up for a year because he just, he wouldn’t do anything with himself...he just completely depended on me to do everything...I just couldn’t handle it.”

Emily: “...we don’t talk about it, we fight about it...we fight a lot...I mean it hasn’t been easy going, it’s, we’ve had tumultuous periods, periods where you know he’s had to leave, we’ve needed to have our space....you know there are periods when I can’t enter his world...he beats up on himself...he wants his space to do that....”

Ann: “...the funny thing is we dated for about...three months and then he took me out for dinner and then told me he didn’t want to go out with me anymore...we didn’t fight well...when I get mad I vocalize right off and when he got mad he would hold it and then blast you after six months and bring up every issue, so we were having problems with that....”

Personal concerns expressed with respect to the developing relationship were generally idiomatic. A sampling of the statements which reflected this aspect of interpersonal challenges are presented below.

Penelope: “...I know when we first got together I mean I was jealous for sure...but gradually I got over that...I mean he has about as many female friends as he has male friends...sometimes I feel kind of weird because I mean I’m older than Kent by 8 years...some days I feel older than others....”

Karen: “...initially I used to get feelings of jealousy...I just grew up in a very, very, very difficult situation and so consequently I began...having a very, very difficult time...this crisis sort of erupts in my life and all of a sudden it was like...I don’t know if I’m capable
of being in a relationship with you [David]...you deserve better you know, basically this is what I told him. And he stuck around.”

Janice: “...he’s always smoked and I can’t stand it...and he’s gonna do it no matter what I say basically....”

Ann: “...me giving up my total independence - that was hard. It was really hard. Because I had always supported myself and I’d always had complete control of all my needs and stuff like that....”

Emily: “...I know what I’m going to have to sacrifice [leaving her second marriage] trying to keep us together, probably lose most of my friends, which is what happened.”

A particularly interesting theme emerged from the women’s perspectives on their partner’s concerns. A number of women (N = 4/8, 50%) described their partners as reticent about getting involved, appearing to need time to develop trust in the participants’ romantic interest in them. The following comments exemplify the partner’s concerns about involvement, from the participants’ viewpoints.

Lisa: “...he was gonna break up with me and then he decided not to...cause he wasn’t sure how I was gonna handle his chair and that kind of...being in a chair...he always thought he would never end up with anybody because of his chair - ‘til I came along.”

Karen: “...I think it was really scary for him...I wonder if part of it was the disability...he was wondering why are you with me?...I think he wanted to know where I was coming from - was I a light frivolous sort of person? And he didn’t want to...put his heart on his sleeve and then find out, oh well, sorry...I’m now onto something else...He wanted to know...is she really what she says she’s about, does she really have these feelings for me?...what is she hoping to get?...what does she want?...then after a while he realized that, you know, this girl really cares enough to bother to even find out what life is
like for me... you know, she means business.”

Sara: “Jack always says ‘I’m so lucky to have you’. Well - I don’t know why.”

Emily: “... for him, on his part, it took an awful lot longer... he was very... very reticent or protective of himself... he went through... you know, relationships - no one’s gonna want me and that the way I am, and what’s gonna happen and why would anyone want me again?”

Janice: “... he (Karl) kept saying ‘you know, don’t feel like you have to stay, you know you can leave, you’re free to leave’... there were other young people in the same room as him that had a girlfriend and never came back. So you know, he kind of thought that I’d make the same choice.”

Cohabitation

For the majority of participants (N = 6/8, 75%) living together common-law was a feature of the coupling process leading to marital commitment. The average length of time cohabiting couples lived together prior to marriage was 2 years 8 months (range: 1 year to 5 years).

In some instances, the decision to live together was a relatively casual one (N = 2/6, 33%), made for primarily pragmatic reasons. For these participants, it was only after living together that the relationship evolved to a more committed union. For most cohabiting participants (N = 4/6, 67%) entering into a common-law arrangement reflected a long term commitment to their partner and represented an important developmental step in preparation for marriage. In some cases a conscious goal of living together was to provide a test period for the relationship. Generally, women who cohabitated and had been married previously (N= 4/6, 67%) were content to continue living in a common-law. They considered formal marriage had far greater significance to their partners than it did to themselves.
A sampling of the participants’ comments on cohabitation are provided below.

Donna: “When I first moved in here it wasn’t with the thought that, oh this is going to be a permanent thing and we’ll always be together. I was just, it was a convenience for me because I had to move into [city] any ways. We were going out at the time. Tim needed a roommate...to help pay the bills. So I thought well, I’ll move in. And so I did.”

Penelope: “...at the time I was working 12 hour shifts so I had sometimes 5 days off so I spent them in [town where partner lived] and then it just sort of progressed from there. I ended up buying a car and then moving to [town] and living there [with partner]...I just sort of did it and it didn’t really make a difference, one way or the other...well, I don’t want to make light of it but being married or not is, to me, doesn’t really make a whole lot of difference, I mean you can be committed to somebody for 50 years of your life and, you know, have a common-law relationship....”

Lisa: “...at first it was just because I needed somebody to help me pay the rent for one, and then I think it was because we just knew right from the beginning we were going to end up getting married, so we just [wanted to be together] yeah.”

Ann: “It [cohabitation] was my husband’s insistence...it was important to him...he kept on asking me...‘do you want to be disabled?’...both of us started living together knowing we would get married...we were committed...I made that quite clear to him too, if you want to live together that’s fine, but you don’t 3 months later walk out and leave a small child [her son from previous marriage] ...you don’t do this with kids...it was a big commitment, it wasn’t like just let’s try this for fun...it [marriage] wasn’t important to me...I’m not in that fantasy, Cinderella, happily ever after mode...once you’ve been divorced.....”

Sara: “...we moved in together [after] 6 months...well I wanted to make sure that,
because he had been in [long term care facility], he had been in hospital...Course he wanted to get out and, you know, but you just have to make sure that it’s for the right reasons...I was hoping never to go through the separation, divorce stuff ever again... I think to make sure everything was okay, but committed to the relationship too...it didn’t really matter to me whether we were married or not.”

Emily: “There was no pressure to get married...I knew at the time that my husband [now ex-husband] and I decided to separate, I knew...that I was in it [committed to relationship]...long, long before then...[time they moved in together].”

Disability-related Challenges

Accommodating a severe physical disability presented specific challenges, with varying degrees of imposition and impact on the couples’ evolving relationships. Participants described the personal implications of their partners’ disabilities as ranging from quite minimal to occasionally overwhelming. Overall, the women interviewed spoke of disability-related challenges as manageable and insufficient to dissuade them from making a marital commitment to their partner.

It is critical to point out that although the challenges discussed in this section were specifically associated with the partners’ SCI, the issues these couples faced are not necessarily unique to persons with a disability. For example, difficulties with fertility and conception, or financial issues, are by no means exclusive to individuals with a SCI.

Disability-related challenges identified by participants were caregiving; financial issues; health issues; restriction of activities/physical limitations; and, sexuality/conception.

Caregiving. The need for assistance with some or all of the activities of daily living (dressing, bathing and grooming, transferring, bowel routines, etc.) is a reality for many individuals with SCI, particularly those with quadriplegia. *Caregiving* refers to the provision of day-to-day assistance with what, for able-bodied persons, are typically self-
care tasks.

The level of SCI was found to be predictive of the extent of physical support that the women were be called upon to render. Negotiating who will be the primary provider of care was a decision some of the participants and their partners faced, sometimes relatively early in the relationship. The impetus for the women's involvement in caregiving was often necessity, or a desire to avoid the intrusiveness of involving a third party. If not before, the issue of caregiving became salient for many participants (N = 5/8, 62%) when the couple began to live together, either before or after marriage.

Karen was not involved in caregiving at all prior to marriage because her partner used the services of a professional attendant.4

For some participants, their partner's self-sufficiency with the activities of daily living made caregiving a nonissue for the couple. Three participants (N = 3/8, 38%) described themselves as having no regular involvement in their partner's self-care activities. Not surprisingly, these women's partners also had the lowest levels of SCI in the sample (T12, T12 and T6). Although Janice was involved with caregiving when her partner was first injured, he subsequently became self-reliant in all aspects of his personal daily care.

Four participants (N = 4/8, 50%) were involved in providing care to their partners during the very early stages of the relationship. The participants identified the following

4 After marriage Karen provided full-time care for her husband; however, she found that "...it seemed to affect the intimacy" and so the couple decided to "...be as normal a married couple as possible...." They rehired David's attendant and found "...that's made a whole difference." Even with this assistance, Karen speaks of her responsibility to help her husband. "I do the care when we're on holidays and what not...or if [attendant] is on holidays...I'm always really sort of a little bit jealous of...you know, women who...get away for the weekend...like there's no way...someone has to visit, come in the home and sleep with David. Who's gonna do that?"
properties of caregiving: physical demands; sense of responsibility; potential for conflict; and the need to psychologically separate caregiving from the relationship.

Penelope: “...there was no home care available in [city] at the time so I was the one doing all the care...which meant that on my days to work, I worked day shift, like I was getting up at 5 every morning...you know I had to make sure he was up and had stuff out for the day before I even left for work you know and then come home from work, put him to bed and it would start all over again in the morning and I found that really tough...I mean it can be physically exhausting.”

Sara: “I did do lots of the bowel routines and things at the start, but mainly because he, we didn’t know that Home Care would come and do these things...at that time Home Care was different. So, we just decided well this is all part of it, then we have to do it so...But it didn’t really worry me too much doing it as long as I knew that he actually cared for me and not just things that I did for him. Because I’ve seen relationships where it’s oh, you know, really just too easy to be there because of the nursing care that people didn’t have.”

Ann: “...when we were dating he would spend weekends at my house so I’d do some of his, do his care on weekends...when we started living together I did it all because he didn’t get any, we didn’t get any, we no longer qualified for any home care...like a lot of times I would like to have just taken off or, you know, like go away for two days or whatever but, the commitment’s there to, to come back and help him or whatever, even if, no matter how mad I am...I would say like 50% of our relationship is, our fighting is based on his care...It’s his needs, his care, I have to do this, I [he] come first no matter what, you know, you’re always the last in bed...he didn’t realize how much work it would entail to me.”

Emily: “...there are some, a lot of really personal things to deal with...but no, it
was always me [providing care], you know, and then he had an accident or something...you know help him falling out of the shower...you can’t be very private...it was just a different kind of help, that’s all.”

The alternative to personally providing care was to employ an attendant. As suggested by the preceding comments, the potential for professional assistance is often dependent upon availability, affordability and/or qualification for these services. Even when an attendant was involved, the participants were called upon to provide emergency and/or part-time assistance.

Karen: “...David had a bowel evacuation basically...and I knew that to wait for his home health aid to come or whatever would be, you know, could be a couple of hours...and he was like ‘I just don’t know’, I said ‘look this is part of our life...I have to do this’, so he let me do it...and I was okay with it, I was fine, I just did it....”

Sara: “...he [partner] always wanted to keep the two separate if possible...he has the same caregiver that comes in every day...it makes things easier... I help him to bed at night and any problems that come up.”

**Financial issues.** For some participants economic pressure played an oppressive role in the couple’s current situation and future quality of life, particularly if the partner was unemployed, had limited opportunities for work, and/or was without an alternate source of income. Many of the participants (N = 5/8, 53%) were, and in most cases anticipated continuing to be, the primary wage earner. One participant described uncertainty about the couple’s financial future because of pending legal proceedings related to the partner’s injury. Increased expenses associated with SCI (wheelchairs, medical supplies, modifications) further burdened many couples’ financial situation. For some, marriage resulted in the reduction or elimination of the partner’s pre-existing government pensions and subsidies, exacerbating financial pressures.
For others, the partner’s level of education, steady employment, and/or disability settlement protected against financial stresses, making fiscal issues less pressing concerns in the couple’s future together.

As a general trend, although participants acknowledged a recognition of potential financial issues, these matters appear to have played a relatively minor role in the participant’s ultimate decision to marry their partner. Sample comments from the narratives are provided below.

Emily: “...I wasn’t really thinking finances, I must have thought I was wonder woman...I just wasn’t thinking real practically, like oh love can conquer anything...so what if he never works for the rest of his life - does it really matter?...he’s got work and, yeah, it was important for him to work, but he knew he could never contribute as much as I could...of course you lose your benefits once you’re married - lose all your extra benefits...Well, I mean finances is a big - it’s a pressure.”

Penelope: “...so many guys that, or even girls for that matter, that end up getting married, lose their funding...I was thinking about that but it wasn’t a priority...I started thinking well I know if we get married you’re gonna lose whatever monies you have coming in and can we live on what I make...?”

Janice: “He tried but who’s gonna hire somebody in a wheelchair? That’s his attitude. He didn’t have, I mean his accident happened so young and he didn’t have a good education under his belt...and you know,[after his accident] he just never started to work full[time]...he did have plans to find work and to, you know, do something with his life...Well, I didn’t think it would be quite as bad as it is...where did all the money go? But then you look back at all the receipts for the medications and...sometimes I wish the law suit would go away...It’s kind of selfish on my part because he deserves what he’s gonna get because, you know, to pay a dollar a catheter and all his medical supplies, like they’re
just so expensive, but it’s interfering with our life together.”

Lisa: “I think at the beginning it was a little harder, because he got his measly $[amount] per month or whatever, and I wasn’t working either, so I was on UI [unemployment insurance]...we just kind of lived day to day and we knew eventually we’d get out of it....”

Sara: “...He has an insurance settlement, so when we first moved out together his income was quite small, but I was working full time so it wasn’t a huge consideration.”

Ann: “...he’s always worked. He has a good job...money has never been an issue with us, which is different than most people.”

Karen: “David’s injury was considered 100% pensionable, so he receives a disability pension which is really good... so [name] paid for his university, paid for [attendant] to come and give him a hand and all this, all this various other sorts of things and the products he buys, his medications that related directly to his injury and all his stuff gets paid for...and here’s David working towards, you know, a fairly reputable career....”

Donna: “...we talked about it...but it was more of a financial planning...Tim was employed, he had a good job...He didn’t have any disability pension because he didn’t, there wasn’t anything the way his accident happened...we weren’t worried we were going to lose anything by getting married...the consideration was well, this is how I spend my money...this is how you spend yours....”

**Health issues.** Individuals with SCI may be at increased risk for developing health problems (i.e. urinary tract infections, pressure ulcers, spasticity) which, on average, result in reduced life expectancies (Ditunno, Jr. & Formal, 1994; Samsa, Patrick, & Feussner, 1993). All participants described varying degrees of experience with their partner’s health problems, including urinary tract infections, spasticity, pain, respiratory problems, autonomic dysreflexia, and substance abuse. In general, the presence and intensity of
future concerns about a partner’s health tended to be associated with participant’s experiences wherein their partner’s well-being was threatened (i.e. unstable medical condition and/or hospitalization).

Three of the participants (N = 3/8, 38%) admitted to future concerns about their partner’s health prior to making a marital commitment. Additionally, some women expressed concerns about their own physical health and ability to assist their partner in the future. Overall, these concerns tended to be balanced against the recognition that health issues are not exclusive to SCI and the future of any individual’s vitality is always unknown.

Emily: “...well what happens if this only gets worse because it’s not gonna get better, it’s not gonna get easier, you know he had bouts of hospitalization, days will be worse, days won’t be better and he will be more dependent...I do worry, I do...but that’s not exclusive, I mean it could happen...my able-bodied husband could have, you know, a quadruple bypass and where would I be?...Cause if my arms and my back goes then, you know, I’m not good to anyone, much less Roger....”

Ann: “So, I guess that’s the big thing that’s always bothered me, is the fact that he probably won’t live as long as me...I also know about kidney failure, lung clots, you know, all this stuff. So I’ve seen all that [as a nurse], whereas somebody just gets septic really quick and goes like that [snaps fingers]...it’s kinda hard...that’s about the only thing that bothers me.”

Sara: “Jack often doesn’t feel well...I think it’s [concern] there all the time. Just because there is lots of problems, all the bladder infections, all the catheter troubles, falling, osteoporosis...like chest infections - he has some dysreflexia too and that took me awhile to understand. If your bladder gets too full, and your blood pressure goes sky high and the first couple of times it happened I thought what’s wrong with him...something has
to be done right this minute, because he gets sick so fast....”

Although over half the participants (N = 5/8, 62%) recognized the potential for health problems in their mates, they did not consider these concerns to be significant at the time they decided to marry their partner. In some cases, participants reported that prior to marriage they were not fully aware of the potential physical complications associated with SCI.

Karen: “Not initially, not initially because I didn’t really know that the potential of his longevity was such, like that...I had no idea...now it is something I think about....”

Janice: “Not at that point because I don’t think I understood it as much...But now seeing how much medication he takes...he’s in the hospital so much, but, you know I try not to think about that....”

Penelope: “I never really think about it. I mean I know there are things that will come up, they may be frequent or he may not be sick for years and years.”

Donna: “…not at the time. He was pretty healthy...some sores and he still kind of sometimes gets those....”

Lisa: “That never entered my mind at all. No. Because he’s a healthy - we get the usual things with being in a chair but you’ve [he’s] been hospitalized what, once”? 

**Restriction of activities/physical limitations.** As one of the participants, Ann, so clearly articulated “…when you date somebody’s who’s disabled you know there’s gonna be limitations...Like you know he’s not gonna mow the lawn.”

Not surprisingly, the general trend observed in the data was that the higher the level of the partner’s injury, the greater the restriction on activities the participants (and their partners) experienced. However, to varying extents, all participants described the need to adjust to the restrictions and limits imposed on the couple’s activities by the partner’s disability.
Informants indicated their partners' physical limitations led to concerns about environmental accessibility, a recognition of increased domestic responsibilities, limits on shared recreational pursuits, and, in some cases, the need to adjust to a slower pace of life. Some representative excerpts from the data which exemplify elements of this subcategory are provided below.

Ann: "...doing lawn work never bothers me, painting the house didn’t bother me, widening doors didn’t bother me...It’s the unexpected...and I can’t cope...when the hot water heater breaks at 4 in the morning and you’re the only one who can stop it...that’s when I fall apart...it’s hard to always be that person...and that’s always when I say I can leave, I can leave now, I need somebody who can help me...and then I’m fine an hour later...But I had six stairs into my house so I had to carry him into the house and put him on another wheelchair...."

Emily: "...it’s hard for me because, you know, I mean there are, there are things that I can’t do around the house, just as far as looking after things, like he can’t get down to the basement so you know, then there’s the stupid - like this goes, or the plumbing goes and the basement’s flooded, you know and the furnace is broken, well you know and then its very frustrating because Roger said ‘if I could get down there I could do it’...I mean it was always, it was like getting the stuff; it was getting around the stairs, it was getting all the stuff you need to do to make it accessible and make it workable...but we did it."

Lisa: "...we met when it was really cold outside so we couldn’t really go anywhere you know, cause Steve, his legs freeze and all that fun stuff and so we pretty much just stayed in the house...That’s always been probably the hardest thing...finding a place to live...the bathroom size."

Donna: (whose partner has a T6 SCI) "...we skied together...we’d go out for supper, go to see a movie that kind of thing...we would go biking, except he would just go
in his chair. I would bike and he would wheel along in his bike...he tried everything...found out that he could do it...when we go out somewhere...that has stairs but no ramp, there are some places like that still, and if I can't find some[one], stop someone on the street, or go in and find someone who will pull him up the stairs, he'll just get out of his chair and crawl up...."

Janice: "...we had to find other things to do because there [were] a lot of things we couldn't do anymore. Um, so we used to go for long drives, just sit and talk a lot...something as simple as going shopping or going to look for something. You know if you, people take it for granted like they go...to ten different places, but we can't do that cause it's frustrating for him getting in and out of the car ten times...like going shopping for stuff like that I do alone, which I don't like to do cause I want his opinion too...."

Karen: "I like to backpack and hike and things like that so...that's something too we're very limited in, you know...and all of a sudden it was like, they [other people] can just go and travel, they can go and do this, and then go and do that and, we can't, I mean there's limitations. All of a sudden the limitations kind of went [gasp], hit me in the [face] before the wedding."

Penelope: "...one thing that kind of, it doesn't bother me so much anymore, is the loss of spontaneity. You know, you can't just say tonight, oh yeah, well let's take off and go to [place] tomorrow you know for a few days because it takes planning. You just can't do that anymore...[friend's] house is totally inaccessible, meaning you have to make sure there's some guys there that can get him up like a dozen stairs, well, to me that's not my idea of, first of all, accessibility, second of all, I don't like depending on other people to get in and out of places...so I don't really choose to go and lots of times we don't for that simple fact."

Sara: "...you get used to taking time to get into the van ... you learn in a hurry it's
slower transportation wise, and things...And it’s not always because Jack doesn’t want to do them [activities] but just that [he] can’t go to the zoo in the snow in a wheelchair you know!"

**Sexuality and Conception.** The degree and type of disruption in male sexual functioning following SCI is dependent upon the level of lesion and the completeness of the injury (Trieschmann, 1980). Almost all the women were sexually involved with their partners prior to marriage. Many of these participants described initial nervousness, concerns, and questions about initiating sexual intimacy with their partners. For some, a diminished emphasis on the physical sex act was a welcomed feature of the relationship, leading to the development of greater emotional intimacy within the relationship.

Overall, the women interviewed reported satisfaction in their sexual relationships with their partners. Some of the informants’ experiences are reflected in the following passages.

Penelope: “...definitely sex changes when...you’re with somebody with a disability, and you tend, you just learn how to do it differently...when I first met Kent I’d read everything on the unit I could about sexuality because personally I really didn’t know...I thought well it’s bound to be trial and error...it was just kind of you did what felt right to us...and what satisfied both of us...I think it’s just like anything else that’s new...you just can’t sort of get enough and it was the same thing [for us]....”

Donna: “...I mean there were questions how, but, you know, once that got worked out and explained, not explained but just understood, you know, that’s, there’s nothing wrong with that [sexual relationship] either...it just took a while to get comfortable enough with each other to talk about it. But now I mean it, it’s just second nature to me....”

Emily: “...all the intimate stuff you know - What do I do? What can I do? Am I
gonna hurt him? Is he gonna hurt me? Um, am I gonna be okay?, like freak out or something... an emotional intimacy was more important than the act, because the act wasn’t an issue...Like all the pre stuff, so the caressing, the fond[ling], the touch, that...the intimate kind of things...more than the actual intercourse...."

Ann: “...I taught a couple of sexuality classes...we used to have a spinal cord program once a week...I was scared...sex wasn’t a focal point in our relationship so we dated...for a long - we’d actually lived together for about six months afterwards without ever having sex...we built such a good relationship and a good foundation before sex became involved in the picture that, like it was just like a bonus. It was like putting the cherry on the top...actually the gratification wasn’t a problem...we have a good sex life...the difference is there’s no spontaneity...that’s about the only difference in our sex life is that it’s a little bit more organized.”

Lisa: “...it’s [sexual relationship] good...no problem there...I think we were both nervous the first time cause I wasn’t sure what to expect and what he could and couldn’t do so...but after that things went well. We’re open that way too, we talk a lot about that too....”

Sara: “...I think its [sex] more of a problem because he worries about things so much, just in case, what if, and [sigh] oh relax, and quit putting worries that you think I have that aren’t there [like whether she is satisfied]...after figuring things out...we didn’t talk to anyone really...you know the one page novels, spinal cord book.”

Janice: “After his accident was really no comparison, I mean it, it was a lot different...We were handed a brochure once and that’s about it.”

Conception issues and the desire for children were discussed by all informants and their partners prior to making a marital commitment. For some couples, plans to have (N = 3/8, 38%) or not to have children (N = 3/8, 38%) were clearly established. For others, a
more ambivalent approach to planning for children prevailed as the couple accepted the possibility of childlessness and adopted a "wait and see" attitude (N = 2/8, 25%). For those couples planning a family, the partner's fecundity was not always known, however, adoption or fertility interventions were recognized options.

Karen: "...he says 'I am fortunate in that I can...get an erection', he says 'there's just not ejaculation' so in that sense he said...'we will have normal sexual function'...He was very up front, he said 'you know, slim to no that we could have children'...so it was, we went okay if fertility is probably an issue, okay lets go to adoption. This is even before we were married...."

Janice: "...as far as having children as well, we talked about the different routes we’d go...just basically we’ll cross that bridge when we get there."

Lisa: "...we knew we wanted them, but we didn’t know how...how to get it to happen...we used to talk about that long before we even got married...because both of us have always wanted a family."

Ann: "I can’t have children...my doctor recommended I have my tubes tied then he said ‘you can still conceive but I don’t think you’ll carry’...I’d have to be on 24 hour confinement...I was on confinement the whole time I was pregnant with [son from previous marriage]. You cannot have children and go on confinement and then be married to somebody [who is] disabled, forget it, so."

Penelope: "We talked about it initially, and ... mutually, it wasn’t just one of us or just me, but we both felt that having someone in a chair and having to look after a child and having to work just isn’t the lifestyle that, that we would choose...it would not be worth it to either one of us...plus I’m not, when I was married the first time we never could have children, you know I went through the whole insemination business and I just wasn’t willing to go through it again...."
Emily: 

"...oh I wanted one...but you know we’d have to go through all the physical things and, plus there was, you know I have a special needs child so I know I’d have to go through all this testing and it wasn’t even, it didn’t even have to do with Roger, and what we would have to do...there’s a point at which you have to really do the right thing and the smart thing...and the situation and my older kids...I don’t know if it would have been good for them...."

Sara: 

"it was just something that Jack was concerned about...he said that he couldn’t have kids so and...if it was really important to me then you know it was something that he didn’t want me to be wishing for kids forever if it was really important - we had talked about it and decided that it was okay [if they did not have children]...."

Donna: 

"We kind of questioned it [the ability to have children together]. We wondered, but neither of us knew for sure, so. I had a pretty good idea I could have them but Tim, he didn’t know - he’s never checked into it so he didn’t know. And we just kind of left it at that, I guess we thought we’d worry about that when the time came...it’s not something that we won’t be happy if we never have them...we can be happy without them, we can be happy with them. Which ever way it goes I guess.”

Coping and Problem-Solving Strategies

Participants revealed a variety of attitudes and strategies which they employed, either alone or in conjunction with their partner, to address interpersonal challenges, disability-related challenges, and difficulties encountered in their social relationships. Coping and problem-solving strategies were conceptualized under four major subcategories: interpersonal negotiation; support from others; attitudinal coping; and behavioural strategies. As a general trend, participants reported the use of a combination

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5Sara and her husband subsequently had two children using reproductive technology to assist with conception.
of approaches, however, tended to rely on some strategies more than others. These subcategories will be discussed separately below.

**Interpersonal negotiation.** Interpersonal negotiation approaches were represented in the data by concepts such as promoting and supporting partner’s independence, communication, compromise, assertiveness, and time apart.

A particularly dominant theme across all participants interviewed was the stance they adopted to promote, support, and maximize, their partners’ extant physical and attitudinal independence. These strategies were primarily motivated by the women’s recognition that maintaining independence was very important to their partner’s sense of personal agency and dignity. Another reason for advancing their partners’ independence was the participants’ desires to reduce the demands placed on their time and energy.

It is important to re-emphasize that virtually all partners in the sample maintained very autonomous attitudes and strove to be as physically independent as possible. In some cases, when necessary, partners gently reminded the women that they were capable of accomplishing certain tasks by themselves. In most situations, the goal of maximal independence was a shared objective.

Informants reported adopting tactics such as withholding services, not assuming responsibility, containing worry, finding equipment, avoiding dependency, encouragement, and teaching as strategies to facilitate their partner’s independence. A selection of comments representing this significant theme in the data are presented as follows.

Janice: “...he was dependent on me...like he used to go out on his own and do a lot of things and now he was just suffocating me...Well, before we got married I insisted that he live on his own...when we got back together that’s when I convinced him to move out, kind of pushed him to go on his own because I didn’t want to take that role of his mom again. So I wanted him to try and be a little bit independent on his own...I want to try and
be as normal as possible...and it just seems like everything’s on your shoulders...and it [doing tasks] just, also keeping him busy, like because he doesn’t have a job...I mean I wanted him to be more independent...."

Donna: “...I made it quite plain that I am not here to get, to look after you. You can look after yourself...I don’t want to be somebody’s mom...Because I don’t want to have to do it all myself...there’s no way, I would rather go crazy...I guess it’s for my own comfort that I ask that he do his share...I foster it, the independence in him because I need it to keep my sanity....”

Ann: “So anyway, I bought him these [special] scissors and I said to him ‘now don’t ask me to cut out anymore newspaper articles’...when we first met...one of our first dates was a wedding, I had to cut up his meal and it just mortified him...it [cutting his own food] was not time efficient was his big excuse and I said ‘well, make it time efficient’...like I get all these little gadgets or these little ways of setting things up for him...so that he can do it...it’s always these little lessons, it’s like ‘okay here are the tea bags, here’s the cupboard, you can reach them, don’t ask me anymore okay!’ And he goes ‘okay’, so its kind of funny...There were things that I tried to get him to do and they just weren’t time efficient. I said ‘okay that’s enough of that struggling’...We have a rule in our house...you must work as hard as you can, so he has to wheel through the house in his manual chair so he can get his exercise...I don’t care how long it takes, if he wants to do it...if he drops a piece of paper on the floor...it is ruder for me to pick it up and throw it in his lap and say here you go.”

Lisa: “...I just kind of stay out of his way...when we’re out and about the only thing I will actually ever help him with is up a curb, or open a door or something...if he doesn’t want the help he won’t ask for the help. And I’m the type of person...it’s like I won’t help you unless you ask me for it.”
Sara: “So I will encourage him to do whatever - you know, if he wants to try it, then we will...but I think it makes him feel so much better that it’s important to me to see that we find a way of doing it...and there’s some things that just aren’t possible...Another time he got stuck on his lift at -27 degrees, up in the air...in the K-Mart parking lot, but I have said to him ‘I can’t worry about you every time you go, that if I do that then I take away your independence’, and I feel that he has to go...‘you should go and do whatever you feel you can do’...because I used to phone him from work when we first moved [in] together - ‘are you okay?’...he said ‘Quit phoning me, you just bug me and then I have to stop doing whatever I’m doing to answer the phone!’...they [medical staff] had a discharge conference [when Jack left extended care facility to move in with Sara]...and they said to me ‘So, what’s Jack going to do all day’ and I said ‘I don’t know, I’m going to work, that’s his problem. I can’t do things for him all day’...I mean he has to decide what he’s going to do all day, it’s not up to me...And I don’t have time to stretch legs. I mean once in a while I will, but if he wants something done he has to find somewhere to do it or do it himself.”

Emily: “...often he’ll say, maybe I leave too much space and I don’t do enough and I won’t coddle him...there are times when he would like me to do more for him and help him...most of the time, I mean he, he just does what he does....”

Penelope: “I know I still worry even through basically I know that he can take care of himself, but it’s, if he’s going out somewhere and he’s not coming home until 10 or 11 at night...a lot of times he wheels home himself from wherever, and I know that’s okay, but it’s the lunatics out there that I worry about...sometimes he reminds me, he’ll say ‘You know I’m not a kid, I can take care of myself’...I just sort of have to step back....”

Karen: “He needs to do as much as he can...so he can contribute to the relationship as well...I have a tendency to take over some responsibilities and David actually gets quite
offended and he says ’no Karen, I need to do that.’ And then I go ‘you’re right, I’m sorry’...He doesn’t run over and pick things up for me! You know I have to bend over and pick them up for myself!”

To complete the discussion of interpersonal strategies, a few brief examples of the more self-explanatory concepts of communication, compromise, assertiveness, and time apart are provided.

Ann: “I stood up to my parents day one and said if you don’t like him after you’ve met him then voice your opinion but stop your bad-mouthing him now. And my parents knew where they stood....”

Emily: “…we try and talk about it and work it out and figure out how not to do it again, or you know do it differently...sometimes apart like, you know, it’s just get in the car...go shopping, go sit by the lake, just you know...blow off some steam....”

Karen: “We usually have...this sort of rule whoever’s talking no one interrupts...so that we’re not interrupting each other, we’re totally listening to the other person and then asking questions...and then we come to a resolution sort of saying oh, that’s how you feel, okay, and then sort of feedback questions of ‘well I sense this, is that how it is?’....”

Donna: “Yeah that was something we worked out too...So if he came home and started cooking, I knew I would do dishes that night. So that’s how we do a lot of things, you know, not just housework, but that’s the easy way to explain it....after you get the anger out, then you can come together and decide some way to solve the problem, discuss it, talk about it, and come up with some kind of solution....”

Support from others. Often the strategy to overcome challenges was to seek support from others. Professional service providers, family, and friends were the primary resources to whom the participants and their partners turned for assistance.

Representative comments which illustrate the category of support from others are
provided below.

Karen: “...other friends who have been married 20 plus years, grown up kids. They’re great to talk to, you know, they’re just such sage advice and...I certainly know I need help....”

Donna: “...so I guess, yeah, you do learn some things and some things you just, you leave. Some things you learn to put on someone else...And we went for premarital counselling....”

Ann: “[her ex-husband] is very supportive of our relationship...Peter can call [ex-husband] and ask him for help, he’ll say ‘[the] lift broke, I can’t get it up’ - ‘no problem, I’ll come over and give you a hand’...he [Peter] says ‘let’s try counselling’ [where they were told]...‘The problem here is you don’t fight properly.’...so...we learned how to fight....self-managed care came in and we were one of the pilot private families...even then they offered us minimal [home care], they gave us, what was it, 6 hours a week....”

Karen: “...and his family really helped me a lot too...I want to talk, David’s mad, he wants to withdraw...So that initially just made me so angry...he didn’t want to talk about it, he didn’t want to deal with it, but we were talking to a priest about it...so it really helped....”

Emily: “...we also went for couples’ counselling...the only time he needed someone from Home Care was after he’d been in the hospital for 6 weeks...he needed heavier care and I would be at work and so he just needed someone home during the day, like to help him transfer...into the tub....”

Sara: “...a lot of help from Home Care...with showers...getting him up in the morning and bowel routines....”

Penelope: “...managed to get him some Home Care for when I was working, so that helped out a lot....”
Attitudinal. Participants described attitudes which they adopted to face challenges and/or to deal with those aspects of life which were not amenable to change. The concepts which reflected these attitudinal approaches were acceptance, reprioritizing, spiritual faith, optimism, and humour. Examples from the data are provided as follows.

Emily: "...I mean some things you have to let go, you decide what your real priorities are and so having a perfectly, you know, maintained house...So, every once in a while you know I have to come back to the...real reason why we met, why we were meant to be together and what threw us together and what has to, what we have to keep sacred to keep the relationship the way it, it is so that we can make it through all this stuff...we felt like we could conquer anything...nothing seemed impossible...."

Karen: "I just kind of put it [hiking] on the back burner...I just have to just accept it...this guy is, you know, priority now...I guess I'd prayed all along through the courtship...I thought, well I've met challenges before in my life and I've dealt with them...I'll just deal with this too...he's [David] a riot, yeah it's quite funny...yeah, we laugh [laugh]...."

Sara: "...I just kind of accepted it...and didn't let it, it didn't stop us going places and doing things...I mean that [caregiving] came along with the stuff...we just decided well this is all part of it then we have to do it so.”

Lisa: "I get that from my mother. My mom is an optimist on everything....we knew we eventually wouldn’t stay that way forever - because we wouldn’t let ourselves.”

Ann: "...I said ‘that was 14 transfers’ [laugh] and he says to me ‘uh yeah well, I guess you don’t want to put me to sleep.’ ‘No I don’t’ [laugh] and he goes ‘okay 14, we’ll stop at 14 today, but 15 tomorrow okay?’...Like one of my friends said ‘oh, you’re disabled, I had no idea’. Peter goes ‘yeah these feet are awful big but you know - can’t do a thing about them!’...I said to him...‘it’s a week before Christmas and I look like shit in
black, so please don’t do it [David was close to death with a serious health scare] now.’
And he says ‘I’ll try to wait a week’.”

Janice: “It was just my life at that time, that’s what I did and that’s what I had to
do... I loved him very much and it didn’t matter to me whether he had the use of his legs or
not.”

**Behavioural strategies.** Many women also described very active, behavioural
strategies which they employed to address problems and overcome difficulties. These
active strategies to resolving problems were primarily associated with meeting disability-
related challenges. The composite concepts of this subcategory were learning/research,
innovation/planning, developing new skills, and equipment/modifications. Examples from
the narratives of the participants are provided below.

Karen: “...what I did was right when we started to [date] um, I decided that I liked
him, before he knew, I phoned up the Canadian Paraplegic Association, got to know
[counsellor] so we went out for lunch and I talked to her. I said ‘I’m interested in David’
and so she gave me information and things to think about as far as the disability goes.
What are...the possible problems, difficulties, what can we face, all about child rearing,
having babies, all that kind of thing... just what life is like in a wheelchair you know, um,
bathroom detail...all sorts of various sorts of things....It’s all new skills. My whole life’s a
new thing, everything’s new [laugh]...he [David] loves the garden...and I’m just not into
gardening at all, but I learned a lot about gardening since...so he has his vicarious
experience.”

Ann: “...Oh, I just look around...I found this in the back of a catalogue...it’s
scissors for people with arthritis....”

Emily: “...everything was new because I had to be cautious...like being in the
elevator, getting up to the door, it’s the getting to a restaurant...in and out of the car...Oh
well, you can find ways to do anything...we've managed to find a way...the closets aren't upstairs, they're downstairs...I mean, I've adjusted to, I don't sleep in my bedroom...I mean I sleep in the living [room on a sofa bed]...I don't care, it's fine, it works, it's not a big deal."

Donna: "...basic living questions like how do you get out of the car? How do you drive your car?...a lot of it [learning] came from just watching him. It wasn't even direct questions...It was just seeing...I mean it might, it, things may have been done a little unconventionally, but still done, you know...well it still happens when we go out someplace...that has stairs and no ramp...if I can't find...someone on the street or go in and find someone to help him up the stairs, he'll just get out of his chair and crawl and then [I] carry the chair up...."

Lisa: "...we research everything to death!...Now that they got all the stuff for people in chairs, you know the cribs that open this way and the stroller you can push...."

Janice: "Actually at first it was only me learning about it [SCI]...they had a lot of seminars for doctors...they just went through all the things that a paraplegic or quadriplegic is gonna have to go through and...I sat in on a lot of those seminars and I learned quite a bit on what's gonna happen and I just kind of fed that information back to him [partner]...."

Sara: "yeah, I can work a screwdriver a little better than before, and I change light bulbs and fix things and develop these new skills...because I didn't really know how to put gas in the car and lots of things you know...he used to have hand controls in the car...basement lift to the downstairs...my Dad fixed...the holes, turned the sidewalk pads around just for us coming...make it as accessible as he could...."

**Relationship Functions**

As the participants’ relationships evolved, an interpersonal environment was
created wherein many of their emotional and more practical needs (and presumably their partners’ needs) were fulfilled, fostering relationship satisfaction. *Relationship functions* refers to contributions to personal well-being which intimate coupling provided to participants - the “content” of the relationship.

Not surprisingly, all participants reported their relationship represented a rewarding and viable union at the time of making a marital commitment to their partner. The data also reflected increased appreciation for the relationship, greater involvement and commitment, and intensified attachment to the partner over time.

The major relationship functions which participants identified were: affection/emotional connection, encouragement/support, personal growth, sexuality/children, companionship, and, economic/domestic roles. These properties (or subcategories) of relationship functions will be discussed briefly below, with selected examples from the participant’s narratives to illustrate.

**Affection/Emotional Connection**

Many participants spoke of a strong bond with their partners. Affection and emotional closeness experienced with their partner was not only intrinsically rewarding to the participants, but also appeared to act as a sustaining factor in the relationship, as evidenced by some of the participants’ comments below.

Karen: “He told me that he missed me...once I came back he realized just how much he cared too and it seemed to kind of cement things....”

Penelope: “...personally I have a really hard time defining love. I guess I think love is different for everybody and what’s important to me is a stable relationship, stable, honest, uh that type of thing, and I think that kind of leads to a deeper feeling, whether that’s love or not, I don’t know.”

Janice: “...he cared for me, I felt that he loved, he loved me...and it’s just a feeling
that, it makes you feel special...I loved everything about him...."

Lisa: “I asked him what it was he liked about me and he told me it was cause he
was comfortable with me which kind of, upset me at first [laugh]. But then I thought
about it and I thought gees that’s actually good, that he was comfortable with me....”

Emily: “...it was very energizing, very powerful between the two of us...love
...passion...we loved each other, we were in love for...forever it felt...this was really a
great big love....”

Donna: “ It wasn’t just all of a sudden, oh my gosh, oh I really love this
fellow...you don’t really notice at first ‘til all of a sudden...its huge....”

**Encouragement/Support**

A number of participants spoke of their partner’s sensitivity, encouragement and
support in areas of personal vulnerability.

Penelope: “Well, he’s always been very supportive, no matter, you know, what I
choose to do or think I should do. He tries to get me to have better self-esteem, cause
that’s always been a problem...I’ve always had a battle with weight...he’s going along on
this diet business with me...he always tries to tell me that I’m not fat and that I should
think better of myself....”

Sara: “Just encouragement to do the things that I wanted to do....”

Donna: “Neither one of us is holding the other back from doing something they
really wanted to do.”

**Personal Growth**

For some participants the relationship, and their partner specifically, contributed to
their own personal growth by expanding horizons and interests, encouraging the
development of new skills, and increasing a sense of personal independence.

Karen: “Yeah, just really being assertive, that’s one thing, is I’ve never, I’ve
usually been very kind of a little bit weepy and quiet, just kind of let me just, you know, kind of disappear into the woodwork....it’s kind of like I’ve been sort of his advocate...it forces you out in the, right in the forefront you know, its been good for me, like I think it’s been good for my character...like just stretching me in ways that I would never have thought the relationship would stretch me and I see that that’s been really wonderful, it’s so good for me as a person...he’s gotten me into different sorts of music that I probably didn’t listen to before...it’s neat because he’s actually sort of broadened my horizons...I was learning and understanding about myself and in that sense it was, there was a certain excitement to it....”

Sara: “...he had helped my self-esteem in that, to have enough confidence to make your own decisions. You know, that he had built me up from being unsure of myself, you know to help, help me along...Well, it’s scary at first if you’re not used to it...going places myself, and driving places - you know? It’s all bigger independence for me...I had to become more independent being with him, that I was used to being told what to do [in her previous marriage] and, and then all of a sudden I’m taking care of the house, vehicles, the - doing all these things. So I had to become more independent in the relationship.”

Emily: “...being with Roger opened up a whole new set of relationships, we had new friends, different friends, it was a different world and it was, it was very genuine....”

**Sexuality/Children**

Another important function of intimate coupling was for the creation of sexual intimacy and, in some cases, procreation. Although most participants were less explicit when discussing their sexual life, this area of their relationship was described by all as satisfying, albeit altered to accommodate disability. For some participants, the diminished emphasis on sexual intercourse was acceptable as other forms of intimacy and sexual expression were found to be rewarding. A few illustrative comments are presented
Emily: "...an emotional intimacy was more important than...the act, because the act wasn’t an issue...Like all the pre stuff, so the caressing, the fond[ling], the touch...the intimate kind of things...more than the actual intercourse...it’s [sexual intercourse] not impossible...but it’s very difficult and then we just kind of said ‘oh, that’s not important after all’...if we can’t succeed doing this, you know...it was not a critical big accomplishment that we had to arrive at...Oh well, you can find ways to do anything [laugh]...just do whatever.”

Penelope: “Yeah, no we, I was very comfortable and I have to admit he’s, you know, he often says well like, ‘what happened to you, you were so [laugh] aggressive when we were um dating kind of thing, or first together.’ And I think it’s just like anything else that’s new, it you know it’s like if you’re...in a new relationship with an able-bodied person it’s like you just can’t sort of get enough...and it was the same thing...Kent is a highly sexual guy.”

Ann: “...I think your relationship shouldn’t be based on sex and I think too many people base their relation[ship]...on physical, on physical contact...we built such a good relationship and a good foundation before sex became involved in the picture...you know you hit a certain age where you realize, like...it’s not everything...actually the gratification part wasn’t a problem...we have a good sex life.”

A desire to have a family in the future, if possible, was expressed by a number of participants (N = 5/8, 63%), as discussed in the subcategory sexuality/conception above. The participants’ comments and considerations regarding conception will not be reiterated here except to note that having children in the future was an important desire for a number of women, which they planned to fulfill with their partner.
Companionship

Sharing activities, interests and spending time with their partner provided participants with companionship. In this way the relationship provided the basis for a close friendship, as well as a love interest.

Sara: "...we can be together and enjoy being together. Uh, as friends as well as, you know, husband and wife. It think that's the main thing. We enjoy each other's company."

Donna: "...we skied together...we'd go out for supper, got to see a movie, that kind of thing. Or he would come out to Kananaskis and then out there we would go biking...."

Ann: "...we do enjoy it [shopping together]...[we] do a lot of things together."

Janice: "We used to always, we used to do things together...."

Penelope: "...we do things like, you know...go to shows and do go out to dinner...we took off to Fernie even though he doesn't ski...."

Economic/Domestic Roles

The provision and/or sharing of domestic and economic roles is another important feature of relationship functions. The notion of adjusted expectations for the performance of roles was identified as a central theme in the couples' domestic lives.

Not surprisingly, the general trend was for partners with higher level SCI to be less involved in fulfilling domestic responsibilities. Participants whose partners were paraplegic were much more likely to report that domestic duties were shared than women with quadriplegic mates. In the latter case, participants reported performing the majority of household tasks, with some help from their partners when feasible. Because of their partner's physical limitations, a number of participants described themselves as assuming nontraditional roles.
As stated earlier, the partner’s level of injury was not clearly associated with their employment status. It appears that higher education and personal motivation towards employment were important factors in determining whether partners worked outside the home or not. Primary responsibility for both being the primary wage earner and performing most domestic duties was a reality for some participants, particularly when their partners were unemployed.

Examples from the participants’ narratives which epitomize this category are provided below.

Sara: “...it’s strange how before [in her previous marriage] it was a big fight about who did the laundry, who, because my ex always thought that the woman should do all these - that you go to work and this is your job and this is your job. Now I’ve got all those jobs and a few more...I do all the housework, I cut the grass, I paint the fence, I [do it all] yeah, and I don’t mind.”

Ann: “...I’ve always done this kind of thing...I’d wire my basement before and then, you know, then my ex-husband would help me drywall, that type of thing. But with Peter I just do it all...I go further, I push myself further...I love it...so, and all the cooking and all the house maintenance...he’s always worked, he has a good job...he has a pension....”

Janice: “...it’s almost like the roles have to change, like he would do more of the easier stuff like dishes and dusting and sweeping whereas I would do more of the, the harder stuff...like going out and shovelling the sidewalks or doing the lawn....He tried [to find work after his accident] but who’s gonna hire somebody in a wheelchair? That’s his attitude...I mean his accident happened so young, and he didn’t have a good education under his belt...and, you know, he just, he never started to work....he’s taken a few courses...He hasn’t finished them....”
Donna: “He does things he can do, I do the things he doesn’t like doing...I vacuum cause he hates doing it because he gets caught in the vacuum hose...He trips over that and everything. So I do that but he does things because I hate doing it.....So if he came home and started cooking, I knew I would do dishes that night.”

Emily: “Well I have...to do it [the domestic tasks] and if I can’t do it then...I have to get somebody who can do it.”

Penelope: “Well, I think that was sort of always, [taken] for granted because I mean I was the one with the steady job and even though he’d kind, you know, he’s been taking, he takes courses every once in a while to upgrade himself, but [laugh] I don’t think he’s ever really committed to that so. Uh, that’s just the way it is, we just get by on whatever, however, we can.”

Karen: [replaying a conversation with her partner] “...so I said to David, ‘so do you want me to work when we have a family?’ ‘No, no stay at home.’ ‘Good.’ - He says ‘are you okay with that?’ ‘Yeah, yeah. It’s what I want dear’.”

Relationships with Others

The category relationships with others refers to significant associations participants described with family members and friends. These relationships were discussed to a large extent within the context of others’ reactions to the participants’ partners and the developing romances. Integrating their new partner into their social network, and joining his, was found to be both negatively and positively influential on the coupling process.

As a general trend, the participants’ family and friends asked questions about the nature and extent of the partner’s disability. Initial concerns and curiosity were sometimes expressed prior to meeting the partner. Typically, these issues were addressed relatively quickly and apprehensions were alleviated.
Half of the participants (N = 4/8, 50%) characterized family and friends as positive (or at a minimum neutral), supportive, and approving of the couple’s relationship. A relatively smooth integration into one another’s social world afforded the participants (and their partners) a larger social network, and avoided external pressures on the relationship which were experienced by those participants who faced conflicted relationships with others. Although the participants’ relationships with their family and future-in-laws varied in terms of emotional closeness and propinquity, overall these participants described their interpersonal interactions as harmonious.

For the remaining participants (N = 4/8, 50%), relationships with family and friends included both positive and negative influences on the couple’s relationship. Conflict and estrangement, particularly with disapproving parents or future in-laws, was a disturbing feature of a number of participants’ relationships with family members and friends. Although disapproval from others was disappointing and saddening, negative reactions were ultimately not experienced by participants as influencing their ultimate decision to marry. A number of women (N = 3/8, 38%) married without both families’ blessing or support. In perhaps a telling comment, Emily suggested that if she had been younger she might not have had the fortitude to withstand the disapproval and judgment she faced in committing to her partner.

Emily: “Certainly, I think if I were younger...I would have knuckled under. I mean it’s all where you’re at, what age you’re at and how much you’ve grown. What sense you have of yourself. Because I can see with the pressure that I had to withstand, I don’t think that I could have and I’m sure that I couldn’t have 15 years ago or 20 years ago....”

Concepts which contributed to the development of this category included acceptance versus disapproval, trust versus distrust, support versus opposition, need for approval, triangulation, compatibility versus conflict, closeness versus distance, affection
versus animosity, expressed versus tacit, proximity, parental relief, resolving differences, and parental concerns. Representative comments from each of the participants are provided to further illuminate this category.

Emily: “Oh, they [Roger’s parents] thought it was great... from their point of view, you know their boy, was doing something and in a relationship, which they had almost given up hope on him ever happening the [sic], you know, the future was sort of bleak... the kids were ecstatic, the kids were thrilled to death... they love him to bits... there’s a whole different level of trust and of course, he’s not Dad, he’s more like a buddy... and my little boy has special needs so, so there was an extra special little affinity between the two of them... kind of an extra special bond... My friends thought I was insane. My friends were very upset... it didn’t bother me because if, the ones who disapproved, it’s, I could have cared less... my family wouldn’t come to the wedding, my sister wouldn’t come to the wedding... because they were, they didn’t approve... it wasn’t dislike for him [Roger] as a person, it was just for the situation and for every father’s or sister’s dream couldn’t you know, if this is the way I was gonna, why would I choose to end my life like this?... Really, it was like um, couldn’t I do better, kind of thing and I didn’t care... I just said I don’t care.”

Ann: “... My mother did not react well... okay my grandmother, although she was in a wheelchair and all that, in her later years she was quite bitter and she was quite resentful... So my mother was afraid I was gonna get into this ‘oh I can’t do this because I’m in a wheelchair’ type of thing. So when we first started dating she called me up and told me that. She said ‘I don’t want you dating him, he’s in a wheelchair’... I said ‘well don’t judge somebody until you meet them. If you meet him and you don’t like him, then fine, voice your opinion’... So my mom and my dad flew up and met him... and then my mom said ‘oh no he’s a nice person’... My parents’ approval has always been important. If
they didn’t like him, well if they didn’t like him I would have probed more. I would have said, ‘you know why don’t you like him?’ If they said ‘because he’s in a wheelchair’, I’d say ‘well you didn’t look beyond the wheelchair.’ But I know my parents are fair...she’s [mother-in-law] come right out and said that she’s sure I married him [Peter] for his money...What my mother-in-law doesn’t know is I’m from a very wealthy family...she assumes I married her engineer son and I’m gonna just, soak him for every cent possible...when we go to see his mother, or when his mother came to visit, she’d stand over him and cut his food and I’d say ‘leave it, he can cut it himself.’ [She would say] ‘Oh no, no, no, he struggles too much’. [Ann would say] ‘Leave it, he’ll do it himself.’ You know. As so, that was a big bone of contention, like, every single thing I asserted on independence she tried to undermine me...it’s taken her a lot of years and it, she probably never will accept me totally, but she also realizes that I’m in for the long haul...[Peter] said to me...‘keep your maiden name cause my family will never consider you part of our family.’ Some of my friends had a hard time...accepting it, but they...well they came right out with it...when they saw Peter they saw, well, here’s gonna be another person just draining off her. And they worried about that...By the time we were getting married, all my friends were very much in support, and my brother-in-laws were in support, my father-in-law was in support, my mom and dad were in support, my sisters were in support, [son’s name] was, I told you my ex-husband was in support. He thought it was the greatest you know...all my family love him....”

Janice: “I think his parents were expecting me to leave...They see everything just on a narrow line...she’s not gonna stay with him because he’s in a wheelchair, because of his disability...it slipped that his mom had asked him if I’m staying with him just because there might be money in the future, which really, it really bothered me and I’ve distanced myself from her because of that. And it’s always in the back of my mind, does she think
that I married him because of that...So, I think that they, they’re always questioning why I stayed with him...I think that she, she feels a sense of relief but she still questions my ability to care for him, and she still constantly checks up...it’s a big contest between the two of us. I feel like I’m competing a lot of the time to win Karl’s approval...I’ve said to him ‘why don’t you say something, why don’t you stick up for me’...and he says ‘well she’s my mother, like what am I supposed to do...Just ignore her’...[when Janice insisted Karl live on his own before marriage] his parents didn’t agree with it. They hated me for it, but now they agree with me on it...[my family was] Very supportive...Whatever I wanted to do is the right decision. Whatever makes me happy. And, and they could see too that he was very able too. He didn’t burden me at all with anything...Friends were very supportive. Nobody ever really said anything to me. I know there was probably a lot said behind my back...after he got out of the hospital people were very surprised that we were still together...his mom is very supportive [of him] like she’ll be there at the snap of a finger but that’s not good. She still babies him.”

Karen: “…I remember feeling a little bit fearful to tell them [her mother and grandmother] because I didn’t know what their reaction was gonna be and I didn’t think it was gonna be terribly favourable...[they reacted] ‘oh Karen, ...you have just another project you’re gonna give up tomorrow’...they had met him and liked him and all that kind of thing but it’s, it’s control, it’s not what they would have wanted...and they basically thought I was taking on more than I could chew...And my mother and grandmother never did, didn’t come to the wedding anyway...some of our friends had a hard time with it...cause a number of these people were not, we don’t even continue to be friends because they’ve cooled with us. I don’t know why people had a hard time with it...I mean it was okay to be friends and it was okay to date and all of a sudden marriage is just something else. ‘What are you doing? Do you know what you’re doing?’...but I...don’t like the back
behind the, behind my back sort of you know, chatter...I think friends that knew David very well, were close to him...were thrilled for him...his family really helped me a lot too cause they knew a lot of what I was going through with the [my] family and they really uh, they were just great.”

Penelope: “…they [her parents] didn’t meet him until about two days before the wedding...I get along well with them [in-laws]...especially his mom was always you know eager to do things, you know, to help me out when I was working kind of thing...I’m sure that they were happy that I was in his life, for sure...I think when he became involved with me seriously and, and they knew that it was going to be permanent, I have the feeling that they felt that it was kind of a relief...the girl that I work with, uh, one that I am quite close with, not that she couldn’t understand it because, we have another mutual friend who is married to a quad so, but she just, I think she was looking at the monetary aspect in that so many guys, or even girls for that matter, that end up married, lose their funding. Okay, so she was looking at it from that aspect.”

Sara: “...my mom said to me ‘Are you sure you’re not just taking your work home with you?’...they [her parents] kind of accepted him once they’d met him...he came to Scotland with me [where her parents lived] and once he’d met them they had no problems with the wheelchair after that...she [her mother] said ‘as long as you’re happy’, then that’s enough for her...And my sister, well the two of them get along really well...she accepts him totally...his whole family are the same, since the day I met them...welcomed [me]...so they’re really supportive...His dad is 86. He had a stroke and he doesn’t talk much but...he thinks I’m okay.”

Lisa: “It [dating partner] surprised my dad but yeah...my dad said to my sister one day ‘we must have raised her well if she can look past the chair’...he knows that Steve treats me good so my dad’s happy that way...as long as his daughter’s treated well...My
mom liked him right off the bat...they love him to pieces...they [Steve’s family] all thought it was great.”

Donna: “Um, my family was really supportive...They really liked him...they had some questions, but that was just questions about how he does he do this, how does he do that...they’ll accept you no matter who you are. They’ll give you a chance and if after knowing they don’t like you, well then that’s too bad. But they, you get a chance with them...I mean they didn’t voice any objections...And his family, I didn’t really care. It [their response] was important in that, if Tim was concerned that they had concerns, then yeah...they’re important to me just because they’re important to Tim...I’m a little bit strange in their eyes and I started to have this influence on their son. But that’s okay, we just, we visit with them for a couple of hours and then we go home...if he was happy, then they were happy for him. If it’s his choice to marry someone who is weird!”

Societal Attitudes and Awareness

The category of societal attitudes and awareness reflects the participants’ experiences and interpersonal interactions within the social world, as the companion of a man with paraplegia or quadriplegia. The emphasis within the societal awareness/attitudes category was on casual interactions; for example, with acquaintances, co-workers or strangers. More complex interpersonal relations with family members and close friends were considered in the relationship with others category.

Attitudinal and environmental barriers to full acceptance and participation in the social world were evident in all participants’ stories. It is not possible to conceal a highly visible disability such as SCI, making it a recognized feature of any social exchange. As many of the narrative examples presented below will indicate, the primacy of disability in social perception was evident. The data revealed participants encountered reactions to their relationship which ranged from curiosity to rudeness. The women in this study
primarily identified negative social incidents which were noteworthy, annoying, or hurtful to them. Many women described episodes where they witnessed or experienced the stigma so often associated with disability, either directly or indirectly.

The major subcategories emerging within this category were social awareness, social assumptions/attitudes, and social actions. The distinction between these categories is subtle, attesting to their interrelatedness. Although for explanatory reasons it is beneficial to discuss these aspects of social behaviour in isolation, this separateness is artificial. In reality, attitudes toward persons with a disability are likely rooted in ignorance and lack of awareness about disability, in this case SCI. These assumptions and attitudes are demonstrated in the social behaviour which participants described in this study. These subcategories are discussed sequentially below.

Social Awareness

Social awareness refers to the general population’s understanding of the consequences and implications of SCI, both in terms of limitations and abilities. Sensitivity to the physical and psychosocial needs of persons with disability was often described as lacking. Rather, misunderstandings and knowledge deficiencies were prevalent in the data.

In general, dealing with people’s direct questions and curiosity was not considered to be problematic to the participants. In most cases they welcomed the opportunity to educate others. More frustrating issues were lack of environmental accessibility, a perceived lack of knowledgeable medical professionals, and the general population’s misconceptions, as indicated in the following comments.

Lisa: “...some women at work are always, ‘oh do you have to do this for him?’ or ‘do you have to do, what, you know [what] kind of things do you have to do for him?’ It’s like I don’t have to do nothing [laugh]. You know that’s usually the first question is,
you know, ‘do you have to help him shower?’ or ‘do you have to help him do this or that?’ ... I got that from my family too, ‘oh what does he do?’ You know so...like I say it was curiosity more than anything...and it was like gees I never realized how...unaccessible this [world] is...it’s getting better but...you know, or for even anybody that’s in a chair...you know...that should be made different so that people in chairs could [do things]....”

Donna: “Um, the people I worked with had never really met Tim and I didn’t make a point of saying, of ‘yes, my husband is in a wheelchair’...But it was always that first time you tell them they, you can just see the questions start flitting across their eyes and their faces go, they change...And then...some of them will ask questions. ‘Well, what happened? How long has it been?’ And, I like those ones...they just come straight out and just ask. I was wondering this...But I’m sure they’ve got other questions that they’d like to ask but, you just don’t, you don’t.”

Sara: [talking about looking to buy a house]...we’ve looked at a few of them [laugh] that’s no good, have a ramp across your living room [because it is sunken]...the real estate agents don’t have much idea....”

Karen: [trying to arrange a hotel room] ”...I’ve actually even said to people ‘have you [really checked], how about if you grab a wheelchair and go in that bathroom and tell me how accessible it really is’, and the lady goes ‘are you out of your mind?’ [I] said ‘no, no, no, I want you to do that, go in the bathroom with a wheelchair and tell me how accessible it is, on the phone.’ And then of course, you know, she’s thinking weird lady [laugh]....”

Penelope: “...some people will, will say to me you know when they meet and they say, find out that Kent is disabled and they say ‘oh yeah but you work with it all day’. I said ‘yeah, but I said you fail to realize how different it is in that he doesn’t need the care,
need the time, that these new injuries need.’ I mean, you know, it’s like 15 minutes in the
morning [and] he’s up and in his chair and that, that’s it for the day...there’s not enough
health care workers, meaning like doctors, that are familiar enough with a spinal cord
injury to know how to - not necessarily care for them - but they don’t know how to deal
with them as a person. I mean, I can remember one time when my husband was in the
hospital and a lot of times, they know their bodies, especially if they’ve been injured a long
period of time so...he’s sweating say on the right side of his body, he knows there’s
something wrong with the left. And this doctor came in because they couldn’t find out
why he was so sick. The doctor came into the room one day and he asked Kent what was
wrong...[when Kent explained] this doctor looked at me like is he crazy. I said ‘no, that’s
how his body, that’s how his body knows.’ [The doctor said] ‘That’s odd - I’ve never
heard of that before’....and it just kind of bugs me that they don’t ever take the time to
listen to what these guys are saying...and as it turned out his left hip was fractured and
that’s why he was having so much discomfort on the right side of this body.”

Janice: “You know, it’s, they think of it as, as marrying, marrying someone who’s
completely incapable and incompetent and just is there. And a lot of people feel that way
because they don’t know. Like, I never knew how a handicapped person functions, other
than their, they can’t really function [laugh]. You know, just the way other people see
them. And a lot of people were surprised to see Karl driving, ‘like you can drive? How
the hell do you drive?’....”

Social Assumptions/Attitudes

Social assumptions/attitudes refers to the conclusions people appeared to reach
about, and the perspectives they demonstrated to the participants with regard to their
partner’s disability. A number of participants articulated circumstances when they
received intrusive, unsolicited warnings about their involvement with their partner. These
attitudes and remarks appear to have been based largely on others’ assumptions about their partner’s (and axiomatically the participant’s future) quality of life. Women described having their judgment overtly or implicitly questioned, feeling they were alternatively pitied or deified for their commitment to their partner. In the extreme, participants were astounded by direct comments which insulted their partner’s dignity and personal worth. Selected comments illustrative of this subcategory are provided below.

Janice: “And she didn’t even know me, really, other than from seeing me there a couple of times and hearing about what happened to Karl and she had a lot to say about [it]. ‘Do you know what you’re getting into? I hope you know what you’re getting into. This is gonna be a lot of work’...So a lot of people thought that it was gonna be a burden on me. And they were trying to warn me ahead of time....actually a lot of people were kind of surprised that we were getting married...They almost felt sorry for me - like do you know what you’re doing?...saying, you know, ‘how lucky you [her partner] are to have Janice’ and, you know, like is that really necessary...people look at it so simply that you married a handicapped person and he’s very lucky...They just assume we got the money [from his accident settlement]...I mean, they figure it’s been 7 years already he must have gotten something....”

Ann: “And you know, one of the nurses actually said to me ‘would it be such a great loss if he died?’...and I said, ‘well, yeah, it would be.’ [speaking both parts] ‘Well, what kind of quality of life does he have?’...Because they asked me if I wanted a no code and I said ‘no dice’. [Interviewer asks what a no code is]...if his heart stops, we’ll just let him go. And I said ‘how dare you ask me that...D’you know, he’s not a vegetable, he’s a human being’...so the first counsellor we went to sided with him completely. Oh, well poor Peter, he’s disabled, you know...my boss at the time thought it was disgusting and told me that, that I would marry half a man...And I was working for a doctor!”
Karen: "...and he [David] gets very frustrated with people who only look at the limitations...I remember talking to a friend of mine who also knew David as well...and he said you know, 'why are you dating David?' And I said, 'cause I love him', and he goes 'that's all I want to know'. He says I didn't want you to say I feel sorry for him, cause he's in a wheelchair...you realize that people in the community think you're pitying him...that's what it looks like but that's not how it is, that's not reality...he just wanted to make sure that I was doing it for the right reason and okay, and not doing it for altruistic [reasons]."

Sara: "You find that people either see you as on welfare or a millionaire because you must have gotten a huge amount of money from somewhere...So there's no in between...people presume a lot of things."

Lisa: "I got a lot of gees, I don't know if, I had one girl [say] 'I don't know if I could do that, marry somebody in a chair'. Like man, are you ever closed-minded, you know, just cause they're in a chair doesn't mean they're any different, you know...they just, something on them doesn't work, it's simple as that. You know, so, that actually gets me ticked right off when people say that."

Emily: "It wasn't that they disliked Roger, but I mean images are images, stigmas are stigmas and...what they saw was what they pictured in their mind, which was not okay...."

**Social Actions**

Social awareness of disability issues, as well as social attitudes and assumptions were reflected in the behavioural incidents which participants reported. Many of the women described becoming accustomed to strangers' staring, avoidant behaviours, occasional inconsideration, and even condescension. Some selected comments are provided to illustrate this subcategory.
Lisa: “Like that was my biggest eye-opener, was how people with disability, I mean even seniors, I work with seniors every day and just listening and talking with some of them, it’s the same thing, I mean they get shoved over, or whatever, and it’s disgusting...we hate going to malls...cause people are so rude. You know, like to get on an elevator...you got a million people on the elevator that are, or could very easily take the escalator and they all crowd in on the elevator....”

Ann: “People stare at us all the time, but we, we’re oblivious to it...in this restaurant...this whole family...they’re sitting there in this little semi-circle staring at us...they watched me all through my salad...all through my main course...but it’s like, you know, if you want to stare at me, stare at me. I don’t care...[when Peter was hospitalized]...doctors are coming in and talking to him like he’s a 6 year old...People will talk to his shoes [avoiding eye contact]...They do...they [her employers] had a Christmas party...and we get up to dance...and one of the doctors brought a chair out into the middle of the dance floor, started flapping around and said ‘look, I’m Peter’...How dare he do this? And everybody at work thought he should apologize...and he never would...You know I don’t mind staring, I don’t mind the comments, I don’t mind a lot of things, but that was the worst...I think that was the only time that I ever, ever had somebody do anything, anything so rude as that!”

One of the participants described her own avoidant reaction to sighting her future partner after his injury.

Karen: “…then in 1984, we started attending the same church and uh, so I noticed him, I saw him and I recognized him right away but I spent the next few months kind of avoiding him. Mainly because I didn’t know how to respond, I didn’t know what to say to him, until he finally cornered me and said, you know, ‘hi Karen, how are you?’....”
Summary of Results

In view of the somewhat lengthy presentation of results, a brief summary of the major findings is presented to consolidate this chapter.

- Based on the participants’ perspectives, the majority of partners (7/8, 88%), had achieved positive adjustment to their disability and displayed fortitude in meeting the daily challenges their impairment and the social world presented to them. In the remaining case, the participant was involved with her partner preinjury and the couple broke up specifically because of his poor adjustment to SCI. It was only after her partner’s attitude and adjustment improved that the couple reunited.

- High levels of autonomy emerged as a major theme in the participants’ descriptions of their partners. Even in cases where the injury level was high and physical assistance was a necessity, an attitudinal stance of maximal self-sufficiency emerged.

- Virtually every participant described a striking willingness to enter into a romantic relationship with a partner with SCI.

- Many of the participants had considerable experience with persons with a disability (N = 5/8, 63%), primarily through their occupational roles (N = 4/8, 50%), but also within their personal experience.

- There was considerable diversity across participants as to the timing of long-term commitment to their partner and the relationship. The participants’ formation of a long-term intention to remain in the relationship did not parallel marital commitment in this sample.

- Fifty percent of the participants indicated they did not consider the formality of marriage had personal significance to them. Most of the aforementioned women (N = 3/4, 75%) had been previously married.

- Previous romantic relationships consistently served as a basis for comparison in
the process of evaluating the participant's relationship with her current partner.

- Most participants \((N = 6/8, 75\%)\) cohabited with their partner prior to marriage, on average for over 2.5 years. The personal significance of living together varied across participants. Generally, women who had been married previously were content to remain in a common-law relationship without the sanctity of marriage.

- Many participants were involved in providing care to their partners \((N = 5/8, 62\%)\), either on a full-time or part-time basis. Partners requiring caregiving assistance were, not surprisingly, those with higher levels of injury, primarily quadriplegia.

- Caregiving and increased domestic responsibility was a source of stress and occasional burden for participants, necessitating strategies to rebalance the relationship. These strains were most significant for women whose partner's were quadriplegic.

- A dominant theme across all participants was the stance they adopted to actively foster and/or support their partner's level of independence.

- Not surprisingly, all participants reported high relationship satisfaction at the time of marriage. The overall quality of the relationship outweighed the sometimes significant inconveniences and concerns associated with their partner's disability.

- All women married to men with quadriplegia assumed primary responsibility for domestic duties; whereas, most women \((N = 3/4, 75\%)\) married to men with paraplegia reported sharing household tasks.

- Partner's level of injury was not clearly associated with their employment status. Higher education levels and personal motivation appeared to be more important factors in a partner's employment status.

- Fifty percent of the participants described negative reactions from family and/or friends in response to their relationship with their partner. Discouraging comments and disapproval were distressing but ultimately were not influential in dissuading participants.
from making a marital commitment.

- All participants described attitudinal and environmental barriers which they faced with their partner.
Chapter 7

DISCUSSION

Introduction

The goal of the present research was to understand able-bodied women's perspectives on making a marital commitment to a partner with SCI and identify the issues and factors which were salient in making that decision.

Although to this point the discussion of categories within this report has treated them in isolation from one another, it seems clear that mate selection and the development of commitment is a complex process. To integrate the various factors that emerged from the data (see Chapter 6), the categories and subcategories can be organized into a set of dynamic interrelationships. A visual representation of the major categories and their hypothesized relationship to each other is presented in Figure 1. Central to marital commitment appears to be the category of coupling, to which all other factors relate. Subcategories within the coupling arrangement are separated by broken lines to suggest their interrelatedness. The other main categories relate directly to coupling, inferring that they either enhance or detract from continuing commitment.

This chapter will first present a description of this tentative model, herein after referred to as the Dynamic Model of Relationship Development (DMRD), comparing it to existing courtship models. It is important to note that, consistent with grounded theory methodology, a second sampling of the literature was conducted, focusing on courtship, relationship development, and mate selection, after data collection and analysis was completed. In this way, consistencies between present findings and the published literature provide an additional source of theory validation. As well, variations from existing theory and empirical findings serve to distinguish discoveries which were unique to this study. These comparisons will also be discussed in the first section of this chapter.
Figure 1
Dynamic Model of Relationship Development

PARTNER'S CHARACTERISTICS

PERSONAL CHARACTERISTICS

OPENNESS / RECEPTIVITY

SOCIETAL ATTITUDES & AWARENESS

RELATIONSHIPS WITH OTHERS

RELATIONSHIP FUNCTIONS:
- affective/emotional connection
- encouragement/support
- personal growth

- acceptance
- trust
- compatibility
- economic/domestic role
Secondly, the major findings will be discussed in light of the specific research questions guiding this investigation, linking the present results to prior research.

Dynamic Model of Relationship Development

An Overview

In general, the DMRD illustrates the coupling process, which commences where all relationships between two people must begin - with meeting. Both the partner's characteristics and the participant's (personal) characteristics are influential in the dynamics of attraction; however, openness/receptivity to a relationship with someone with a SCI also appears to be a necessary condition. Without the participant's initial acceptance of her potential partner's disability, and openness to enter into an romantic association, that type of relationship would simply not develop. As depicted in Figure 1, the category openness/receptivity is conceptualized as a predisposition strongly related to the personal characteristics of the participants; however, partners' characteristics were also found to be influential on the willingness to enter a relationship with someone with a severe disability. In this way, openness/receptivity can be viewed as performing a gating function to connection, and ultimately to relationship development.

As the couple connects and begins to spend more time together, participants described a phase of discovery and creating intimacy, in which they learned more about each other, recognizing areas of commonality, compatibility, shared values and goals, and other evidence of mutuality. Disclosure and sexual intimacy also appears to facilitate the development of feelings of closeness, bondedness, and warmth within the dyad, thereby increasing emotional investment in the relationship.

The women (and their partners) all faced varying degrees of both interpersonal challenges and disability-related challenges in their relationships, which they successfully managed with a range of coping and problem solving strategies. For many,
cohabitation marked the beginning of a long-term commitment to their partner. For others the decision to live together had less significance at the time. In either case, living together seemed to have the dual effect of fostering investment in the relationship and providing evidence to the participants of the viability of their union.

Throughout the course of coupling, evaluation and commitment was found to be an ongoing and/or evolving process, rather than a distinct period of contemplation, followed by a decision to be committed. As stated previously, the evaluation/commitment process could be either quite explicit and cognitively based, or implicit and more affectively based. As well, many participants demonstrated an intermediate approach, employing objective reasoning, while also relying on their intuition and/or feeling about their partner, their relationship, and its progression. Evaluation/commitment seemed to be particularly influenced by relationship functions, although it appeared that all coupling subcategories were also important. The salience of relationship functions was highlighted as virtually every participant considered the quality of their relationship, their attachment to their partner, and their personal satisfaction as a member of the dyad, outweighed often significant difficulties associated with their partner's SCI.

It was evident that successful evolution to marital commitment required accommodation to disability on the women’s part, and presumably if this had not been achieved, marriage would not have taken place. Although the most significant adaptations took place during the initial stages of coupling, a need to accommodate SCI was ever-present in the participants’ lives. Perceived burden associated with their partner's disability was generally found to wax and wane, depending upon participants’ own coping abilities and environmental events.

While coupling processes are primarily internal to the dyad, the data suggests they are imbedded in and influenced by the external social environment, as depicted by
relationships with others and societal attitudes and awareness. These categories are shown to be overlapping as both this data and other research (i.e. Trieschmann, 1988; Yuker, 1994) suggest societal attitudes and assumptions about disability likely influence the attitudes and behaviours of family and friends as well. Societal attitudes and awareness appeared to primarily impact coupling via disability-related challenges, interpersonal challenges, and accommodation to disability. Both positive and negative reactions to the couple’s relationship were experienced by the women in this study. Not surprisingly, positive responses appeared to be nurturing to the coupling process, whereas negativity was often distressing and introduced the potential for disruption in the couple’s relationship, particularly in the case of parental opposition. These external challenges to the participants’ relationships demanded the implementation of effective coping/problem solving strategies.

Models of Courtship

The extant theoretical frameworks for premarital relationship establishment can be roughly divided into four groupings: evolutionary models; compatibility models; interpersonal process models; and social exchange models. Although no attempt is made here to review these bodies of literature, it will be beneficial for this and future discussion to briefly present these theoretical approaches.

Evolutionary Models

Darwinian explanations of sexual selection underlie modern evolutionary explanations of mate choice. Within this framework, both men and women are theorized to be motivated in their mate selection preferences by a desire to enhance their reproductive success. Sex differences in human mating have been primarily explained on the basis of differential parental investment.

Because women are limited in the number of offspring they can produce, their
reproductive strategies are purported to differ from men's. For women, parental investment in each child is quite intense, involving long periods of gestation, lactation, and child care. In light of the foregoing, women are theorized to be more selective than men in their choice of a mate, seeking partners who will procreate genetically fit offspring and parentally invest in their progeny. In contrast, men have evolved a tendency to seek a variety of partners to ensure genetic propagation. As they can potentially produce an unlimited number of children, and less parental investment in each child is required, men can afford to be less discriminating in their selection of mates (Hendrick & Hendrick, 1992; Townsend & Roberts, 1993).

Overall, the reproductive constraints women face makes access to resources and locating men who will invest in her and her children on a long-term basis a priority. Men's reproductive strategies are focused on finding accessible, fertile women, ensuring paternity, and minimizing commitment and investment (Buss & Schmitt, 1993; Kenrick, Sadalla, Groth, & Trost, 1990).

Consistent with evolutionary theory, comparisons of gender differences in mate selection preferences suggest women do show greater interest in men's potential for resource acquisition (earning potential and other related socioeconomic characteristics). In contrast, men have demonstrated stronger interest in young, physically attractive partners, with the interpretation being they are seeking to enhance their reproductive success (Sprecher, Sullivan, & Hatfield, 1994; Townsend & Roberts, 1993). These hypotheses were not supported by Buss and Barnes (1986) who found that, for both genders, the qualities of kindness and understanding, personality and intelligence, were rated as more desirous than qualities which would be predicted by an evolutionary framework, such as good health, wants children, and good heredity. These, and other, inconsistent findings suggest evolutionary models may be inadequate to explain human courtship (Hendrick &
Compatibility Models

Compatibility models posit that marital choice is made on the basis of matching demographic and/or psychological variables. The earliest models of courtship emphasized a single dimension of relationship development. For example, similarity (i.e. birds of a feather flock together) and/or complementary needs (i.e. opposites attract) were advanced as the basis for relationship formation. Similarity has been consistently found to be important to attraction and liking in a general sense (Aronson, 1988) and may be a particularly significant factor during relationship initiation. Complementary hypotheses suggest individuals seek out others who offer the greatest promise of need gratification. Matching may be based on selection of a partner with a complementary need structure, rather than a similar one (Hendrick & Hendrick, 1992). These unidimensional models have typically been presented as involving sequential, stage-like progression towards marriage (Cate & Lloyd, 1992; Hendrick & Hendrick, 1992).

One example of a compatibility model, the stimulus-value-role model, distinguishes between open field and closed field relationship contexts. In an open field (i.e. a large university class) individuals who do not know each other are free to choose whether or not they wish to interact. Physical attractiveness and other surface characteristics are considered more important stimulus characteristics in an open field context. In a closed field (i.e. a small dinner party), because of proximity or role expectations, individuals are required to interact and therefore have the opportunity to learn about the other person’s attitudes, feelings, etc.

Within the stimulus-value-role model, relationships progress from awareness of one another, to a value comparison stage where interests, attitudes, and beliefs are explored through self-disclosure. Successful completion of the two prior stages leads to
the role stage wherein the way the couple actually behaves with each other is crucial for relationship progression and stability.

Although stage models of courtship are intuitively appealing, they generally have not been empirically supported (Cate & Lloyd, 1992; Hendrick & Hendrick, 1992).

**Interpersonal Process Model**

Although similarity and other static factors may play a role in relationship development, particularly early in the relationship, the *interpersonal process model* posits it is the interactional nature of the dyad that is of critical importance in courtship. This particular model suggests multiple pathways in the progression to commitment and marriage, without clearly demarcated stages of development. Behavioural interactions of partners in a dyad help to shape the development of premarital relationships. Within this framework, mate selection choices are recognized as influenced by a complex interaction between partners, as well as their extended social environment (i.e. family, social networks, etc.). Despite variation, common developmental patterns can be discerned. The interpersonal process model emphasizes interaction, change over time, and a variety of influences on the relationship. As well, the model accounts for varied time progressions in courtship; specifically accelerated, prolonged and intermediate development toward commitment. Although there is growing empirical support for this model, further research is required (Cate & Lloyd, 1992; Hendrick & Hendrick, 1992).

**Social Exchange Models**

Social exchange theory has provided a foundational framework for considering intimate relationships (and other social interactions as well). Individuals are presumed to weigh the costs and rewards associated with all social interactions and are reinforced to continue in an relationship when (a) the intrinsic rewards outweigh the costs, and (b) when the availability of more rewarding alternatives is considered to be low. The underlying
assumption is that people seek the “best value” they can achieve in mate selection (Kenrick, Groth, Trost, & Sadalla, 1993). Commitment and stability is theorized to occur when dyad members are satisfied and rewarded in their relationship, and when they perceive that equally or more desirable relationships are not readily available (Floyd & Wasner, 1994). Basic social exchange theory has been expanded by many authors to include constructs such as equity; which emphasizes the importance of a fair distribution of costs and rewards across members of the dyad; commitment, psychological attachment and intention to maintain a relationship with an orientation to the future; and, investment, the result of time, effort, self-disclosure or indirect links to other relationships such as family or friends (Hendrick & Hendrick, 1992; Lin & Rusbult, 1995).

Rusbult and Buunk (1993) advanced interdependence theory as “the most fully developed model of dyadic relationships” (p. 176). Expanding upon basic social exchange principles, interdependence theory focuses on the interaction between partners which yields outcomes with rewards and costs. The value of a dyadic interaction is defined by the balance of personal rewards and costs; however, motivations may transform as the relationship develops, leading individuals to waive immediate self-interest and focus on broader goals. Rather than achieving satisfaction based on personal desires alone, vicarious positive experiences may be associated with a partner’s achievements or happiness. In this way partners’ rewards and costs become jointly experienced. As well, dyad members come to develop a dependence on each other for need gratification in important areas of their lives such as affection, emotional closeness, sexual gratification, and instrumental support.

According to interdependence theory, two important factors in an ongoing relationship are satisfaction level and degree of dependence. The evaluation of outcomes relates to experienced satisfaction levels. Individuals are theorized to assess satisfaction
on the basis of his or her comparison level, the personal expectations one holds for a relationship. Individual's qualitative expectations are presumed to differ according to factors such as personal love styles (i.e. companionate versus passionate love).

Internalized standards may be influenced by previous dyadic experiences, by observation of others' relationships, and by comparison to the partner's outcomes. The latter comparison incorporates notions of equity, assuming satisfaction depends not only on absolute individual outcomes, but also on an assessment of whether or not input/output ratios across partners are comparable (Rusbult & Buunk, 1993).

In the context of interdependence theory, the degree of dependence between individuals represents the standard by which individuals decide whether to maintain or terminate a relationship. The availability of quality, alternative relationships is theorized to influence dependence on the partner and/or relationship. Rusbult and Buunk (1993) further extend interdependence theory in the investment model: "a theory of the process by which individuals become dependent on and committed to their relationships" (p. 175). According to the investment model, the state of dependence is subjectively experienced as commitment. Increasing interdependence often leads to a reorientation in outcome expectation, reflecting a shared life and desire for joint outcomes (Rusbult & Buunk, 1993).

In general, the investment model proposes that individuals feel more committed to their relationships when they feel both satisfied and believe they have poor quality alternatives to their relationship. When relationships suffer unsatisfying periods, as most can be expected to, this model postulates invested resources such as time, emotional energy, personal sacrifice, and the linking of personal identity to the relationship, are influential in weathering the storm. These investments can be "...powerful inducements to continue a relationship..." (p. 186) (Rusbult & Buunk, 1993).
**Premarital Relationship Stability**

In their review of factors that influence the development and stability of premarital dyads, Cate and Lloyd (1992) reported increased levels of love, commitment, investment in the relationship, relationship satisfaction, effective communication behaviours, similarity, and social network support, were among factors found to be predictive of relationship continuance. Because these factors have not been found to represent unique predictors when compared to each other, the authors speculate they may measure a latent construct, probably that of relationship quality. Commitment is one of the few variables which may play a unique role in relationship stability. External factors, such as social network support have rarely been studied as predictors of premarital breakup. There is evidence to suggest that stable pairings enjoy significantly high support from others. Network support, especially that provided to female partners, shows promise as a unique predictor of courtship stability, a finding that is consistent with the contentions of the interpersonal process model that relationships are sensitive to external influences (Cate & Lloyd, 1992).

**The DMRD in Context**

The relationship between the major categories emerging from the current study, as depicted in the DMRD, will be discussed in the context of existing models of courtship and relevant extant literature. The current data suggests both consistencies and variations in relation to existing relationship development theories and these will be examined more critically below.

**Consistencies**

A number of themes emerging from this data share properties with postulates of the courtship models discussed above and these features are briefly outlined below.

**Similarity/compatibility.** Significant themes which emerged from the participants’
descriptions concerning the initiation of their relationships (connecting and discovery/creating intimacy) included attraction and the discovery of commonality, shared interests and goals, and compatibility. These shared characteristics and/or attitudes were found through a process of mutual self-disclosure and generally were held by the participants as partial explanations for their pairing. These elements of coupling are consistent with theories of attraction (Aronson, 1988; Hendrick & Hendrick, 1992) and compatibility models which emphasize similarity and complimentary factors as important in forging relationships; however, when one partner has a severe disability the notion of matching on the basis of physical attributes seems less relevant.

**Evaluation/commitment.** The present data reflects evaluative processes which parallel social exchange premises in general, and more specifically interdependence theory. Overall, the participants evaluated the impact of disability-related challenges and interpersonal challenges within the context of relationship functions (satisfaction) in a fashion that could be conceptualized as the weighing of rewards and costs. Furthermore, a dominant theme in the data was the participants' comparison of their current relationships to the quality of earlier dyadic involvements, and determining the former to be superior to anything they had experienced previously. It seems likely that these previous relationship experiences influenced the participants' personal expectations for a relationship, and informed the women's perceptions of the availability of rewarding alternatives.

The present findings are consistent with interdependence theory, as it seems likely the participants' assessment that they were involved in a rewarding relationship, coupled with a perceived lack of quality alternatives, would increase dependence and therefore feelings of commitment and investment in the relationship.

**Relationship characteristics.** At a very general level, it appears that participants in
this study married their partners for many of the reasons that have been found to be predictive of relationship stability and continuance. Specifically, for the women in this sample, similarity to their partner, love and attachment, commitment, substantial investment in the relationship, relationship satisfaction, and open communication fostered confidence in the couples' potential for a long-term future together. Empirical evidence suggests these factors are generally important to both relationship maintenance and progression (Cate & Lloyd, 1992).

**Relationship progressions.** The participants in this study revealed considerable diversity in the development of long-term commitment to their partners and relationships. For some the decision to marry occurred relatively swiftly, while for others the movement from friendship to marriage represented a rather protracted evolution, often involving cohabitation. In other circumstances, conflict and even temporary separation characterized relationship progression. These findings are consistent with empirical investigations within the interpersonal process model which have elicited three major pathways toward marriage: 1) *the accelerated courtship* represents a rapid course to commitment, reflecting lower interpersonal conflict and relationship maintenance demands; 2) *the intermediate courtship* which denotes relatively slow progression toward marital commitment, reflecting low conflict, but with initial hesitancy; and 3) *the prolonged courtship* which has an up-and-down progression to marriage, reflecting increased levels of conflict and ambivalence about commitment (Cate & Lloyd, 1992).

**Variations**

A number of discoveries emerging from this investigation highlight unique features of relationship development in the context of disability which appear inconsistent within some, or all, extant courtship theories. These major departures will be discussed below.

**Access to resources.** More than half the women in this sample were, and in most
cases would likely continue as, the primary wage earner in the dyad. These women were fully cognizant of this eventuality throughout the course of relationship development. This finding suggests, for these participants, access to resources was not a primary, or even secondary motivation for relationship involvement or progression. In some cases, participants recognized there was a relatively high probability of financial hardship with their chosen mate.

All participants who desired children within the relationship recognized the difficulties they might face with conception. These women knew artificial insemination or adoption were the probable routes to offspring for them. It appears that evolutionary explanations may not be particularly potent for relationships in the context of a severe disability, such as SCI. The purportedly feminine desire for access to resources and the primacy of reproductive success is not consistent with this data.

**External influences.** This study has highlighted the significance of external social influences on the dyad and the coupling process. Perhaps because negative societal attitudes are particularly salient for persons with a disability, and by association their partners, the impact of external forces on the relationship may have been more keenly experienced by participants. Many of the participants in this study had their judgment called into question, as were their motivations for involvement with someone with a disability. While for these participants external pressures were resisted, it is conceivable that these influences could also represent significant barriers to relationship progression, possibly resulting in the termination of relationships.

The influence of positive external influences was more subtle to detect; however, acceptance, support and affection from extended social networks appeared to foster relationship satisfaction via expanded positive connections with a partner's significant others and the resulting affiliative rewards.
Although the above finding is consistent with the interpersonal process model, which recognizes the role of external influences on a developing relationship, most existing theories of courtship have not incorporated social forces, such as cultural norms, religious prescriptions, and/or social network relations. This data suggests that familial and social relationships, as well as social attitudes, may be important factors to consider in developing an understanding of romantic relationship progression.

**Individual factors.** The unique challenges of SCI highlight some specific individual characteristics which emerged as important factors in courtship. In particular, partners' positive adjustment to disability, fortitude, and autonomous attitudes were found to be important to relationship development from the participants' perspectives. For partners with SCI, stigmatized disability often leads to increased social distance and diminished opportunities for intimacy (i.e. Artinian, 1990; Olkin & Howson, 1994). Therefore, it appears a necessary condition for initiating and developing a relationship is meeting someone who they are not only attracted to, but someone who accepts their impairment and is willing to consider a person with SCI a suitable romantic partner. The openness and receptivity to involvement demonstrated by the participants in this study was striking. Although all relationships can be presumed to face interpersonal challenges, the additional difficulties which accompany SCI appear to demand well developed coping and problem-solving strategies. The participants in this study demonstrated flexibility, unconventional thinking, and resilience in adapting to the wide range of challenges they faced as a result of their partners' impairments. Taken together, the results of this study suggest the importance of specific personal characteristics, at least for relationships in the context of disability.

While individual factors may be implicit in existing courtship models, they have not been stressed beyond their role as matching variables. Although there is evidence to
suggest a growing interest in the role of individual factors in relationship development, to date personality characteristics, attitudes, etc. have not been found to be particularly valuable predictors of relationship phenomena (Cate & Lloyd, 1992; ), perhaps explaining their relatively minor role in extant models.

**Relationship motivations.** Participants in this study often spoke with admiration of their partners and the daily challenges which they met. Although participants did not overtly describe themselves as unselfish, they demonstrated through their actions a willingness to subordinate their own needs, when necessary, to assist their partners (particularly those with quadriplegia). This observation does not intend to suggest the women in this study were selfless, for clearly all participants considered themselves to be benefiting from their relationships; however, a motive beyond self-interest and simple need-gratification seemed apparent. The salience of love, bondedness, and altruism in the participants' relationships was highlighted.

Although love and affection are recognized as contributing to premarital (and no doubt marital) relationship stability (Cate & Lloyd, 1992), these affective components of relationships do not appear to be emphasized within existing models of courtship. Rather, courtship theories tend to emphasize individualistic goals and benefits as the basis for relationship progression, giving apparently less import to more intangible aspects of relationship formation, such as love. There is a growing body of empirical evidence on romantic love; however, there remains a dearth of research examining the relationship between this complex construct and relationship quality (Hecht, Marston, & Larkey, 1994).

Overall, the model developed from this data appears congruent with many existing theories of courtship, bolstering the validity of some of the present findings. As well, the focus on courtship in the context of SCI has served to draw our attention to unique
findings which are not readily explained by existing models.

The next section of this chapter will discuss the major findings in relation to the research questions guiding this investigation and previous research.

A Discussion of Major Findings

The specific research questions directing this exploratory study were:

1. What are the processes through which able-bodied women decide to make a marital commitment to a partner who has been spinal cord injured?

2. What are the specific issues, psychosocial factors, fears, challenges and sources of optimism which are salient in making this decision.

The DMRD represents the findings resulting from the above queries, reflecting both the process of commitment and major contributing factors which were salient for the participants. Although both process and content are linked within this model, responses to the above research questions will be addressed separately below.

Progression to Marital Commitment

The preceding presentation and discussion of the DMRD has both directly and indirectly addressed the first research question. To avoid redundancy, only a succinct summary will be provided here in order to consolidate findings, elaborating only where it is deemed necessary.

Multiple pathways and time trajectories to marital commitment were found across the women's stories. Despite variation, common patterns could be discerned. Generally, the women expanded their appreciation for their partner's characteristics to include valuing and investing in the intimate relationship the couple created together. By negotiating and overcoming disability-related, interpersonal, and social challenges (particularly negative reactions from others) through a variety of existing or acquired coping and problem-solving strategies, the participants appeared to gain confidence in the
strength of their relationship, becoming increasingly accommodated to their partner’s disability. Over time, and particularly if the couple lived common-law, shared history, feelings of love and/or psychological attachment, as well as increasing investment in the relationship appear to have contributed to growing commitment. For most women in this sample, the decision to marry was made over time and seemed to be primarily based on affection for their partner, confidence in the viability of the union as demonstrated over the history of the relationship, a shared vision for the future, and an assessment that the quality of the relationship outweighed any difficulties that might have to be faced.

Interestingly, the process to marital commitment for this sample typically included cohabitation. Most participants lived in marital-like situations for, on average, over 2 years and progression to marriage was not always anticipated. The women lived with their partners for a variety of reasons and with varying levels of commitment. For some, cohabitation was a “let’s see what happens” proposition, without long-term commitment; for others it was a clear step towards the goal of marriage; and for yet others it was a test of the relationship without the stated intention to marry.

In any event, it appears that marital-like experience provided the participants in this study with confidence in their pairing through the demonstration of compatibility, continued affection and commitment, and relationship satisfaction. Many participants felt that since they had been able to successfully deal with challenges which had arisen in their common-law relationships, they would capable of overcoming any future difficulties. This evolutionary progression towards marriage appeared to make the decision to marry less momentous and frightening. Rather, for these participants, marriage was the formalization of their tested commitment to the relationship, and a continuation of a life they had already created with their partner.
Factors Influencing Marital Commitment

The primary issues and factors which emerged from this investigation are discussed below in response to the second research question. The relationship of these findings to the published literature is also provided where appropriate.

Partner’s Characteristics

As stated previously, participants overwhelmingly described their partners as demonstrating positive adjustment to their disability and fortitude in dealing with the challenges of impairment. A few participants expressly speculated that they might have been disinclined to become romantically involved if their partner had not displayed such a positive attitude. This finding is consistent with evidence that positive attitudes displayed by persons with a disability toward their impairment often have a positive effect on the attitudes of others towards them (Yuker, 1994).

The partners’ high levels of autonomy was a dominant theme across the women’s narratives. The desire to be maximally independent was striking in most participants’ descriptions of their mate. It seems likely that a partner who strives to minimize the impact of his disability on a potential partner would make a more attractive candidate for a long-term relationship than an individual who has come to rely, perhaps to excess, on others. As such, individuals who are autonomous may be more successful in attracting mates postinjury. Crewe, et al. (1979) hypothesized that individuals who were able to attract new mates after SCI might have unique characteristics. In their investigation, these authors discovered greater levels of independence in the activities of daily living for those in postinjury marriages as compared to preinjury unions. The present research would suggest that both positive adjustment to disability and autonomy, may be two essential qualities which are important both in forging new relationships and maintaining existing ones. Alternatively, it should not be forgotten that a couple might come to a mutually
satisfying arrangement involving greater dependency on the part of the individual with a
disability.

It appears that individuals who were single at the time of injury, perhaps out of
greater necessity, may attain higher levels of functional independence. The present data
offers one case study which is consistent with that theme. Janice was the only participant
who was involved with her partner preinjury. She became very devoted to Karl and was
heavily involved in assisting him throughout his rehabilitation. Janice described Karl’s
parents as doting toward him after his discharge from the hospital which, from her
perspective, fostered unwarranted dependency. It is possible her own involvement in
Karl’s recovery unwittingly had a similar effect. In any event, her partner’s lack of
autonomy became a significant issue in their relationship, eventually resulting in a
temporary separation.

Another possible explanation for the high levels of positive adjustment and
autonomy found in this sample is that the men’s preinjury characteristics have continued
and aided in the adjustment to SCI. There is empirical evidence to suggest that an internal
locus of control, good cognitive coping strategies, good social skills, and effective
problem-solving styles are associated with better psychosocial adjustment to SCI
(Buckelew, Baumstark, Frank, & Hewett, 1990; Craig, et al. 1990; Elliot, Godshall,
Herrick, Witty, & Spruell, 1991; Schulz & Decker, 1985). It may be that individuals with
strengths in these areas make a better adjustment to SCI and are attractive as marital
partners.

Openness/Receptivity

Although the participants themselves would likely not identify their openness to an
intimate relationship with a man with SCI as salient in making the decision to marry, in the
absence of this initial disposition, it is difficult to image the coupling process would ever
begin.

As stated throughout this report, an unhesitating willingness to enter into a dating/romantic relationship emerged across the vast majority of the women in this sample. Only Emily expressed initial concern; however, that was not only because of her partner’s disability, but perhaps more significantly, she was married with children at the time she met her future mate. These two factors contributed to her conundrum about becoming involved.

Although women who view disability as a barrier to intimacy were not located and included in this investigation, it remains somewhat surprising to this investigator that higher levels of concern were not expressed about becoming and/or remaining romantically involved with a partner with SCI. An identified preconception prior to data collection was that the impact of disability would translate to participant caution and protracted deliberations prior to making a marital commitment. Perhaps because most of the participants lived with their partners before marriage, this assumption was not supported by the data.

There are a number of potential explanations for the openness/receptivity finding in this study. As many of the women had considerable experience in their professional and personal lives with persons with disabilities, the contact hypothesis may partially account for a willingness to enter into a romantic relationship with a man with SCI. The basic premise of the contact hypothesis is that given the opportunity for interactions with disabled people that are personal, rewarding, and afford the individuals equal status, these experiences usually provide positive information and lead to the development of positive attitudes to those with impairments. These contact relationships between individuals with a disability and nondisabled persons may take the form of friendships, socializing, caretaking, helping, or working together, etc. Information and contact have been found to be
the most important able-bodied person characteristics that shape attitudes toward people with disabilities (Yuksel, 1994). Certainly for those women in the sample in occupational or volunteer roles with persons with disabilities, their experience could be expected to shape positive attitudes and enhance their capacity to see the individual first and not the disability.

Two of the participants (Lisa and Donna), when asked, attributed their openness to dating someone with a SCI to personal values and beliefs which were emphasized in their upbringing. Treating everyone with dignity and recognizing all persons as equal were internalized principles these participants reported they adhered to. An additional explanation might also be found in the manner in which these women met their mates. Both Lisa and Donna were introduced to their partner through their friendship network and spent time with their future partner in a closed field. As opposed to an open field encounter where they might have chosen not to interact, in a closed field social scripts and constraints likely dictated interaction and the opportunity was provided to get to know each other, on at least a limited basis. Not only Lisa and Donna met their partners in a closed field. All of the participants, with the exception of Janice, met their future spouses within these contexts.

Two further considerations which may have relevance to the discovery of openness and receptivity relate to the participants' relationship histories and the nature of a SCI impairment. Firstly, many of the women in this sample reported either unsatisfying previous relationships, or in the extreme, neglectful and abusive ones. The kindness and gentleness that many of the participants recognized in their partners may have influenced their willingness to consider entry into a more intimate kind of relationship.

Secondly, although this hypothesis is recognized as highly speculative, it is also possible that the nonprogressive nature of SCI makes this kind of impairment more
acceptable than, for example, multiple sclerosis or renal disease, where the future outcomes are unknown. Although clearly SCI represents a very significant disability, uncertainty as to outcome is minimized as compared to other progressively disabling conditions.

Disability-related Challenges

A number of significant challenges associated specifically with the partners' SCI were found; however, for many participants the most ongoing stressors appeared to be caregiving and/or the need to assume expanded domestic and/or economic roles. All of the women partnered with men with quadriplegia, and one participant whose partner was a higher level paraplegic, were involved to some degree in providing care to their mates. Caregiving was an accepted component of these relationships, and the level of burden experienced by participants was found to vary over time. The additional demands (physical and time) of providing care for their partners, coupled with increased domestic responsibilities because of their mate's restricted physical capacity, and temporary imbalances between the caregiver and intimate partner roles, occasionally contributed to participants' feeling overwhelmed by the totality of their workload. The reality of caregiver stress has been a documented outcome for many individuals who provide ongoing assistance to others (i.e. Kester, et al. 1988; Schulz, et al. 1987; Singer & Irvin, 1991).

It is interesting to note that of the five women actively involved in caregiving, four had occupational roles in health professions. A common theme within the literature is that caregiving may be more ego-syntonic for women in light of socialization to be caring and nurturing (i.e. Rolland, 1994). The question of whether or not participants felt their self-concept was related to their chosen roles in helping professions and their willingness to marry someone with a severe physical impairment was raised with attendees at the focus
group meeting. Seventy-five percent of participants who were in attendance were actively involved in providing care. They gently corrected the researcher, stating that they did not consider themselves to be caregivers but, rather, their mates' partner who secondarily provided assistance. They accepted their caregiving role as a necessary part of being together and did not feel that it reflected any inherent or socialized tendency to be giving and supportive. It is difficult to comment on this response for, theoretically, it makes sense that women drawn to the helping professions might be predisposed to a willingness to provide care to others. This question is not answerable from the results of this study.

**Coping/Problem-solving Strategies**

Many effective strategies were developed to cope with challenges facing the couples. A particularly dominant theme which emerged across all participants was their self-described attitudinal and behavioural stance of promoting and supporting their partner's autonomy and physical independence. This finding can be interpreted in a number of ways. As most of the women stated, motivations for this strategy included concern for their partner's sense of self-determination and self-worth, as well as a personal need to manage the physical workload and demands on their time. The participants' attitudes also imply assumptions which may underlie the foundation of their relationships. It appears that overall, participants were willing to accommodate their partner's disability and assume a heavier domestic and/or economic role within the relationship; however, they wanted their partners to make contributions to the union which were commensurate with their abilities. The women encouraged role performance and shared responsibility when it was feasible. It seems implicit that the participants expected relationship contributions to be not only about practical issues, but also related to emotional giving.

Maximizing and maintaining a partner's autonomy can be an effective strategy to counteract the stress and burden of the potential skews which can occur when dual roles...
exist, i.e. patient-caregiver and equal partners (Rolland, 1994). Although the latter comment is interpretive and speculative at this time, it is consistent with Artinian’s (1990) findings that the marital role performance of dialysis patients was based on a process of bending normative expectations, but not expecting too little or too much. The participants’ fostering of independence is also consistent with Crewe, et al.’s (1979) speculations that new spouses in postinjury unions may feel less obliged to provide care to partners, who are generally more independent if they were single at the time of their injury.

**Evaluation/Commitment**

The personal significance of marriage appears to be a particularly salient factor in making a marital commitment. As stated previously, a number of women were not particularly motivated to marry, but rather were content to continue living common-law. In these cases, it was their partners who desired a marital commitment. Interestingly, most of these participants had been married previously and were not planning to have children in their new relationship. Perhaps, a failed marriage leaves one hopeful about the future of any relationship, but somewhat disillusioned about the significance of marital commitment. Rather, marriage is viewed as an ongoing decision to remain together much like cohabitation and, particularly if children will not be involved, the legal formality seems less important. As Ann said: “Marriage to me is as long as we can tolerate it...I’m not in that fantasy, Cinderella, happily ever after mode....”

Consistent with the above reasoning, most participants who highly valued the institution of marriage had not previously been married and their future plans included having children with their partner. Considerable variation as to the personal significance of marriage was also found within the women who were motivated to marry, ranging from “It just seemed like...the next thing to do because we had been living together” to “…a divine calling” with religious and moral proscriptions against divorce.
These findings are consistent with past research which has established that the willingness to cohabit is associated with a reduced emphasis on the importance of marriage as an institution. Cohabiters have also been found to be older, have lower levels of religiosity, more liberal attitudes towards sexuality, and less traditional gender roles (Huffman, Change, Rausch, & Schaffer, 1994).

Clearly, commitment is a difficult construct to define and measure. Commitment represents a subjective, psychological state with both cognitive and emotional components. It is generally agreed that commitment represents a long-term orientation and a desire to maintain a relationship (Rusbult & Buunk, 1993). It seems evident from this data that entry into the state of cohabitation or marriage is not necessarily enlightening about levels of commitment unless one also understands the personal significance of those actions for the individuals involved. As Nock (1995) states: “We are left, therefore, to ponder whether there is one institution of marriage or several” (p. 106).

Relationships with Others & Societal Attitudes and Awareness

A key finding in this research was the impact of external social influences on the coupling process. In particular, many participants faced substantial negativity in their relationships with others regarding their choice in a mate. These responses ranged from implicit concern and innuendo to explicit opposition; however, all participants were resistant to these external pressures on their relationship. This finding echoes Vargo’s (1984) discovery that spouses of newly injured men received discouraging comments about the prospects for their marriage from medical professionals. It is likely these types of disapproving and rejecting behaviours are rooted in ambivalent societal attitudes towards persons with disabilities. When individuals encounter a person with a serious disability, they often feel admiration; however, they also typically feel pity, awkwardness, embarrassment and occasionally resentment in their interactions with them (Yuker, 1994).
What is particularly noteworthy is that all participants who experienced these negative reactions from parents, extended family, and friends, were able to withstand questioning of their judgment and remain undaunted in their decision to commit to their partner, suggesting both resiliency and high levels of autonomy.

In this sample, the women’s average age at marriage was 30 years and so perhaps maturity was an important factor in their fortitude against social challenges to their relationships. As well, it is possible that emotional support and the overall quality of the union with her partner had a bolstering effect on the women. Consistent with previous research (Neumann, 1980, as cited in Neumann, 1991; Simmons & Ball, 1984), it appears these women are particularly independent and autonomous, with an inherent or developed ability to resist outside pressures and to challenge conventions. All of the foregoing factors alone or in combination could serve to explain the participant’s commitment in the face of disapproval.

**Coupling and Relationship Functions**

Perhaps the most important factor influencing commitment and the decision to marry is the very nature of the relationship itself. The quality of the union as reflected in subjective experiences of love and affection, the general emotional climate of the relationship, and the instrumental support afforded to the participants appeared to be amongst the most heavily weighted issues in making a marital commitment for the women in this study. Consistent with previous findings of satisfying marital relations when one partner has a SCI (Crewe & Krause, 1988; Simmons & Ball, 1984), the women in this study reported high levels of relationship satisfaction at the time of marriage. It seems successful negotiation of the coupling process is fuelled by growing or sustained relationship satisfaction, leading these participants to make a marital commitment.

A final comment seems warranted addressing the love styles of participants.
Although not overtly described, considering the gestalt of the women’s presentations and comments, it is the researcher’s impression that there was qualitative variation in the subjective experiences of love.

Love is another difficult construct to define. What does it mean to say you are “in love”? In his *triangular theory of love*, Sternberg (1986) has conceptualized the construct as intimacy, passion (romance, physical attraction, and sexual consummation) and decision/commitment. Ultimately, love is a highly subjective experience. In common language usage, the word itself has multiple meanings, perhaps explaining why the ancient Greeks had at least five words for the concept (O’Sullivan & Leary, 1992).

In his thorough review of 20 years of research on love, Bierhoff (1991) described multidimensional approaches to the measurement of love. Three primary and three secondary love styles have been described by Lee (1976, as cited in Bierhoff, 1991) and have been validated as empirically distinguishable aspects of love. In general, the participants did not speak extensively or explicitly about their subjective feelings of love except to suggest that they loved their partner. The reader is therefore cautioned that the linkages made below between love-styles and the women’s experiences are highly speculative and impressionistic.

*Romantic love* (Eros) is an immediate attraction which causes physiological arousal and sexual interest in a partner. This kind of love style appears to characterize the experiences of Lisa, Emily and Janice in particular, who described powerful attraction and “love at first sight” experiences which were potent and not readily deniable.

*Best-friends love* (Storge) develops out of close friendship over a longer period of time, frequently on the basis of similarity in terms of interests, social background, etc. Sexual contact is less emphasized in the development of this kind of love and may begin relatively late in the progression of the relationship. Ann, Karen, Sara and Donna
described relationship development which seems consistent with this love-style.

With altruistic love (Agape: compound of Storge and Eros) the care and assistance of another is often quite central to the relationship and unselfishness is a salient component of the relationship. This love-style may particularly describe Penelope’s experience, although her relationship development is more tentatively placed within this typology.

Conclusions

Overall, the experiences recounted by the women in this study led to the development of a tentative theoretical model which conceptualizes making a marital commitment to a man with a SCI. Generally the present findings suggest that the processes through which able-bodied women decide to make a marital commitment to a partner with SCI overlap substantially with existing models of courtship, however, unique differences were also discovered.

Many of the postulates of relationship development theories have relevance for this study’s findings. In particular, participants described similarity and compatibility as important features in the initiation of their relationships, a finding consistent with theories of attraction and elements of the compatibility models. Participants’ evaluation of their relationships with a view to making a marital commitment paralleled social exchange premises generally, and interdependence theory specifically. The women did appear to assess the challenges they faced within their relationships (costs) against relationship satisfaction (rewards), also considering perceived alternatives via comparison of their current union with previous relationships. The salient characteristics of the participants’ relationships included variables known to be predictive of relationship stability and continuance, such as love and attachment, commitment, substantial investment in the relationship, relationship satisfaction, etc. And lastly, considerable diversity in relationship
progression was discovered which seems consistent with the three major pathways toward marriage purported by the interpersonal process model.

Investigation of unique marital circumstances and considerations may serve to draw our attention to phenomena not readily accounted for by existing theoretical models. Four major areas of discontinuity with some existing courtship models were also discovered in this research. Firstly, most of the participants in this investigation could not be characterized as seeking maximized reproductive strategies or access to resources, as suggested by evolutionary theory. Secondly, this research has highlighted the significant role external social influences may play in relationship development, suggesting the need to explore and perhaps incorporate into existing models these external forces which may impinge or support the coupling process. Thirdly, individual factors, both the participants' and the partners', emerged as important components of relationship development in the context of disability, raising the question of their potential inclusion within existing courtship models. And finally, relationship motivations discovered in this investigation highlighted the absence of attention to experiences of love, bondedness and altruism in extant courtship models. Although presumably the intrinsic benefits of love and bondedness are reflected in rewards, relationship satisfaction, and investment within social exchange models, this research draws attention to the lack of specific attention to the affective components of relationship progression.

The results of this study suggest that the processes through which able-bodied women decide to make a marital commitment to a partner with SCI are substantially similar to how individuals in the general population might be expected to, based on the existing literature. Uniquely, this research suggests that specific qualities in able-bodied partners such as maturity, autonomy, resistance to social negativity and conventions, and flexibility in role performance may be important to courtship in the context of disability.
Relationship progression to marital commitment appeared to demand the participants accommodate to their partners' disability, employ successful coping and problem-solving strategies, and develop personal confidence that future challenges, both interpersonal and disability-related, could be met. Otherwise, love and attachment, relationship satisfaction, interdependence/commitment, compatibility and similarity, and investment in the relationship appear to carry the most significant influence in the decision to marry, as it does in the general population (Cate & Lloyd, 1992). This research would also suggest that cohabitation as a progressive step towards marriage may be an important part of the process of evaluation, commitment and the ultimate decision to marry.

Limitations of the Study

Three limitations to the present study should be noted: a) selection bias; b) the retrospective nature of accounts; and c) inadequate description of the personal characteristics of the participants.

Although representativeness is not the goal of qualitative methodologies, it is important to recognize that the women who volunteered to participate in this project are not necessarily representative of women who marry men with SCI postinjury, or of women in general. It may be that atypically outgoing, confident women who are in highly satisfying relationships agreed to participate in a project like this. It is conceivable that women in unsatisfactory marriages would be less inclined to discuss their relationships with a stranger. At least one of the participants in this study admitted she is in a marriage she currently considers to have a uncertain future, providing some evidence that not only women in good marriages were prepared to volunteer for this study. There is similarly no evidential basis for necessarily believing these participants are necessarily distinct from other members of this population. Although the sample is small, a reasonable range of diversity across demographic variables such as age, occupation, partner's level of injury,
partner employment versus unemployment, socioeconomic status, involvement in caregiving and prior marriage was obtained.

It would have been particularly informative to have recruited women who had decided against making a marital commitment to a man with a SCI. Exploration of factors which contributed to relationship termination would have provided another perspective on the issues which are salient in contemplating marriage to someone with a severe physical disability. Unfortunately, these women were not located for this investigation. As a result, the reader should bear in mind that the model developed in this project reflects the experience of women whose relationships successfully progressed to marriage.

The retrospective nature of this study may leave it vulnerable to criticisms of potential distortions in participants’ recall for historic events. Although it is recognized these personal accounts may represent as much construction as description, this data provides insight into the participants’ inner, experiential perspective on marital commitment. Understanding the world from the women’s vantage points necessarily involves seeking to understand their construction of meaning for events in their lives (Chenitz & Swanson, 1986). Although longitudinal research designs which followed couples from meeting through courtship would be preferable to retrospective designs, given the realities of research constraints, this is rarely achievable. Hopefully this project provides rudimentary insight into a virtually unexplored substantive area.

On a related issue, with an interview methodology one must always be concerned about establishing rapport to ensure high quality data. A potential limitation in any study of this nature is the inability to engage the participant and provide a safe, secure environment for comfortable disclosure. Happily, that does not appear to have been the case in this study. Perhaps because the researcher is married to a man with a SCI and the
participants were aware of that, the development of rapport and the women’s candour appeared to have been enhanced. One participant specifically articulated that view:

Karen: "...Well, a lot of it’s easy to share with you because...you know you’ve been there, doing that...If you weren’t maybe I might not be quite so open...."

On a final point, it may have been useful to have had both participants and/or their spouses provide a detailed description of the personal characteristics of the women in this study. This inclusion in the research design would have enhanced the opportunity to gather data on the personal characteristics of the participants, which is currently lacking in this research.

Future Research

This exploratory study has made an initial effort at understanding the impact of SCI within the context of courtship and marital commitment from able-bodied women’s perspectives. Future endeavours would do well to focus on the viewpoint of men with SCI to extend the work begun by Yoshida (1994). To understand relationship progression in the context of SCI it is essential to understand these processes from both gender perspectives.

Another substantive area in need of attention is that of injured women’s experiences in courtship after SCI. Women with SCI have rarely been the subject of investigation, perhaps because they represent the minority of SCI, approximately 18% (Trieschmann, 1988). Brown & Giesy (1986) have suggested that proportionally more women than men are not partnered after SCI. The cultural pressure on women to be physically attractive as mates and the cultural norm to provide nurturance, may present unique problems for them in courtship. Asch and Fine (1988) argue that men spurn women with disabilities “...because they fail to measure up on grounds of appearance or of perceived abilities in physical and emotional caretaking” (p. 19) The experiences of
women with SCI and able-bodied male partners would be a welcomed contribution to our understanding of courtship in the context of disability. As well, exploration of partnerships where both individuals have disabilities are needed.

Finally, the characteristics of able-bodied partners who cohabitate with or marry individuals with SCI have primarily been merely speculated about. Although this exploratory investigation begins to identify specific qualities these able-bodied women may possess, further investigations are sorely needed.
REFERENCES


Sociology Press.


Journal of Family Issues, 16, 53-76.


*Spinal Columns, 11*(1), 15. (Available from the Canadian Paraplegic Association [Alberta], #305, 11010-101 Street, Edmonton, Alberta, T5H 4B9)


Dear

Re: Postinjury Marriage to Spinal Cord Injured Men: Women's Perspectives on Making a Commitment.

Maureen Milligan is a Master of Science student at the University of Calgary. She is currently undertaking a study which will attempt to describe the process by which able-bodied women decide to make a postinjury marital commitment to men who are permanently disabled as the result of a spinal cord injury. Ms. Milligan became interested in this area of research partly out of her own experience as a woman married to a partner with a spinal cord injury and also as a result of the scarcity of research into the interpersonal and social implications of spinal cord injury.

This is an exciting new project and we are happy to assist Ms. Milligan by informing our members and inviting all interested women, who meet the undernoted criteria, to participate in this worthwhile research undertaking. Ms. Milligan considers that the results of this study will be of benefit to clinicians in understanding the nondisabled partner's experience, redressing the general lack of attention to the spouses of persons with spinal cord injury; will contribute to general knowledge and challenge societal attitudes towards what are often considered "mysterious" relationships; begin to identify the challenges and/or barriers, as well as the facilitating factors to marriage postinjury; and stimulate research interest in this historically ignored area.

To qualify to be in the study you must (1) be female; (2) at least 18 years of age; (3) have made a postinjury marital commitment to a male with a spinal cord injury which has resulted in permanent disability (paraplegia or quadriplegia); and (4) at the time of marital commitment you were able-bodied and free of any life-threatening medical condition. Your current marital status (i.e. divorced; did not marry) is not important for involvement in this study. Participation in the study would involve two separate interviews which would be arranged for a time and place at your convenience. It is anticipated that each interview would involve 1 to 2 hours of your time. All responses will be maintained in the strictest of confidence and considerable efforts have been put in place to protect the privacy of participants and ensure anonymity and confidentiality.

This letter is to advise you that we will be contacting you by telephone in the near future to invite you to participate in this project and ask if you would be willing to have
your name and telephone number provided to the researcher. As well, if you know of anyone who meets the above criteria and would be interested in participating in this project, please refer them to this office. Should you have any questions, the researcher will be more than happy to answer them and discuss the study with you in greater detail to aid you in deciding whether or not you wish to be involved. Participation in this research project is, of course, on a purely voluntary basis.

If you would prefer that we not call you, please do not hesitate to contact our Southern District office (236-5060) to decline participation. We encourage you to consider volunteering for this interesting and timely research project.

Yours truly,

(Current signature of the Southern District Office of the Canadian Paraplegic Association)
APPENDIX B

INFORMATION FOR PARTICIPANTS

Research Project Title:
Postinjury Marriage to Spinal Cord Injured Men: Women's Perspectives on Making a Commitment

Principal Investigator:
Maureen S. Milligan
Home 686-3984
Office 220-5887

Research Supervisor:
Dr. A.H. Neufeldt
Office 220-7347

Purpose: The goal of this research project is to begin to understand the process by which able-bodied women decide to marry spinal cord injured men. The principal investigator is unaware of any published study which has specifically looked at this important question. Results from this study will help clinicians working in the rehabilitation field understand the nondisabled partner's experience, the challenges and/or barriers to marriage, as well as factors which facilitate marriage postinjury. As well, this study will contribute to general knowledge, challenge social attitudes and begin to redress the historical lack of research attention to the spouses of persons with spinal cord injury.

Time Commitment: Participants who volunteer for this research project will be interviewed on two separate occasions, with each interview anticipated to last between 1 and 2 hours. The second interview is intended to clarify and elaborate on the information obtained during the first interview. Interviews will be conducted in a setting of the participant's choice, at a negotiated time which is mutually convenient to the participant and the researcher. The total time commitment for the two interviews is anticipated to range between 2 and 4 hours.

Participants will also be invited to participate in a focus group meeting which would be attended by all interested informants. The purpose of this meeting would be to present the research findings and invite feedback from the participants. It is expected that this meeting would involve a further 2 hours of time. Attendance at this focus group meeting would be optional.

Confidentiality: It is recognized that it is essential to respect all participant's right to privacy and confidentiality and a number of steps have been taken to accomplish this. All interview data will be maintained in the strictest of confidence. To protect the participant's identity, each informant will be asked to select a pseudonym for use during
the interview process. Any reference to other persons or places will be omitted from transcriptions of the interview. A single list of proper names and their corresponding pseudonym will be maintained in a password protected computer file in the researcher's home office. Any reference to participants in the written report will utilize pseudonyms.

With the participant's consent, all interviews will be audiotaped and interview notes will be taken. Taped interviews will be transcribed. All transcriptions will be maintained in password protected computer files with audiotapes and printed copies kept in a secured location in the researcher's home office. Upon completion of the study all audiotapes will be erased and the master list linking participants' names with the data will be destroyed.

**Possible Risks and Benefits:*** It is not anticipated that participation in this research project will involve any extraordinary risk to the participants, beyond that which is associated with daily life. There may be the potential for an emotional reaction to the sharing of personal, intimate experiences. If the need should arise, The Canadian Paraplegic Association (Alberta) offers an array of personal support services, including family, sexuality, and crisis counselling and are available to provide support if a referral is necessary as a result of participation in this investigation. In the event that other professional services are deemed more appropriate, the researcher will take personal responsibility for arranging an appropriate referral.

Beyond contributing altruistically to the expansion of general and practical knowledge, a possible benefit of participation in this study is the opportunity to meet and speak with other women who are also married to a partner with a spinal cord injury (if the participant decides to participate in the focus group meeting). This opportunity has the potential to provide a mutually supportive experience for participants. As well, participants may benefit from articulating their experience by gaining new insight and/or perspective about their marital commitment.

**Questions or Concerns:** All participants will be provided with a summary of the findings of this research project. Participants are invited to ask questions, voice concerns, and/or terminate involvement in the study at any time. The researcher, or her supervisor, may be contacted at the above numbers any time. As well, the Joint Faculties Research Ethics Committee at the University of Calgary may be contacted through Karen McDermid (220-3381) to address any complaints.
APPENDIX C

INTERVIEW GUIDE

DATE: ____________________________
TIME: ____________________________
PLACE: ___________________________
PSEUDONYM ______________________

1. How did you meet your and become romantically involved with your husband?

2. What, if any, hesitations did you initially have about becoming involved with your partner?
   probe: prior experience with persons with disability?

3. Please describe for me what the early stages of your relationship were like?
   probe: interests, activities
   feelings for each other

4. In what ways, if any, did your partner's disability affect your relationship?
   probe: physical demands/limitations?
   socially?
   emotionally?
   sexually?
   communication? (did you talk about these issues?)

5. How did your friends and family respond to your relationship?
   probe: supportive? concerns? opposed?
   did they express their feelings/thoughts to you?
   how important were their attitudes to you?
   partner's family and friends?

6. How did you and your partner arrive at a decision to become married?

7. How did you know this was the man you wanted to marry?
8. How did you imagine your married life?
   - probe: plans, roles, children

8. What, if anything, were your concerns, fears, and/or reservations about marrying your partner?
   - probe: most important consideration

9. How did you address these concerns, if any?

10. What issues/factors gave you confidence when contemplating marriage to your partner?
    - probe: relationship characteristics?
    - your own personal characteristics?
    - partner's characteristics?

11. How did you make your decision about marriage to your partner?
    - probe: partner's involvement?
    - time span of contemplation?
    - issues
    - social support?

12. Was there anything else that was important to you in making your decision regarding marriage?

13. What, if any, specific changes, accommodations, or modifications did you and/or your partner have to make to facilitate your married life together?
    - probe: pragmatic issues (i.e. physical environment)?
    - roles?
    - interpersonal/relationship factors

14. How did other people respond to your decision to marry?
    - probe: family/friends
    - social world in general

15. Is there anything that you would like to tell me - that you think would be important for me to know - that I haven't asked you about?
APPENDIX D

CONSENT FORM

I hereby agree to participate in a research investigation at the University of Calgary entitled "Postinjury Marriage to Spinal Cord Injured Men: Women's Perspectives on Making a Commitment" conducted by Maureen S. Milligan (a Master of Science student) under the supervision of Dr. A.H. Neufeldt, of the Programme in Clinical Psychology at the University of Calgary.

I understand that this study will explore the experience of able-bodied women making a marital commitment to a man with a permanent disability as a result of a spinal cord injury. I understand that audiotaped interviews and written notes will be used to develop a detailed description of my experience in making a postinjury marital commitment to a partner with spinal cord injury. I understand that I will be interviewed on two separate occasions and will also be invited to participate in a focus group meeting to discuss the findings of this study.

I understand that my participation is completely voluntary, and that I am free to withdraw my consent and terminate my participation at any time without penalty. I also acknowledge the researcher's right to terminate my participation at any time.

The general plan of this study has been outlined to me, including possible known risks. I understand that this study is not expected to involve risks any greater than those ordinarily found in daily life and that all possible safeguards have been taken to minimize risks.

I understand that the results of this study will be coded in such a way so as to shield my identity. The data to be collected will only be accessible to the researcher, her supervisor and, possibly, on a limited basis, a research assistant. Data will be maintained in a secure place in the researcher's home office.

This consent form, a copy of which has been given to you, is only part of the process of informed consent. It should give you the basic idea of what the research is about and what your participation will involve. If you would like more detail about something mentioned here, or information not included here, please ask. Please take the time to read this form carefully and to understand any accompanying information.

Your signature on this form indicates that you have understood to your satisfaction the information regarding participation in the research project and agree to participate as a subject. In no way does this waive your legal rights nor release the investigators, sponsors, or involved institutions from their legal and professional responsibilities. You are free to withdraw from the study at any time. Your continued participation should be
as informed as your initial consent, so you should feel free to ask for clarification or new information throughout your participation. If you have further questions concerning matters related to this research, please contact Maureen Milligan (686-3984) or her supervisor, Dr. A.H. Neufeldt (220-7347).

If you have any questions concerning your participation in this project, you may also contact the Office of the Vice-President (Research) and ask for Karen McDermid (220-3381).

__________________________________________  __________________________
(Name - Printed)                              Date

__________________________________________  __________________________
Participant                                   Date

__________________________________________  __________________________
Investigator                                  Date
# APPENDIX E

## DEMOGRAPHIC INFORMATION

### PARTICIPANT:

<table>
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<th>Occupation</th>
<th>Employer</th>
<th>Date of Birth</th>
<th>Marital Status</th>
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<td>(Bus.)</td>
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### (SCI) SPOUSE:

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<th>Level of Injury</th>
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### MARITAL INFORMATION:

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<th>Previous marriages?</th>
<th>Children prior to marriage?</th>
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<tr>
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<td></td>
<td>(Self)</td>
<td>(Partner)</td>
</tr>
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</table>
Number of children in family

Number of children together

Where you involved with your partner preinjury?