

**Community Acceptance and Social Inclusion of Individuals
with Spinal Cord Injury: A Qualitative Study.**



By

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*This thesis is submitted in total fulfilment of the requirements for the subject RESEARCH
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Statement of Authorship

Except where it is made in the text of the thesis, this thesis contains no material published elsewhere or extracted in whole or in part from a thesis presented by me for any other degree or seminar. No other person's work has been used without due acknowledgement in the main text of the thesis. This thesis has not been submitted for the award of any other degree in any other tertiary institution. The ethical issue of the study has been strictly considered and protected. In case of dissemination of the findings of this project for future publication, the research supervisor will be highly concerned, and it will be duly acknowledged as an undergraduate thesis.

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Dedication

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List of Abbreviations

BDT	Bangladeshi Taka
BHPI	Bangladesh Health Professions Institute
CBR	Community-Based Rehabilitation
CRP	Centre for the Rehabilitation of the Paralysed
InSCI	International Spinal Cord Injury Survey
IRB	Institutional Review Board
ITC	International Test Commission
NGO	Non-Governmental Organization
OT	Occupational Therapy
OTA	Occupational Therapy Assistant
SCI	Spinal Cord Injury
WHO	World Health Organization

Abstract

Background: This qualitative study explores community acceptance and social inclusion of individuals with Spinal Cord Injury (SCI) experiences after rehabilitation. Also understand the processes of community acceptance and social inclusion among individuals with spinal cord injury.

Aim: To Understand process of community acceptance and social inclusion among individuals with spinal cord injury (SCI).

Methods: For this study, a qualitative research method using the grounded theory approach was selected. Purposive sampling was used by including 15 participants (4 female, 11 male) who had at least 1 year of living experience in a particular community. The data saturation process was utilized to reach this particular number of participants. Data were collected through in-depth, semi-structured, face-to-face interviews and analyzed using open, axial, and selective coding with constant comparison.

Results: Findings revealed a dynamic, multi-stage process. Initially, SCI led to social rupture characterized by stigma, perceived burden, and exclusion. Rehabilitation and support systems facilitated rebuilding confidence and reframed identity. Inclusion became possible within enabling environments that supported participation. Respect was gained through meaningful contribution, particularly employment and family roles. However, inclusion remained conditional and required ongoing negotiation. Over time, sustained participation and collective advocacy contributed to broader community norm shifts.

Conclusions: Community acceptance and social inclusion are evolving social processes shaped by personal agency, support systems, and structural contexts. Holistic rehabilitation approaches addressing social and structural dimensions are essential to ensure sustainable inclusion of SCI survivors in Bangladesh.

Keywords: Spinal Cord Injury, Community Acceptance, Social Inclusion, Stigma, Rehabilitation, Grounded Theory, Bangladesh.

CHAPTER I: INTRODUCTION

1.1 Background

Spinal cord injury (SCI) is a profound and life-altering condition that not only impairs physical functioning but also significantly disrupts an individual's emotional, social, and psychological life. While rehabilitation programs primarily focus on physical recovery, the process of community acceptance and social inclusion following rehabilitation often receives insufficient attention (Dijkers, 2021). As a result, many individuals with SCI face considerable challenges in returning to work, maintaining relationships, and re-establishing meaningful roles within their communities.

The transition from hospital-based care to community life is frequently shaped by social stigma, isolation, and discrimination, which inhibit full participation in social, educational, and economic activities (Chapin & Holbert, 2020). These challenges are particularly pronounced in low- and middle-income countries such as Bangladesh, where limited accessibility, entrenched social attitudes toward disability, and weak implementation of inclusive policies further complicate post-rehabilitation life for individuals with SCI. Despite medical and technological advancements that enhance physical recovery, many SCI survivors continue to struggle with the social and emotional dimensions of reintegration, highlighting the gap between functional recovery and meaningful community participation (Lemke et al., 2022; Mackenzie et al., 2021).

Although a substantial body of literature addresses the medical and psychological aspects of SCI recovery, the process through which community acceptance and social inclusion are negotiated after rehabilitation remains

underexplored. Existing studies acknowledge that societal attitudes, lack of community engagement, and exclusionary practices act as significant barriers to inclusion; however, fewer studies examine how social supports, structures, and networks interact over time to shape inclusion as an evolving process rather than a single outcome (Veerbeek et al., 2021; Levins et al., 2020).

Community acceptance and social inclusion for individuals with SCI are influenced by multiple interconnected factors operating at personal, relational, and structural levels. Support networks involving family members, peers, rehabilitation professionals, and community actors play a critical role in facilitating re-engagement with community life (Jørgensen et al., 2023). At the same time, accessible infrastructure, inclusive workplace practices, and supportive public policies significantly affect the extent to which SCI survivors are able to participate in social, educational, and employment activities (Mackenzie et al., 2021). Despite progress in disability rights, persistent barriers such as negative stereotypes, limited awareness, and systemic discrimination continue to restrict meaningful participation, particularly within workplaces and public spaces (Sherry, 2022; Jørgensen et al., 2023).

Importantly, community acceptance and social inclusion should be understood not as static outcomes but as dynamic, ongoing processes that unfold over time. The experiences of SCI survivors may shift as they encounter new social environments, changing expectations, and varying levels of support, leading to fluctuations in their sense of belonging and participation (Veerbeek et al., 2021). Positive experiences of acceptance at the individual level may contribute to broader changes by influencing community attitudes and encouraging more inclusive practices, thereby generating

potential ripple effects at institutional and societal levels (Lemke et al., 2022; Levins et al., 2020).

This qualitative study seeks to address these gaps by exploring the process of community acceptance and social inclusion among individuals with SCI in the post-rehabilitation phase, with particular attention to the Bangladeshi socio-cultural context. By examining the lived experiences of SCI survivors, the study aims to understand how individuals negotiate acceptance, identify the structures that enable or hinder inclusion, and explore the key turning points that shape their sense of belonging within the community. Through this process-oriented focus, the study aims to generate insights that can inform rehabilitation practices, community initiatives, and policy development, ultimately contributing to more inclusive and empowering environments for individuals living with SCI.

1.2 Justification of the study

Spinal cord injury is a life-altering condition affecting approximately 27 million individuals worldwide, with rising incidence due to trauma, chronic diseases, and aging populations (World Health Organization [WHO], 2013). While advancements in medical and rehabilitation services have improved physical recovery outcomes, the process of community acceptance and social inclusion following rehabilitation remains a critical and often unmet need. Evidence indicates that a substantial proportion of SCI survivors experience social isolation, restricted participation in meaningful social roles, and diminished quality of life after discharge, underscoring the limitations of rehabilitation models that prioritize physical function over social reintegration (Hammell, 2007; Reinhardt et al., 2011).

Community acceptance and social inclusion are central to psychological well-being and long-term adaptation for individuals with SCI; however, these are shaped by complex and interacting personal, relational, and structural factors (Furlan, 2020). Persistent barriers such as inaccessible infrastructure, social stigma, and weak policy implementation continue to undermine inclusive participation. In low- and middle-income countries, including Bangladesh, these challenges are intensified by resource constraints, limited enforcement of disability legislation, and culturally embedded perceptions of disability. For example, a significant proportion of public spaces remain inaccessible to wheelchair users, and misconceptions about disability frequently result in workplace discrimination and social marginalization (Reinhardt et al., 2011; Furlan, 2020). Although facilitators such as social support networks, inclusive community initiatives, and assistive technologies have demonstrated potential to enhance participation, their effectiveness and sustainability within specific socio-cultural contexts remain insufficiently understood (Boschen et al., 2003).

Existing literature on SCI rehabilitation has largely emphasized clinical outcomes or quantitative indicators of participation, often treating social inclusion as a measurable end point rather than an evolving social process. As a result, the lived experiences of SCI survivors as they negotiate acceptance, exclusion, and belonging within their communities are frequently overlooked (Hammell, 2015). This gap is particularly significant in contexts such as Bangladesh, where social relationships, family structures, and community norms play a decisive role in shaping inclusion. Qualitative, process-oriented inquiry is therefore essential to capture how individuals interpret, respond to, and navigate these social realities over time (Barclay et al., 2016).

Grounded theory, particularly a constructivist grounded theory approach, is well suited to addressing this gap, as it enables the systematic exploration of social processes as they unfold within specific contexts. By centering the perspectives of SCI survivors, constructivist grounded theory allows for the co-construction of meaning between participants and researcher, acknowledging how social inclusion and community acceptance are shaped through interaction, interpretation, and context (Charmaz, 2014). This approach is particularly appropriate for examining community acceptance as a dynamic process rather than a fixed outcome, and for generating theory that is grounded in the lived experiences of individuals navigating post-rehabilitation life.

This study therefore seeks to explore the process of community acceptance and social inclusion among individuals with SCI in Bangladesh, with the aim of developing a contextually grounded understanding of how inclusion is achieved, challenged, and sustained over time. By mapping the interplay between personal agency, relational dynamics, and structural conditions, the study aims to generate insights that can inform rehabilitation practices, guide policy development, and support community-level initiatives. In doing so, the research aligns with the WHO's mandate for equitable, community-based rehabilitation and contributes to the development of culturally responsive strategies that promote meaningful participation and long-term social inclusion for individuals with SCI (WHO, 2013).

1.3 Operational Definitions

Community Acceptance

The extent to which SCI survivors are welcomed, respected, and included in community life (Lemke, Ross, & Priebe, 2022).

Social Inclusion

A process of improving access to opportunities, respect for rights, and full participation in society for disadvantaged individuals (WHO, 2013).

Grounded Theory

Grounded theory is a qualitative research methodology aimed at developing theory that is “grounded” in data collected from participants. It involves a systematic, iterative process of data collection and analysis, using techniques such as coding, memo writing, and constant comparison to identify patterns and categories that explain a social process or experience (Glaser & Strauss, 1967).

Constructivist grounded theory

Constructivist grounded theory is an interpretive approach that emphasizes the co-construction of meaning between the researcher and participants. It recognizes that social realities, such as community acceptance and social inclusion, are shaped through interaction and interpretation, making it particularly suitable for exploring complex, context-dependent social processes (Charmaz, 2014).

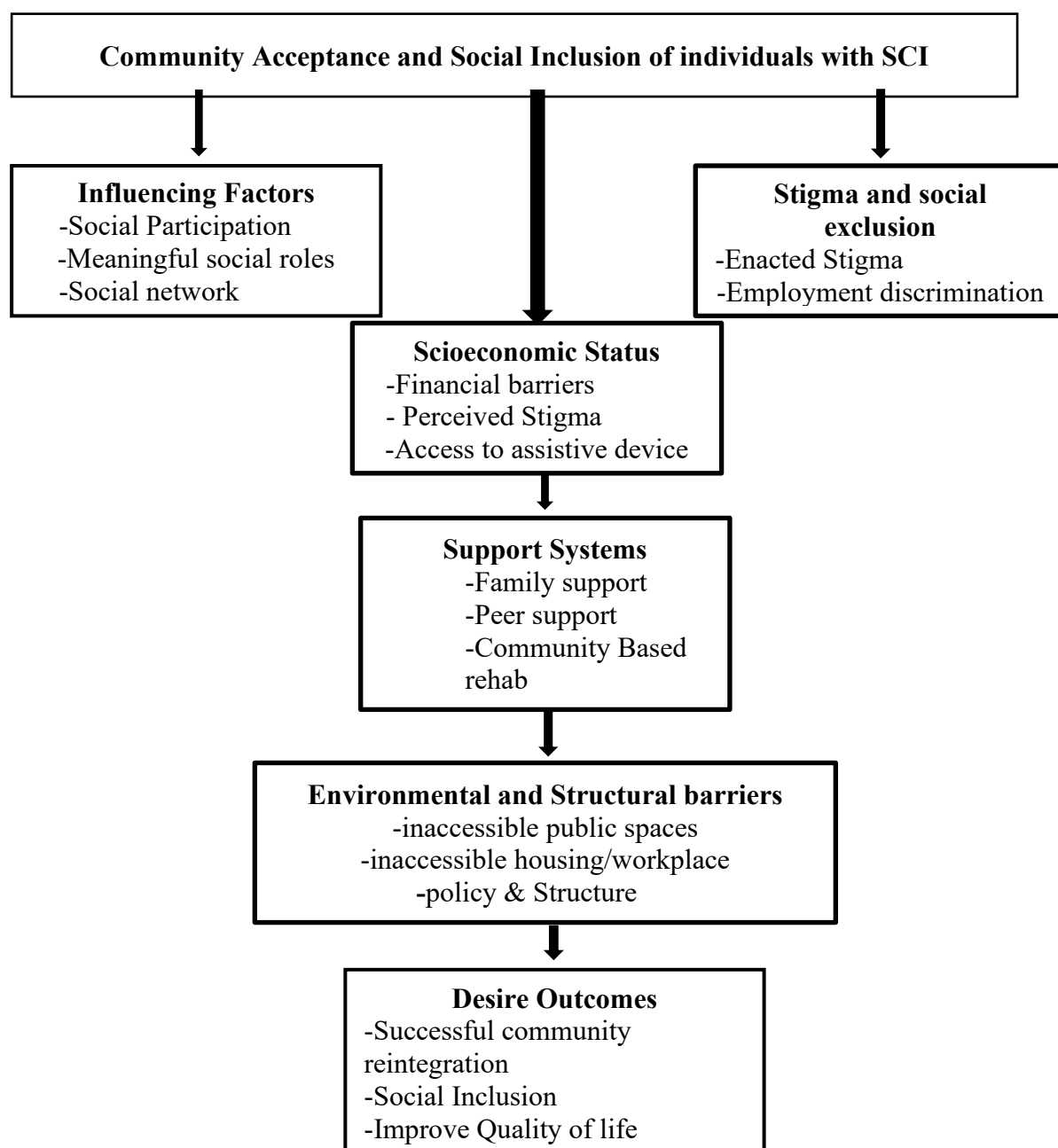
1.4 Aim of the study

To Understand process of community acceptance and social inclusion among individuals with spinal cord injury (SCI).

CHAPTER II: LITERATURE REVIEW

Using search engines and databases like PubMed, Google Scholar, ResearchGate, and Google, the researcher has reviewed some of the literature related to this study. In this part, the researcher gives a concise summary of this literature.

Figure 1: Overview of literature review findings



2.1 Introduction:

Spinal cord injury (SCI) is a catastrophic life event that disrupts not only physical functioning but also the psychological and social dimensions of an individual's life. While rehabilitation is essential for restoring physical capacity, it represents only one stage in a longer and more complex process of community re-engagement. Many individuals with SCI achieve measurable physical improvements during rehabilitation, yet continue to face significant challenges when attempting to resume everyday activities and social roles within their communities. These challenges extend beyond bodily impairment and are shaped by social attitudes, environmental conditions, and the availability of systemic support, all of which influence community acceptance and social inclusion.

Existing literature highlights the multifaceted nature of community reintegration following SCI, emphasizing the importance of participation in work, education, and social activities for psychological well-being, life satisfaction, and overall quality of life (Fekete et al., 2017). However, despite widespread agreement on the benefits of participation, studies vary considerably in how social inclusion is conceptualized and measured. Many studies operationalize inclusion through outcome indicators such as employment status, participation frequency, or quality-of-life scores, offering limited insight into how inclusion is achieved, negotiated, or sustained over time.

Research consistently identifies stigma as a major barrier to social participation and community acceptance among SCI survivors (Ownsworth et al., 2023). While there is strong agreement that stigma contributes to social exclusion, existing studies tend to focus on the presence or intensity of stigma rather than examining how individuals

interpret, respond to, and navigate stigmatizing experiences in their daily lives. As a result, the dynamic processes through which SCI survivors manage stigma and seek acceptance within their communities remain insufficiently theorized.

Similarly, environmental and structural barriers—such as inaccessible public spaces, transportation systems, and workplaces—are widely documented as obstacles to social inclusion. However, much of the literature treats these barriers as static conditions rather than examining how individuals adapt to, resist, or negotiate these constraints over time. This limits understanding of how community acceptance unfolds within real-world contexts, particularly outside high-income settings where infrastructural limitations are more pronounced.

Overall, the literature provides valuable descriptive insights into the factors associated with social participation and reintegration following SCI, yet it largely emphasizes outcomes, barriers, and correlates rather than the underlying social processes. Few studies explore how SCI survivors themselves make sense of inclusion, belonging, and acceptance, or how these experiences evolve across the post-rehabilitation period. This limitation is especially evident in low- and middle-income countries, including Bangladesh, where socio-cultural norms, family structures, and community expectations play a central role in shaping social inclusion, yet remain underrepresented in existing research.

Accordingly, this literature review adopts a critical lens to examine not only what is known about community acceptance and social inclusion among individuals with SCI, but also what remains unexplained. By highlighting the limitations of outcome-focused and variable-driven approaches, this review establishes the need for a qualitative, process-oriented methodology—specifically a constructivist grounded

theory approach to generate a contextualized understanding of how community acceptance and social inclusion are constructed and experienced by SCI survivors in everyday life.

2.1.1 Community Acceptance and Social Inclusion of SCI Survivors

Community acceptance and social inclusion are central concepts in the literature on spinal cord injury (SCI), particularly in relation to long-term well-being following rehabilitation. Existing studies consistently emphasize that successful reintegration into society requires more than physical recovery and depends on the ability of SCI survivors to resume meaningful social roles, engage in work, and participate in community life. Within this body of research, community acceptance is often discussed in relation to social attitudes and interpersonal interactions, while social inclusion is commonly framed as participation in social, economic, and cultural activities.

Despite broad agreement on the importance of these concepts, the literature reveals considerable variation in how community acceptance and social inclusion are conceptualized and operationalized. Many studies treat social inclusion as an outcome measured through indicators such as employment status, frequency of social participation, or levels of independence. While these measures provide useful information about participation levels, they offer limited insight into how acceptance is developed, negotiated, or challenged over time, particularly from the perspectives of SCI survivors themselves.

Several studies emphasize that reintegration involves regaining socially valued roles and achieving independence in daily life. However, these studies often assume that reintegration naturally follows rehabilitation progress, without adequately examining the social interactions and contextual factors that shape acceptance within

communities. As a result, community acceptance is frequently implied rather than explicitly examined, leaving the relational and interpretive dimensions of inclusion underexplored.

Moreover, existing research tends to focus on individual adjustment and functional capacity, with less attention to how broader social structures and cultural norms influence inclusion. This individualistic orientation risks overlooking the ways in which acceptance is co-constructed through interactions between SCI survivors, family members, employers, and community actors. Consequently, while the literature identifies key domains associated with inclusion, it does not sufficiently theorize community acceptance and social inclusion as dynamic social processes embedded within specific socio-cultural contexts.

This limitation is particularly evident in studies conducted in high-income countries, where established social services and accessibility standards shape experiences of inclusion differently than in low- and middle-income settings. In contexts such as Bangladesh, where social relationships, family obligations, and community norms strongly influence everyday life, community acceptance cannot be assumed to follow rehabilitation outcomes. Yet, empirical research exploring how SCI survivors in such contexts experience and interpret acceptance remains scarce.

Overall, while existing studies underscore the importance of community acceptance and social inclusion for SCI survivors, they predominantly describe desired states or measurable outcomes rather than explaining the processes through which inclusion is achieved or denied. This gap highlights the need for research approaches capable of capturing the evolving, context-dependent nature of acceptance and

inclusion, thereby reinforcing the relevance of a constructivist grounded theory approach for the present study.

2.2 Influencing Factors

The literature identifies a range of factors that influence community acceptance and social inclusion among individuals with spinal cord injury (SCI). These factors are commonly described as barriers or facilitators of reintegration and are often examined in relation to participation outcomes. However, existing studies tend to address these factors in isolation, offering limited insight into how they interact over time to shape the broader process of inclusion.

Social participation is frequently highlighted as a key indicator of successful reintegration. Participation in meaningful social roles such as employment, education, volunteering, and community activities are consistently associated with improved mental health, self-esteem, and quality of life among SCI survivors (Fekete et al., 2017). While this association is well established, much of the literature conceptualizes participation as an endpoint rather than examining how individuals with SCI gradually regain, negotiate, or abandon social roles within their communities. As a result, the pathways through which participation contributes to acceptance and belonging remain underexplored.

Social relationships and networks are also widely recognized as important influences on inclusion. Studies emphasize the role of family members, friends, and peers in providing emotional support, practical assistance, and opportunities for social engagement (Baehr et al., 2022). Although these studies demonstrate that strong social networks are associated with better psychosocial outcomes, they often do not examine

how these relationships evolve over time or how they mediate experiences of acceptance and exclusion in different social settings.

Environmental and attitudinal factors further shape the inclusion of SCI survivors. Inaccessible public spaces, transportation barriers, and discriminatory workplace practices are consistently identified as obstacles to participation (Middleton et al., 2022). At the same time, negative societal attitudes toward disability can undermine confidence, discourage social engagement, and limit opportunities for meaningful roles. However, the literature frequently treats environmental and attitudinal barriers as fixed conditions, offering limited exploration of how individuals adapt to, resist, or navigate these constraints in everyday life.

Overall, while existing research provides valuable insights into the factors associated with community acceptance and social inclusion, it largely adopts a variable-oriented perspective. Factors such as social participation, support networks, and environmental accessibility are often examined independently, rather than as interconnected elements within a dynamic social process. This fragmented approach limits understanding of how community acceptance is constructed through ongoing interactions between individuals, social relationships, and structural conditions, highlighting the need for a more integrative, process-focused analysis.

2.3 Stigma and Social Exclusion

Stigma is consistently identified in the literature as one of the most significant barriers to community acceptance and social inclusion for individuals with spinal cord injury (SCI). It operates at interpersonal, institutional, and societal levels, shaping how SCI survivors are perceived and treated within their communities. Existing studies widely agree that stigma contributes to social exclusion, restricted participation, and

diminished psychological well-being; however, there is variation in how stigma is conceptualized and examined.

2.3.1 Enacted stigma

Enacted stigma refers to overt discriminatory behaviors and negative social reactions directed toward individuals with SCI. Studies document experiences such as avoidance, exclusion from social activities, and unequal treatment in public and professional settings, all of which undermine opportunities for social engagement and reinforce marginalization (Ownsworth et al., 2023). While these findings establish the presence and consequences of enacted stigma, much of the literature focuses on documenting instances of discrimination rather than examining how SCI survivors respond to, negotiate, or resist stigmatizing encounters over time.

2.3.2 Perceived stigma

Perceived stigma, which involves the anticipation or internalization of negative societal attitudes, is also widely discussed in the literature. Research suggests that fear of judgment and self-stigmatization can discourage SCI survivors from seeking social interaction, employment, or community participation, thereby reinforcing cycles of withdrawal and isolation (LaVela et al., 2022). However, perceived stigma is often measured using self-report scales, which capture its intensity but provide limited insight into how such perceptions are shaped through social interactions or how they change across different stages of post-rehabilitation life.

2.3.3 Employment discrimination

Employment discrimination represents a critical domain in which stigma manifests structurally. Studies consistently report low employment rates among SCI survivors, attributing this to discriminatory hiring practices, lack of workplace accommodations, and assumptions about reduced productivity (Ottomanelli & Lind, 2009). While the association between stigma and poor vocational outcomes is well established, existing research tends to treat employment status as an outcome variable, offering limited understanding of how stigma interacts with workplace cultures, policies, and individual coping strategies to influence vocational inclusion.

Across these domains, stigma is predominantly examined as a static barrier or predictor of negative outcomes rather than as a dynamic social process. Few studies explore how experiences of stigma accumulate, diminish, or transform over time, or how SCI survivors actively interpret and manage stigmatizing interactions in pursuit of acceptance and belonging. This gap is particularly relevant in socio-cultural contexts where disability is strongly shaped by moral, familial, or cultural meanings, such as in Bangladesh, yet remains underrepresented in the literature.

In summary, while the literature clearly establishes stigma as a central obstacle to social inclusion for SCI survivors, it provides limited theoretical explanation of how stigma operates within the broader process of community acceptance. Understanding stigma as a socially negotiated and context-dependent process, rather than merely a barrier, is essential for advancing knowledge on how inclusion is achieved or constrained in everyday community life.

2.4 Support Systems

Support systems are consistently identified in the literature as crucial facilitators of community acceptance and social inclusion for individuals with spinal cord injury (SCI). These systems operate at multiple levels and include both informal supports, such as family and peer networks, and formal mechanisms, such as community-based rehabilitation services. While existing studies agree on the importance of support systems, they vary in how these supports are conceptualized and in the extent to which their role in the process of social inclusion is examined.

2.4.1 Family support

Family support is widely recognized as one of the most influential forms of assistance for SCI survivors, particularly in the early stages following injury. Families often provide emotional reassurance, physical care, and practical assistance, including transportation, daily living support, and facilitation of rehabilitation activities. Research consistently shows that strong family support is associated with improved psychological well-being, reduced anxiety and depression, and greater resilience among SCI survivors (Bhattarai et al., 2018).

However, while the positive contribution of family support is well documented, the literature also highlights potential challenges. Over-reliance on family members can limit independence and contribute to caregiver burden, leading to stress and strained relationships (Ide-Okochi et al., 2013). Despite acknowledging these tensions, most studies examine family support as a static resource rather than exploring how family dynamics evolve over time or how they influence SCI survivors' experiences of autonomy, acceptance, and belonging within the wider community.

2.4.2 Peer support

Peer support plays a distinctive role in the reintegration process by connecting SCI survivors with individuals who share similar lived experiences. Studies suggest that peer networks provide practical advice, emotional validation, and role modeling, helping individuals adapt to life after injury and reducing feelings of isolation (LaVela et al., 2022). Peer mentors, in particular, are often described as sources of hope and motivation, demonstrating the possibility of meaningful participation despite disability.

While the benefits of peer support are well recognized, existing research tends to focus on psychosocial outcomes such as improved confidence and reduced isolation. Less attention is given to how peer interactions contribute to broader processes of community acceptance, such as facilitating re-entry into work, negotiating social stigma, or navigating inaccessible environments. As a result, the role of peer support in shaping long-term inclusion trajectories remains insufficiently theorized.

2.4.3 Community-Based Rehabilitation

Community-Based Rehabilitation (CBR) represents a formal support mechanism designed to extend rehabilitation services into community settings. The literature highlights CBR as an effective approach for promoting continuity of care, social participation, and functional independence following discharge from institutional rehabilitation (Hossain et al., 2016). By involving families, local communities, and service providers, CBR programs aim to support SCI survivors within their everyday environments.

Evidence from low- and middle-income countries, including Bangladesh, suggests that CBR can improve psychosocial outcomes, enhance community participation, and reduce mortality among individuals with SCI (Hossain et al., 2016).

However, despite these positive findings, many studies focus on program effectiveness rather than examining how SCI survivors experience and engage with CBR services over time. Consequently, there is limited understanding of how CBR contributes to sustained community acceptance or how contextual factors influence its effectiveness in everyday life.

Across family, peer, and community-based supports, the literature consistently underscores the importance of support systems in facilitating social inclusion. However, these supports are often examined independently and primarily in relation to short-term outcomes. Few studies explore how different forms of support interact or how they collectively shape the evolving process of community acceptance and social inclusion. This gap limits understanding of how SCI survivors navigate multiple sources of support while negotiating autonomy, stigma, and belonging within their communities.

2.5 Environmental and Structural Barriers

Environmental and structural barriers are consistently identified in the literature as major constraints on the community acceptance and social inclusion of individuals with spinal cord injury (SCI). These barriers operate at the level of the built environment, institutional policies, and workplace practices, shaping the extent to which SCI survivors can participate independently in social, economic, and cultural life. While the presence of such barriers is well documented, existing studies often treat them as fixed conditions, offering limited insight into how individuals experience, negotiate, or adapt to these constraints over time.

2.5.1 Inaccessible public spaces

Inaccessible public spaces such as parks, transportation systems, healthcare facilities, and commercial buildings are widely reported as significant barriers to social participation for SCI survivors. Studies consistently highlight the absence of ramps, elevators, accessible toilets, and reliable transportation as factors that restrict mobility and limit engagement in everyday community activities (Middleton et al., 2022). These infrastructural limitations often result in reduced social interaction, dependence on others, and withdrawal from community life.

While there is broad agreement regarding the impact of inaccessible public spaces, much of the literature focuses on documenting physical barriers rather than examining how SCI survivors navigate these environments in practice. Few studies explore how individuals develop coping strategies, rely on social networks, or modify participation patterns in response to environmental constraints. This gap is particularly evident in low- and middle-income countries such as Bangladesh, where infrastructural limitations are more pronounced and accessibility standards are inconsistently enforced.

2.5.2 Inaccessible Housing and Workplace

Housing and workplace accessibility are critical determinants of independence and social inclusion for SCI survivors. Research emphasizes that inadequate housing modifications such as narrow doorways, inaccessible bathrooms, and lack of ramps can confine individuals to limited spaces, undermining autonomy and social engagement (Middleton et al., 2022). Similarly, inaccessible workplaces and failure to provide reasonable accommodations remain major barriers to vocational reintegration.

Although studies consistently report low employment rates among SCI survivors, they often attribute this to environmental and organizational barriers without examining the processes through which these barriers are experienced and addressed. Workplace discrimination, lack of adaptive equipment, and inflexible work arrangements are typically presented as explanatory factors, yet limited attention is given to how SCI survivors negotiate accommodations, engage with employers, or exit the workforce over time (Odagiri Utiyama et al., 2022).

2.5.3 Policy & Structure

Beyond physical accessibility, broader structural conditions—such as policy frameworks, enforcement mechanisms, and societal priorities—shape the inclusivity of environments. The literature frequently calls for universal design and inclusive policies as solutions to environmental barriers (Ruoranen et al., 2015). However, many studies adopt a normative stance, emphasizing what should be done rather than examining how policies are implemented or experienced in everyday contexts.

In countries like Bangladesh, gaps between policy intent and practical implementation are common, further complicating the inclusion of SCI survivors. Yet empirical research examining how these structural conditions influence lived experiences of acceptance and exclusion remains limited.

Overall, the literature clearly establishes environmental and structural barriers as significant constraints on social inclusion for SCI survivors. However, by treating these barriers primarily as static obstacles or policy deficiencies, existing studies offer limited understanding of how individuals interact with their environments over time. Examining environmental accessibility as part of a dynamic process—shaped by personal agency, social support, and institutional responses—is essential for

understanding how community acceptance is enabled or constrained in real-world settings.

2.6 Desired Outcomes

The literature commonly presents successful community reintegration, social inclusion, and improved quality of life as the desired outcomes of rehabilitation and post-rehabilitation support for individuals with spinal cord injury (SCI). These outcomes are frequently used as indicators of adjustment and recovery, reflecting the extent to which individuals are able to resume social roles, participate in community life, and experience psychological well-being.

2.6.1 Successful community reintegration

Successful community reintegration is generally described as the ability of SCI survivors to re-engage in social, economic, and cultural activities, including employment, education, family roles, and community participation. Studies consistently report that engagement in meaningful social roles contributes to a sense of purpose, identity reconstruction, and improved mental health (Fekete et al., 2017). However, reintegration is often discussed as a goal to be achieved rather than as a socially mediated process shaped by acceptance, exclusion, and negotiation within everyday interactions.

2.6.2 Social inclusion

Social inclusion is similarly framed in much of the literature as an end state characterized by equal access to opportunities, participation in social activities, and absence of discrimination. While this framing highlights important normative goals, it often overlooks how inclusion is unevenly experienced and contingent upon social relationships, environmental conditions, and institutional responses. Consequently,

social inclusion is frequently measured through participation levels or access indicators, offering limited insight into how individuals with SCI experience belonging or acceptance within their communities.

2.6.3 Improved quality of life

Improved quality of life is widely recognized as a key outcome associated with successful reintegration and inclusion. Research demonstrates strong associations between participation, social support, and quality-of-life indicators such as life satisfaction, emotional well-being, and self-esteem (Middleton et al., 2022). However, quality of life is typically treated as an individual-level outcome, with limited attention to the social processes through which community acceptance and inclusion contribute to well-being over time.

Overall, while the literature clearly establishes the importance of reintegration, social inclusion, and quality of life as outcomes, it tends to emphasize *what* outcomes are achieved rather than *how* they are produced. This outcome-oriented focus obscures the underlying processes through which SCI survivors navigate social barriers, mobilize support, and seek acceptance within their communities, reinforcing the need for research that examines inclusion as a dynamic and socially constructed process.

2.7 Summary of the Literature Review

This literature review highlights that community acceptance and social inclusion are critical to the long-term well-being of individuals living with spinal cord injury (SCI). Existing research provides substantial evidence that social participation, supportive relationships, accessible environments, and inclusive policies are associated with improved psychological health, vocational engagement, and quality of life. At the same time, the literature consistently identifies stigma, environmental barriers, and structural

discrimination as persistent challenges to successful reintegration following rehabilitation.

Despite these contributions, several important gaps remain. First, much of the existing literature conceptualizes community acceptance and social inclusion as outcomes measured through indicators such as employment status, participation frequency, or quality-of-life scores. While valuable, these approaches offer limited understanding of the social processes through which inclusion is negotiated, sustained, or disrupted over time. Few studies examine how individuals with SCI interpret acceptance, respond to exclusion, or navigate changing social relationships in everyday community settings.

Second, the literature is dominated by quantitative, variable-oriented studies conducted in high-income countries, including the United States, Australia, and the United Kingdom. These studies often rely on hospital-based or clinical samples and provide limited insight into post-rehabilitation community life, particularly in low- and middle-income countries. Qualitative research exploring lived experiences of community acceptance remains scarce, and grounded theory studies examining social inclusion in SCI contexts are notably absent in Bangladesh.

Third, existing studies rarely explore identity-related, emotional, and role-based transformations that occur after rehabilitation. The ways in which SCI survivors reconstruct their sense of self, renegotiate social roles, and redefine belonging within family and community contexts remain underexplored. This gap is particularly significant in Bangladesh, where socio-cultural norms, family structures, and community expectations strongly influence experiences of disability and inclusion.

Finally, although many studies identify barriers and facilitators of inclusion, they often examine these factors in isolation, without theorizing how they interact as part of a broader, evolving process. As a result, the literature lacks explanatory frameworks that capture the dynamic nature of community acceptance and social inclusion across time and context.

In response to these gaps, the present study adopts a constructivist grounded theory approach to explore the process of community acceptance and social inclusion among individuals with SCI in Bangladesh. By centering the voices of SCI survivors and examining their lived experiences in the post-rehabilitation phase, this study seeks to generate a contextually grounded theoretical understanding of how inclusion is constructed, challenged, and sustained within everyday community life.

2.7.1 Key Gaps in Literature

- Most studies are from high-income countries like the USA, Australia, and the UK.
- Very few qualitative studies from South Asia; no post-rehab studies from Bangladesh.
- Focused more on hospital-based data rather than community life
- There is limited investigation into emotional, identity-related, and role-based changes experienced after rehabilitation.
- Existing studies rarely explore how SCI survivors themselves define or interpret “inclusion” and “acceptance.”
- There is limited investigation into emotional, identity-related, and role-based changes experienced after rehabilitation.
- No grounded theory studies have been conducted in Bangladesh illustrating acceptance and inclusion in SCI context.

CHAPTER III: METHODS & MATERIALS

3.1 Study Question, Aim and Objective(s)

3.1.1 Study Question

How do individuals with spinal cord injury (SCI) experience community acceptance and social inclusion after rehabilitation, and what processes influence their reintegration into society?

3.1.2 Aim of the Study

To Understand process of community acceptance and social inclusion among individuals with spinal cord injury (SCI).

3.1.3 Objectives

1. Explore how SCI survivors experience acceptance and inclusion in their communities after rehabilitation.
2. Identify the structures, supports, and social practices that enable inclusion.
3. Understand the processes through which SCI survivors re-engage with community life.
4. Identify key experiences and turning points that foster a sense of belonging.
5. Explore how community acceptance becomes stabilized and sustained over time, and how inclusion at the individual level can contribute to broader community or structural change.

3.2 Study Design:

3.2.1 Study Method

The student researcher used the qualitative research methodology in this study, as it aim to understand the community acceptance and social inclusion of individuals with spinal cord injury (SCI) after rehabilitation. This study focuses on how participants interpret and make sense of their experiences, allowing theory to emerge from the data rather than being imposed beforehand. Grounded Theory is particularly suited for examining processes and understanding the social dynamics that shape participants' experiences. The aim of my study is to Understand process of community acceptance and social inclusion among individuals with spinal cord injury (SCI). The purpose of the study was to gain a deep understanding of how individuals with SCI engage with their communities post-rehabilitation, particularly in terms of inclusion and belonging.

By focusing on participants' interpretations of their experiences, this methodology allowed the researcher to explore the complex social processes that influence their reintegration into society. Qualitative research "explores the meaning of human experiences and creates the possibilities of change through raised awareness and purposeful action" (Taylor & Francis., Jul 4, 2022). Qualitative methods also provide access to people's subjective worlds and meanings, as well as to marginalized groups that are frequently invisible in Western psychology due to factors like gender, sexual orientation, race, or culture (Braun & Clarke, 2013).

In this study, the researcher sought to understand the factors that facilitate or hinder the inclusion of individuals with SCI, with a specific focus on the social, cultural, and structural elements that impact their experiences. The research process involved conducting interviews with participants in their natural environments, allowing for an

authentic exploration of their lived experiences. Through this approach, theories emerged from the data, shedding light on the dynamic and evolving nature of community acceptance and social inclusion for individuals with SCI.

3.2.2 Study Approach

This study employed a Constructivist Grounded Theory approach (Charmaz, 2014) to explore the process of community acceptance and social inclusion among individuals with spinal cord injury (SCI) following rehabilitation. This approach was selected because it is well suited to examining complex, evolving social processes and generating theory grounded in participants' lived experiences rather than pre-existing frameworks. Community acceptance and social inclusion were therefore conceptualized as dynamic processes shaped through social interaction and contextual conditions, rather than fixed outcomes.

Consistent with constructivist assumptions, meaning was understood as co-constructed through interactions between the researcher and participants, and reflexivity was maintained throughout the research process. Sampling followed an iterative, theoretically informed approach. Initial participants were recruited based on their experience of completing rehabilitation and returning to community life, and subsequent sampling was guided by emerging concepts to deepen and refine developing categories related to acceptance, exclusion, and belonging.

Data were collected through in-depth, semi-structured interviews, allowing participants to describe their experiences in their own terms while enabling flexibility to pursue emerging issues. Particular attention was given to significant moments of social engagement, such as returning to work, rebuilding social relationships, and participating in community activities, as these moments often revealed shifts in

participants' perceptions of belonging. Reflexive notes were maintained to document the researcher's influence on data generation and interpretation.

Data collection and analysis occurred concurrently, following the iterative procedures of constructivist grounded theory, including initial and focused coding, constant comparison, and memo writing. Analysis aimed to understand how participants interpreted their experiences and how meanings related to community acceptance and social inclusion were constructed across contexts. Theoretical saturation was considered achieved when further data no longer contributed new insights to the emerging categories.

Unlike descriptive qualitative or thematic approaches, constructivist grounded theory seeks to develop an explanatory framework that accounts for how social processes unfold over time. This approach enabled the study to move beyond identifying barriers and facilitators to theorizing how SCI survivors actively navigate social relationships, structural constraints, and personal challenges in their pursuit of community acceptance.

3.3 Study Setting and Period

3.3.1 Study Setting

The study setting is an essential component of a research study. The participant and the student researcher decided on an ideal location for data collection as the study setting's nature, context, environment, and logistics may influence how the research study is carried out (Majid & Board Member, 2018). Data for this study will be gathered from the CRP (Centre for the Rehabilitation of the Paralysed), Chapain area, where individuals with spinal cord injuries (SCI) who have undergone rehabilitation are permanently residing. This setting is ideal for the study as it provides a unique

environment where post-rehabilitation SCI survivors are actively navigating daily life within a supportive community. The student researcher conducted every interview in a setting that was calm and welcoming to participants.

3.3.2 Study Period

Study period was from 15 June 2025 to 15 December 2025 and the data collection period was from 15 August, 2025 to 15 September, 2025.

3.4 Study Participant(s)

3.4.1 Study Population

The study population were individuals with SCI who are living in the community following rehabilitation.

3.4.2 Sample Size

The Sample Size consists of 15 individuals with spinal cord injury (SCI), all of whom are actively engaged in various jobs, providing valuable insights into their experiences of community reintegration and social inclusion after rehabilitation.

3.4.3 Sampling Techniques

In this study, the student researcher used purposive sampling to conduct the study. In purposive sampling, Purposive Sampling will be used by the student researcher to guarantee participants have personal knowledge of SCI reintegration. This method allows for flexibility, meaning participants will be selected based on emerging themes rather than a fixed list. By including diverse perspectives— both successful and challenging reintegration experiences—the study will gain a deeper understanding of social inclusion. Sampling will continue until theoretical saturation is reached, ensuring that no new insights emerge. This approach will provide meaningful, real-world data to better capture the complexities of community acceptance for SCI survivors. The student researcher chooses subjects and study locations based on their ability to provide

relevant information on the study's main phenomena and research challenge and also the researcher decides what needs to be known and sets out to find people who can and are willing to provide the information by knowledge or experience (Tongco, 2007).

3.4.4: Sample Size Justification

- The study included 15 participants, based on time constraint and theoretical saturation.
- In grounded theory, the focus is on gathering rich, detailed insights rather than large numbers (Charmaz, 2014).
- This range offers a balance—broad enough to capture varied experiences, yet focused enough for meaningful analysis and theory building (Creswell & Poth, 2018).

3.4.5: Inclusion criteria

- Individuals aged between 18 to 50 who have sustained a spinal cord injury (SCI).
- Must have completed the formal Spinal Cord Injury rehabilitation program from CRP.
- Living in the community for at least 1 year's post-rehabilitation.
- Willing to provide informed consent

3.4.6 Exclusion criteria:

- Individuals currently undergoing inpatient rehabilitation or living in a long-term care facility.
- Individuals with severe cognitive impairment that may hamper effective communication.
- Individuals who do not consent to participate in the study.

3.4.7 Participant Overview

Participant selection is one of qualitative research's most invisible and least critiqued methods. Researchers do not just collect and analyze neutral data; they decide who matters as data (Reybold et al., 2012). The study population consists of 15 individuals with spinal cord injury (SCI), all of whom are actively engaged in various jobs, providing valuable insights into their experiences of community reintegration and social inclusion after rehabilitation. One of them was from the Hindu religion, and the rest belonged to the Islamic religion. The names of the participants were coded with pseudonyms to maintain confidentiality.

Due to ethical concerns, participants were given a pseudonym to protect their confidentiality (Goodyear et al., 2007; NHMRC, 2023). An overview of the identified participants is provided in Table 4.1 below.

Table 1*Participants overview*

Pseudo Name	Occupation	Age	Sex	Duration of living in the community, livig area, migration area	Marital status
Naeem	Shopkeeper	38 years	Male	22 years, semi-urban,Bikrampur rural area.	Unmarried
Hasan	OTA	35years	Male	25years, semi-urban, Keranigonj rural area.	Married (after injury)
Karim	Executive Director	50 years	Male	37 years, semi-urban, Dhamrai savar, rural area.	Married
Mizan	Security guard	43years	Male	21 years, semi-urban,Jamalpur, rural area.	Married
Sharmeen	Tailor	32years	Female	21 years,semi-urban,Narayangonj, rural area.	Married (after injury)
Arif	Receptionist	30 years	Male	21 years,semi-urban,Hemayatpur, semi-urban area.	Unmarried
Farid	Retired OTA	50 years	Male	25 years,semi-urban,Deuga,sava r rural area.	Married (after injury)
Mitu	Receptionist	24 years	Female	2 years,semi-urban,Jhenaidah , rural area.	Unmarried
Tania	Receptionist	27 years	Female	5 years,semi-urban,Dhamrai, rural area.	Unmarried

(Continued on next page)

Table 1(*Continued...*)

Pseudo Name	Occupation	Age	Sex	Duration of living in the community, livig area, migrante area	Marital status
Rafiq	Shopkeeper	38 years	Male	12 years, semi-urban, Noaga, rural area.	Married (after injury)
Nasima	Peer counselor	42years	Female	23years, semi-urban, Noakhali, rural area.	Married (after injury)
Mahin	Receptionist	38years	Male	12years, semi-urban, Puran dhaka, Urban area.	Married (after injury)
Sabbir	Arabic Teacher	39years	Male	5years, semi-urban, Kachua thana, Chadpur, rural area.	Married
Imran	Mobile technician	28years	Male	6 years, semi-urban, Jamalpur, rural area.	Married
Tanvir	Shopkeeper	32years	Female	21 years, semi-urban, Narayangon j, rural area.	Married (after injury)

3.5 Ethical Considerations

The Declaration of Helsinki, which is a set of ethical principles developed by the World Medical Association, outlines key obligations for researchers, ensuring respect for human dignity, rights, and well-being, while balancing scientific knowledge with individual protection (World Medical Association, 2024). The following ethical criteria for research were provided in alignment with the principles outlined in the Declaration of Helsinki.

3.5.1 Ethical Clearance from IRB

Ethical clearance was sought from the Institutional Review Board (IRB) through the Department of Occupational Therapy at the Bangladesh Health Professions Institute (BHPI). Before gathering participant information, formal authorisation was obtained from the respective CRP authorities and scheduled at a time that was convenient and comfortable for each participant.

3.5.2 Informed Consent

Information Sheet: All participants received an information sheet from the student researcher covering all the study details such as the background of the researcher, aim of the research, participation details, eligibility, risks and benefits, confidentiality of participants and data, data collection method and storage, utilization of results and promotional results.

Consent Form: After providing study details and explaining the purpose of the study, participants chose to participate voluntarily. The consent was obtained by written consent from the participant after confirmation from the participant that data had been collected.

Withdrawal Form: Participation was voluntary, so they had the right to withdraw their consent before data analysis. The withdrawal form has been attached with the information sheet and consent form.

3.5.3 Unequal Relationship

The student researcher may have some familiarity with the participants, as they all graduated from the BHPI. The researcher is a student, while the participants are all experienced professionals, so their viewpoints on the topic are different. As a result, the student researcher's opinion had no impact on the participants' answers.

3.5.4 Power Relationships

The student researcher ensured that there were no unequal relationships among the participants and that the dynamics remained neutral and equitable throughout the study (NHMRC, 2023).

3.5.5 Risk and Beneficence

There was no risk or benefit involved in this study.

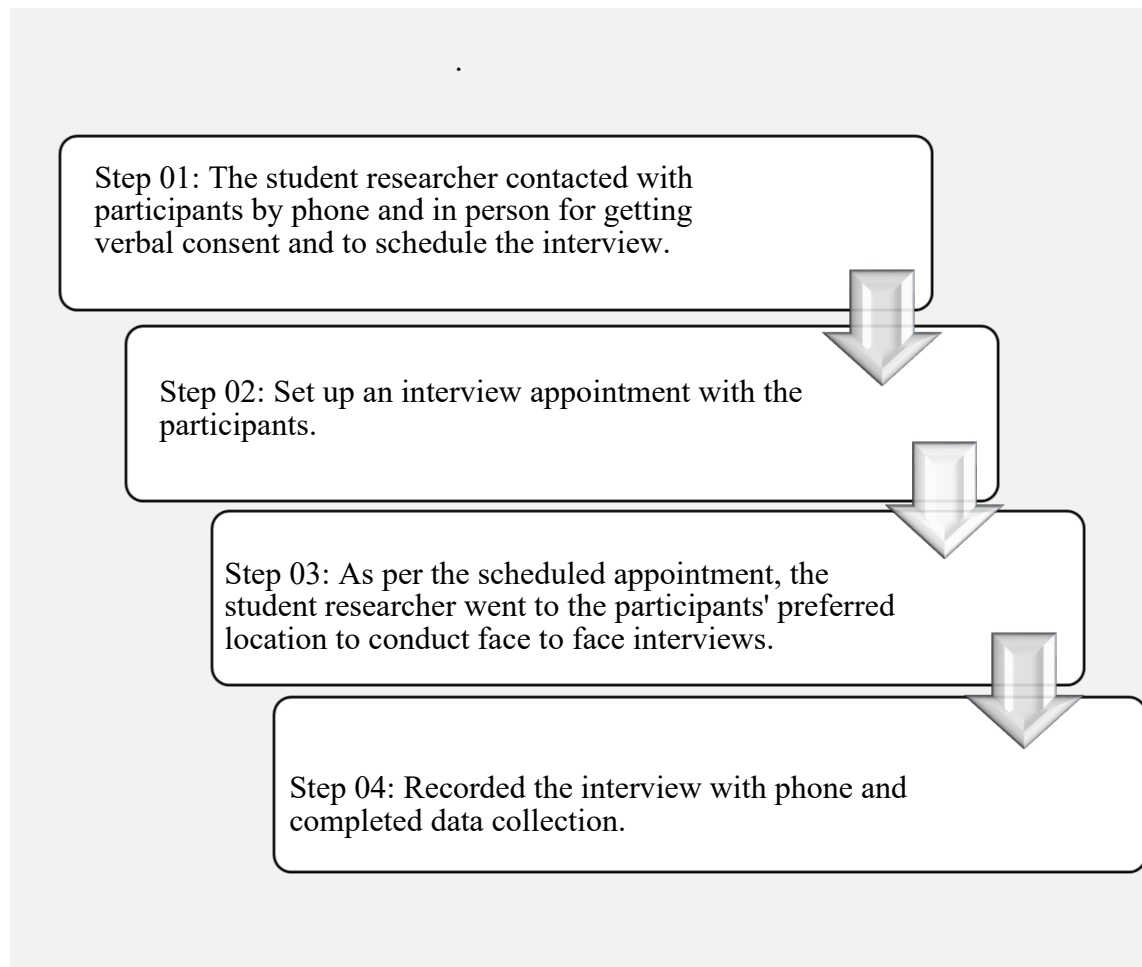
3.5.6 Confidentiality

The student researcher ensured and maintained the confidentiality of the participants. Their name and identity were not disclosed to anyone except for the supervisor. The student researcher also got the volunteer to sign a transcription contract requesting that they not reveal any information. The participants were also informed that their identity would not be disclosed for any future purposes, including reports, publications, conferences, or any other written or oral discussion.

3.6 Data Collection Process

3.6.1 Participants Recruitment Process

The student researcher will approach CRP and community organizations like SCIDAB that support spinal cord injury (SCI) survivors, seeking permission to recruit participants. Once approval is obtained, interested individuals who have completed SCI rehabilitation and have been living in the community for at least 6 months will be invited to participate.

Figure: 2*Overview of the participation recruitment process***3.6.2 Data Collection Method**

The student researcher will collect data through face-to-face, in-depth, semi-structured interviews. An interview is one of the most popular ways to collect qualitative research information because it is seen as speaking, and speaking is natural (Griffie, 2005). Through interviews, the researcher collects data directly from the participants, and it is significant in unfolding opinions, experiences, values, and various other aspects of the population under study (Showkat & Parveen, 2017). An in-depth interview is a verbal conversation in which one person (the interviewer) tries to get information from another person (the listener) by asking questions, and it usually takes place in a conversational setting, allowing participants to explore topics that are important to them (Longhurst,

2009). Data was collected and recorded by mobile phone recorder. The interviews lasted for 25-30 minutes.

3.6.3 Data Collection Instrument

A self-developed interview guide was used in the study to conduct the research. The interview guide has been developed through the literature review (Al-Bannay et al., 2014; Malkawi et al., 2020; Shafaroodi et al., 2014; Su et al., 2006; Tukuitonga, 2018). The interview guide focuses on cultural factors such as social class and status, social customs and rituals, ethnicity, race minority, personal factors, gender, local dialect, religious factors, environment factors, and the country's cultural context. Also, the student researcher developed a sociodemographic information sheet to collect general information like name, age, gender, occupation, status of injury (duration since injury, type of injury) ,living status (living situation, living condition, living in community since), employment status, marital status , wheelchair type etc. from the participants.

3.6.4 Field Test

The field test was conducted with two participants through the pilot interview. An interview pilot is a practice interview that can be used for a variety of reasons, such as getting started, preparing interview questions, and receiving input on the subject and interview technique (Griffie, 2005). After the field test, some questions were modified, such as questions about religious and occupational areas. 15th September 1 question was added to the interview guide. The questions helped to set a more comprehensive context for the participant's experiences and provided useful background for the ongoing conversation.

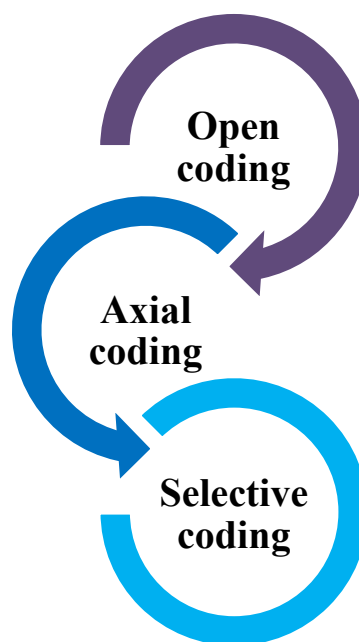
3.7 Data Management and Analysis

Data was analyzed by the grounded theory method. Grounded theory provides a process for creating categories of information (open coding), connecting the categories (axial coding), building a "story" that connects the categories (selective coding), and concluding with a theoretical set of ideas (Creswell, John W. & Poth, 2016).

The aim of open coding is to extract the categories from the data, while axial coding seeks to determine the relationships between the categories. The third stage, known as selective coding, involves identifying and characterizing the central category (Kasurinen, 2012).

The steps of data analysis are given below in Figure 3.2.

Figure: 3
Step of data analysis



Stage 01: Open Coding

During the preliminary phase of research, the student researcher conducted a thorough examination of the collected data. Subsequently, the data was segmented into individual components and concepts. The student researcher then proceeded to label these

concepts with descriptive codes. Throughout the coding process, the newly acquired data was continuously compared with previously coded data to detect similarities and variances. The initial codes were an extensive list of codes that underwent a rigorous verification process by the supervisor to ensure their authenticity and accuracy.

Stage 02: Axial Coding

The axial coding process followed the generation of an extensive set of open codes. This process involved sorting and organizing the codes into broader themes by identifying the connections and interactions between them. Additionally, the researcher considered how these themes related to and influenced one another. After completing the axial coding process, the supervisor reviewed the list to ensure that the research was proceeding in the intended direction.

Stage 03: Selective coding

During the final stage of coding, the student researcher narrowed their focus to selective coding. They fine-tuned and merged the axial coding and identified main categories that best represent the study's core idea. Based on these categories, the student researcher created a comprehensive theoretical model that describes the relationships between the core category and other subcategories.

3.8 Trustworthiness and Rigour

Trustworthiness was maintained by methodological and interpretive rigour (Curtin & Fossey, 2007)

3.8.1 Methodological Rigour

Congruence:

For the research, a grounded theory approach with a qualitative study design was chosen, which appropriately matches the goals and objectives of the study (see section 3.2: Study Design).

Responsiveness to social context:

A face-to-face interview occurred by manual convenience in an appropriate setting (see section 3.3.1: Study Setting)

Appropriateness and adequacy:

The study employs purposeful sampling to select participants. In this study, nine participants were chosen based on a set of inclusion and exclusion criteria. Interviews were conducted in person to gather data (see sections 3.4.2 and 3.6.1: Sampling Techniques and Participant Recruitment Process).

Transparency:

The student researcher gathered and examined information. Because the supervisor actively participated in each stage of the data analysis process and provided a range of perspectives for the data, there was no chance of bias (see sections 3.6 and 3.7: Data Collection Process and Data Management and Analysis).

3.8.2 Interpretive Rigour

Authenticity:

The study findings and interpretation were presented with the participants' verbatim quotations. The student researcher asked the participants if they understood the explanation that had been given after their statements.

Coherence:

Data was adjusted to meet the aim and objectives. The student researcher translated the data from Bengali, their first language, into English by transcribing the information verbatim. After hearing the audio recording, the study supervisor went over each transcription to check once more, and the student researcher began data analysis (see section 3.7: Data Management and Analysis).

Reciprocity:

The original data was not altered as the student researcher translated it verbatim. There was no discussion of data analysis with participants (See section 3.7: Data Management and Analysis).

Typicality: The student researcher provided a thorough description of the study's context so that readers could grasp it (see sections 3.4.5 and 3.7: Participant Overview and Data Management and Analysis).

Permeability of the researcher: The student researcher strictly followed the ethical guidelines. The student researcher finished the entire research strategy after consulting with the supervisor and making necessary checks to ensure the study's objectivity (see section 3.7 Data Management and Analysis).

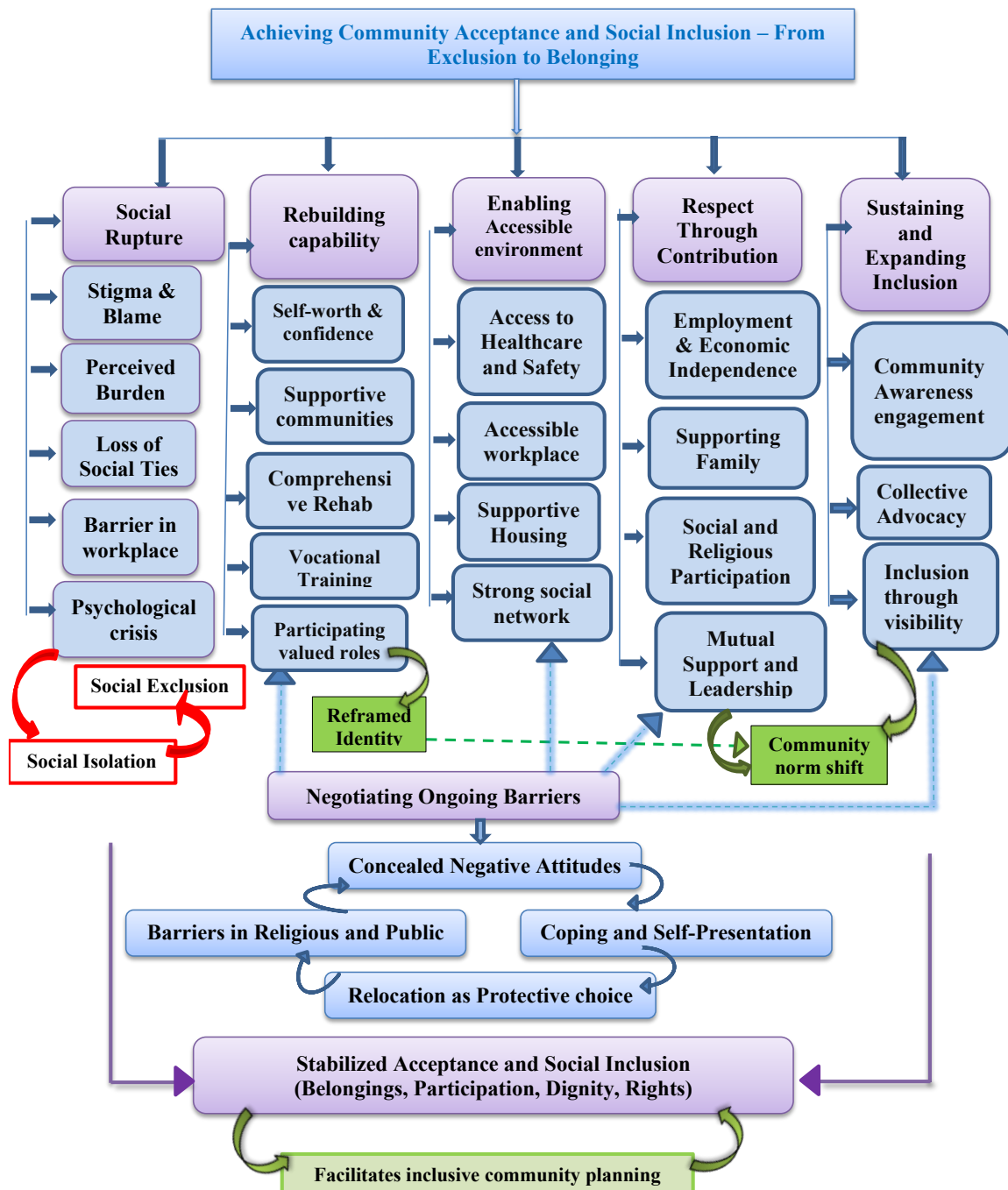
CHAPTER IV: RESULTS

The results of this constructivist grounded theory study are presented in this chapter. This chapter provides a thorough analysis of the interview data and the new perspectives gained regarding community acceptance and social inclusion of individuals with spinal cord injury (SCI) after rehabilitation. Overall, participants described community acceptance and inclusion as a process, not a single event—one that develops through changes in (a) how others respond to them, (b) how they regain confidence and capability, and (c) whether community environments practically allow participation.

The core process explains how participants moved from being treated as socially “less,” avoided, pitied, or blamed, toward being recognized as legitimate members of family and community life. Belonging was not described as simply “being present” in society; rather, it was achieved when participants could (a) participate in ordinary life, (b) be treated with dignity, and (c) be seen as contributing members of households and communities.

Figure: 4

Theory: Community Acceptance and Social Inclusion of individuals with SCI



4.1 Social Rupture after SCI

This category captures the early disruption of social life after SCI and explains how exclusion was produced through stigma, moral labeling, relationship loss, institutional barriers, and emotional crisis. This category included five subcategories: Stigma and Blame, Feeling Like a Burden, Loss of Social Connections, Barriers in Education and Religious Spaces, and Emotional Crisis.

4.1.1 Stigma and Blame

Participants described being judged through moral or religious explanations for disability, as well as being treated as “abnormal.” These explanations shaped how communities responded and often reduced social participation. Mitu described direct moral labeling in her home community:

“After rehabilitation, my heart was very heavy... people there said many things to me... suggesting that my condition was the result of some sin... Afterwards, I wouldn’t leave the house much; I wouldn’t talk to people or mix with anyone; I stayed inside all the time.”

Arif emphasized that such beliefs persist because people lack knowledge about SCI: “Many people don’t know and say that it’s the result of sin, or that it happened because of some sin”. Farid described the CRP-area as different precisely because people were less likely to hold these superstition-based explanations, noting that local residents did not view SCI as “the result of sin”. These accounts show how stigma and blame shaped early exclusion and encouraged withdrawal.

4.1.2 Percieved Burden

A prominent exclusion experience involved being positioned as dependent and socially burdensome. Participants described both internal fear of burden and community

comments that explicitly framed them as long-term liabilities. Imran's account shows how unemployment after returning home intensified this stigma:

“Being unemployed, sitting at home... being a burden on the family, and the people around me would constantly say... ‘He has become a burden on the family, he won’t be able to do anything else’... So, I took it as a challenge...”

Participants also described institutional practices that reinforced “burden” narratives by restricting opportunities. Mizan described being denied a loan specifically because he used a wheelchair: “They saw me as a wheelchair user and said, ‘We don’t give loans to disabled people.’ They rejected me with neglect and disrespect.” Such experiences functioned as structural exclusion—blocking routes to economic participation and reinforcing dependency.

4.1.3 Loss of Social Ties

Participants commonly reported reduced contact with friends and diminished social interaction after SCI. Karim described how acceptance could appear polite on the surface while remaining stigmatizing underneath: “People have accepted me with respect, but sometimes... disrespect unnoticed... they... talked, but went far away and said ‘lame.’” This kind of hidden stigma created uncertainty about belonging, participants could not fully trust that inclusion was genuine. Several participants also described friendship loss linked to inaccessible education or inability to continue social routines.

4.1.4 Barriers in Faith and Education

Inaccessibility in education and religious institutions functioned as a powerful form of exclusion because it prevented ordinary participation and reinforced “difference.”

Tania described requesting accommodation when her classes were on an upper floor and being denied:

“My class was on the fourth floor, so after my spinal cord injury I requested them a lot to shift my class to the ground floor... they did not do it. Because of that, I could not continue my studies.”

Mitu described a similar experience where she applied for class accommodation and ultimately quit her studies. Religious participation was also constrained. Rafiq described not being able to pray inside the mosque: “Inside the mosque, there’s no proper place to pray... I have to pray outside the mosque.” These experiences show that exclusion was not only social attitude—it was embedded in infrastructure and institutional routines that defined who could participate.

4.1.5 Psychological Crisis

Participants described emotional collapse, hopelessness, and depression as part of early exclusion. Mitu described, “I often thought it would be better to die than to live, but later, I was very depressed... Coming out of that and working now is a lot for me.”

Mahin described a severe crisis immediately after injury: “When I had the accident and saw that my leg wasn’t moving, I tried to commit suicide... But later... [a therapist] encouraged me...”

These accounts demonstrate how exclusion, stigma, and barriers were experienced not only externally but also internally, shaping motivation, self-worth, and willingness to re-engage with community life.

4.1.6 Social isolation and Exclusion

Across interviews, the rupture following SCI did not remain limited to an initial period of shock or practical disruption. For some participants, it developed into a secondary outcome: social isolation and exclusion. This occurred when stigma, reduced mobility, and diminished contact combined to shrink everyday interaction opportunities. Karim's account illustrated how apparent surface-level politeness could coexist with devaluing labels, producing cautious withdrawal: "they... talked, but went far away and said 'lame'". Mitu similarly described how stigmatizing interpretations in her home community contributed to staying inside and avoiding mixing with others.

In these cases, rupture became self-reinforcing: fewer interactions reduced chances for supportive responses, which increased withdrawal and deepened social exclusion.

4.2 Rebuilding Confidence and Capability

This category explains how participants regained functional independence, confidence, and future orientation after SCI through rehabilitation learning, emotional support, skills development, education, and achievement. This category included four subcategories: Learning to Live With SCI, Emotional Support and Role Models, Education and Job Training, and Sports and Personal Achievement.

4.2.1 Learning to Live With SCI

Participants emphasized rehabilitation as learning everyday living skills—mobility, self-care, and safe routines. Participants described how learning wheelchair skills and adapting daily life became foundational for later social inclusion. This learning reduced dependence and created the practical possibility of community participation.

Nasima described rehabilitation as learning "everything about living well, from beginning to end." This learning included wheelchair skills, daily routines, and the

practical knowledge needed to navigate life with SCI. Mahin credited wheelchair skills training in OT for making “many things... easy now.” Arif similarly described that adjustment took time, but gradually he accepted his condition and learned to adapt to environments.

4.2.2 Support Systems

Participants described encouragement from staff and peer role models as critical in rebuilding hope. Mahin’s account illustrates how crisis shifted toward possibility through encouragement and observing other SCI survivors: “[A therapist] encouraged me... ‘your head and hands are fine... Have you seen... [another SCI survivor]...’ I was inspired...”

Tania described gaining new friends and supportive relationships after relocation to the CRP-area, emphasizing how social support was not only emotional but also practical: “After coming here, I have gained many new friends they help me a lot... This is a big thing for me.” These experiences show that rebuilding capability was inseparable from rebuilding social connection.

4.2.3 Education and Job Training

Education and vocational training were repeatedly described as major turning points that enabled participants to regain social roles. Hasan described completing training and employment pathways through CRP and BHPI, while also describing institutional support for accessibility (e.g., moving classes to ground floor). Participants framed training as converting “possibility” into real opportunities. Mitu explicitly framed employment as identity transformation: “Because of CRP, I am now self-reliant. This is my new identity, that I am working even as a disabled person.”

Similarly, Tania described gaining employment after vocational training and emphasized how employment stabilized her ability to reside permanently in an enabling area.

4.2.4 Sports and Personal Achievement

Sports and achievement were described as building confidence and public recognition. Participants described participation in events, competitions, and programs as sources of pride and visibility. These achievements functioned as evidence—both to themselves and to others that life after SCI could include capability, contribution, and respect

4.2.5 Reframed Identity

Participants' descriptions indicated that rebuilding capability through rehabilitation, training, and renewed participation did not only restore function—it produced a reframed identity. As participants learned skills, re-entered education or work, and navigated public spaces more independently, they increasingly described themselves as capable actors rather than dependent recipients of care. Mitu expressed this shift explicitly:

“Because of CRP, I am now self-reliant. This is my new identity, that I am working even as a disabled person”. Nasima similarly linked capability and work to personal and social value “I have a job, and that’s why I have value”.

In this way, capability rebuilding served as the bridge between recovery efforts and the identity change that later enabled sustained inclusion and contribution.

4.3 Finding an Enabling Community Environment

This category explains why many participants described the CRP/Savar area as a practical foundation for inclusion and permanent settlement. It shows that acceptance

was supported by built environment, service access, housing stability, and disability normalization. This category included four subcategories: Access to Healthcare and Safety, Accessible Roads, Buildings, and Toilets, Secure and Supportive Housing, and Living Among Peers.

4.3.1 Access to Healthcare and Safety

Proximity to CRP was described as a form of security, especially when participants contrasted it with lack of services in home areas. Imran explained why living near CRP supported inclusion and survival:

“If I stay in my village... I won’t get the right treatment... there is no system even to enter the hospital... If I face a problem now... I can rush to CRP.”

This “health safety” enabled participants to live more confidently and sustain daily participation.

4.3.2 Accessible Living

Accessibility was described with detailed attention to roads, ramps, toilets, and entrances. Arif described how even when buildings had internal accessibility, entry stairs blocked participation:

“I got many job offers but couldn’t take them... inside... big rooms... big washrooms, but the steps were at the entry... The same is true for hospitals.”

Participants repeatedly connected accessible design with independence and dignity. Sabbir contrasted the CRP-area with other places:

“Here... there are internal ramps, and bathrooms are accessible... In other places, I would have to modify things myself.”

4.3.3 Supportive Housing

Housing stability (quarters and accessible residences) was described as central to permanent settlement. Mizan connected employment support directly to secure living: “I got a quarter here with my family. I got a secure life here.”

Tania similarly described that lack of transport and mobility barriers pushed her back toward CRP-area residence, where a quarter enabled independent living. These accounts show housing as both practical infrastructure and a social foundation that stabilizes participation.

4.3.4 Shared Presence

Participants described social normalization in areas where many wheelchair users live. This peer density reduced stigma and increased mutual support.

Farid compared union-level isolation with CRP-area concentration, emphasizing that in CRP-area “countless SCI patients” live together, and negative attitudes were less common. This normalization made participants feel less “different” and more included in everyday life.

4.4 Gaining Respect Through Contribution

This category explains how participants experienced acceptance becoming visible when they could contribute through work, family responsibility, social participation, helping others, and leadership. This category included four subcategories: Employment and Economic Independence, Supporting Family Responsibilities, Participating in Social and Religious Events, and Helping Others and Taking Leadership.

4.4.1 Employment and Economic Independence

Employment was repeatedly described as a primary pathway to dignity and recognition. Nasima directly connected work to social value: “Today, I have a job, and that’s why I have value.”

Rafiq described community reactions to his business: “Many are happy to hear that I am running a shop while sitting in a wheelchair... ‘Will you be able to do it?’... but it’s going well.”

Arif described how organizational affiliation shaped respect: “Since I work at CRP, a brand is attached to me, and people respect me based on that.” These accounts demonstrate that work functioned as a socially legible role that countered stigma and re-established membership.

4.4.2 Supporting Family Responsibilities

Participants linked inclusion to being able to fulfill family roles. Farid explained that he worked so society could not say his wife’s husband is disabled and cannot take responsibility; he emphasized educating his daughter and maintaining family dignity.

Naeem described pride in supporting parents despite being “sick.” Sharmeen described running her household without father or brother and described affection and social harmony as part of her moral identity.

Mitu described sending money home to parents and feeling proud when her family told others she has a job. Tania described managing her own expenses as partial responsibility.

4.4.3 Participating in Social and Religious Events

Participants emphasized that belonging required participation in social life (weddings, invitations, community events) and religious practice. However, participation depended on accessibility and community response. Naeem described continued participation in local events even after experiences of disrespect elsewhere:

“I have faced disrespect... going to the temple... there was a problem... But I do go to the local events here... and if there is a wedding ceremony... I go.”

Farid framed participation as necessary strategy for social positioning:

“If we keep to ourselves, people will not accept us... if someone invites me, I must participate... If I rely on getting sympathy... they consider me worthless.”

4.4.4 Mutual Support and Leadership

Many participants described helping other SCI individuals as a way to strengthen mutual respect and inclusion. Sharmeen described continuing to support others while also describing why she reduced volunteering due to social risk:

“Before, I used to volunteer... cut their nails... feed them... Now... you will go to do good work, and they will spread bad rumors about you. That’s why I’ve given up on it.”

Naeem described peer support through lending money and motivating others into business, while Hasan described structured leadership in SCI organizations and how CRP’s approach to dignity shaped his sense of worth. These accounts show that helping others reinforced inclusion by shifting participants from passive recipients of care to recognized contributors and leaders.

4.5 Negotiating Ongoing Barriers

This category explains how inclusion remained conditional and required continuous negotiation due to disrespect, inaccessible spaces, and social risk. This category included four subcategories: Hidden Disrespect and Negative Attitudes, Religious and Public Space Exclusion, Coping and Self-Presentation Strategies, and Choosing Supportive Environments.

4.5.1 Concealed Negative Attitudes

Karim illustrated how superficial politeness could conceal stigmatizing judgment: “They... said salam... shook hands... but went far away and said ‘lame.’”

Arif described being ignored at a tea stall—waiting a long time and leaving, interpreting it as annoyance about wheelchair space. Naeem similarly described times when people used harsh labels such as “cripple,” emphasizing that language itself operated as exclusion. These micro-exclusions were painful because they suggested that “acceptance” could be fragile and situational.

4.5.2 Barriers in Religious and Public Space

Several men described difficulties accessing mosques. Karim explicitly demanded an accessible environment because he “can’t enter the mosque.”

Rafiq’s experience of praying outside the mosque demonstrates how religious inclusion depends on design and community accommodation: “There’s no proper place... I have to pray outside the mosque.”

These experiences show that exclusion is not only about mobility; it touches dignity, faith practice, and social membership. They demonstrate that acceptance involves more than social attitudes; it requires access to meaningful spaces.

4.5.3 Coping and Self-Presentation Strategies

Participants described coping strategies to protect dignity in public. Arif explicitly linked clothing to how people treated him:

“If I go out wearing a lungi... people will look at me one way, but if... shirt and trousers... people will look at me differently.”

Others described emotional strategies such as ignoring negativity, maintaining patience, and focusing on contribution rather than stigma.

4.5.4 Relocation as a Protective Choice

Several participants described leaving or avoiding environments where stigma and physical barriers were strongest. Mitu described leaving the village due to both stigma and lack of practical help:

“I couldn’t cross the road... I called people for help... no one came forward... people said... my condition was due to my sin. That’s why I actually left the village.”

Sabbir similarly described returning home only once in years because dirt roads and household barriers made movement extremely difficult (Sabbir). These accounts show relocation as both a coping strategy and a structural necessity for inclusion.

4.6 Sustaining and Expanding Inclusion

This category explains how acceptance became more stable over time when inclusion was embedded in routines, mutual aid networks, collective advocacy, awareness work, and role modeling. This category included four subcategories: Building Support

Networks, Collective Advocacy for Accessibility, Community Awareness and Engagement, and Inspiring Others and Creating Change.

4.6.1 Building Support Networks

Participants described daily mutual help as central to sustained inclusion. Tania described practical support from friends related to illness and bladder management.

Mahin described the advantage of seeing others like him and managing bladder issues easily in this environment. These networks reduced isolation and supported continued work and participation.

4.6.2 Collective Advocacy for Accessibility

Participants described collective efforts to improve accessibility in markets, roads, and public structures. Naeem's account clearly shows inclusion expanding through community-level action: "We achieved this through agitation... We achieved the accessibility of City Center and New Market here through agitation." Mahin described how performances were intentionally used to raise awareness and push structural change:

"The main objective... was to create a movement (agitation)... to implement the structural environment, transport system, and surrounding structures for people with disabilities."

4.6.3 Community Awareness and Engagement

Participants described the need for awareness and implementation of disability rights in Bangladesh. Hasan explicitly described CRP's dignity-based approach as different from other places: "They never consider people with disabilities to be 'disabled.' They give them first priority... They see us... as a healthy person."

Farid described running awareness programs in schools, colleges, and madrasahs, and engaging chairmen, members, and teachers to identify obstacles and promote acceptance. Over time, he described improved communication where authorities consult disabled residents on construction and infrastructure decisions. This suggests a stabilization mechanism where inclusion becomes durable when disabled people become legitimate stakeholders in local governance.

4.6.4 Inclusion through Visibility

Participants repeatedly described their lives as evidence to others that SCI does not end meaningful life.

Mizan said others feel hope seeing him work as a guard and he advises new patients; Tania said seeing them work and manage expenses inspires others; she motivated another patient who later worked at CRP; Farid said SCI patients gain courage seeing how far he has come and that he is considered a role model; Nasima emphasized that being respected and working as an SCI woman including marriage was a major achievement that others notice; Imran described how community views shifted when people saw his business success after being labeled a burden. Others described motivating peers into work, sports, and participation. In this way, inclusion at the individual level contributed to broader community change by normalizing SCI presence and demonstrating capability.

Across categories, the findings show a clear process: SCI first disrupted belonging through stigma and barriers, then rehabilitation rebuilt capability and hope, and permanent inclusion became possible when participants lived in enabling environments that supported participation. Acceptance became stronger when participants were able to contribute through work, family responsibility, and leadership,

while ongoing barriers required negotiation through coping strategies and relocation decisions. Over time, inclusion stabilized and expanded when mutual networks and collective advocacy produced structural accessibility and social awareness—allowing SCI survivors not only to be included, but also to shape the conditions of inclusion for others.

4.7 Community Norm Shift

Participants' accounts further suggested that community norm shift emerged when three processes aligned over time: reframed identity, respect through contribution, and sustained/expanding inclusion. As survivors began to see themselves—and present themselves—as competent and socially legitimate, their increased participation and contribution made disability more visible in everyday community life in non-pitying ways.

For example, Arif described how employment shaped recognition: “a brand is attached to me, and people respect me”, while Rafiq described how running a shop in a wheelchair prompted community attention and reassessment (“many are happy to hear...”).

At the collective level, advocacy and repeated visibility in markets, transport spaces, and events created a local expectation that wheelchair users belong in public life, not at the margins. In this way, inclusion extended beyond individual acceptance to reshape what the community came to treat as “normal” participation.

CHAPTER V: DISCUSSION

This chapter describes the new theoretical insights that the present study has contributed to understanding community acceptance and social inclusion among individuals with spinal cord injury (SCI) in Bangladesh. It discusses the findings in relation to the relevant literature reviewed earlier and highlights areas of convergence, divergence, and extension. To the best of my knowledge, this is the first constructivist grounded theory study in Bangladesh to systematically explore the post-rehabilitation process through which SCI survivors experience, negotiate, and sustain community acceptance and social inclusion. The findings of this study are organized into six interrelated categories: Social Rupture after SCI, Rebuilding Confidence and Capability, Finding an Enabling Community Environment, Gaining Respect Through Contribution, Negotiating Ongoing Barriers, and Sustaining and Expanding Inclusion. Each theme is analyzed in relation to existing literature.

The results of this study are consistent with previous research identifying stigma as a major barrier to social participation and community inclusion among individuals with SCI (Ownsworth et al., 2023). Participants in this study described enacted stigma, moral labeling, and being blamed for their injury, which aligns with literature highlighting enacted and perceived stigma as central mechanisms of social exclusion. However, while prior studies primarily document the presence and intensity of stigma, the current study extends the literature by demonstrating how stigma initiates a process of “social rupture,” leading to withdrawal, identity crisis, and disrupted belonging. In contrast to variable-oriented studies, this research shows how stigma is experienced dynamically over time and how survivors actively negotiate and reinterpret stigmatizing encounters in everyday life.

The findings regarding employment discrimination and economic exclusion are also parallel to previous studies reporting low employment rates and workplace discrimination among SCI survivors (Ottomanelli & Lind, 2009). Participants described being denied loans, rejected from jobs, or judged incapable due to wheelchair use. These findings support existing evidence that structural discrimination limits vocational reintegration. However, unlike much of the literature that treats employment as an outcome variable, this study demonstrates that employment functions as a socially valued role that reshapes public perception and restores dignity. Work was not merely economic participation but a symbolic marker of value, transforming individuals from “burden” to “contributor.” This process-oriented explanation adds theoretical depth to existing research.

Environmental and structural barriers identified in this study are consistent with literature documenting inaccessible public spaces, housing, transportation, and workplaces as major obstacles to inclusion (Middleton et al., 2022). Participants described inaccessible mosques, upper-floor classrooms, entry stairs in offices, and lack of transport as barriers limiting participation. These findings confirm that physical accessibility remains a foundational determinant of inclusion. However, this study differs from prior research by conceptualizing environment not as a static backdrop but as an active condition shaping whether contribution and participation can stabilize acceptance. The identification of “enabling community environments,” particularly the CRP/Savar area, illustrates how accessibility, proximity to healthcare, and peer density collectively create a context where inclusion becomes sustainable.

The literature consistently emphasizes the importance of support systems, including family support, peer networks, and community-based rehabilitation

(Bhattarai et al., 2018; Hossain et al., 2016). The findings of this study align with these perspectives, as participants described emotional encouragement, peer inspiration, rehabilitation training, and structured institutional support as critical turning points. Similar to existing studies, peer role models fostered hope and confidence. However, this study advances the literature by demonstrating how support systems interact with skill development and environmental opportunity to rebuild capability. Rehabilitation was not only functional recovery; it was a process of identity reconstruction that made social participation imaginable again.

The study also corroborates previous research linking social participation and meaningful roles with improved well-being and quality of life (Fekete et al., 2017). Participants consistently connected belonging with employment, family responsibility, leadership, and participation in religious and social events. These findings support literature describing social roles as central to reintegration. Nevertheless, while existing research frequently conceptualizes reintegration and inclusion as outcomes, this study conceptualizes them as evolving processes. Acceptance became stronger when individuals could visibly contribute, and it stabilized over time through repeated participation, mutual support, and collective advocacy.

One significant contribution of this study is the identification of inclusion as conditional and continuously negotiated. Although literature acknowledges ongoing barriers, it often presents reintegration as a linear progression. In contrast, participants in this study described hidden disrespect, micro-exclusions, inaccessible religious spaces, and the need for coping strategies such as self-presentation management and relocation. This suggests that inclusion is fragile and context-dependent. The concept of relocation as a protective and strategic choice extends current knowledge by

illustrating how individuals actively restructure their social environments to secure belonging.

Furthermore, the findings respond directly to gaps identified in the literature review. Existing studies rarely explore emotional, identity-related, and role-based transformations after rehabilitation. This study demonstrates that SCI initially disrupts identity through stigma and dependency narratives, but rehabilitation, employment, and leadership facilitate identity reconstruction. Participants moved from internalized burden to recognized contributor, showing that acceptance is co-constructed through interaction rather than solely determined by impairment level.

Another key contribution is the identification of collective advocacy and awareness-building as mechanisms that expand inclusion beyond the individual level. While literature often recommends policy reform and universal design (Ruoranen et al., 2015), this study illustrates how SCI survivors themselves participate in agitation, awareness programs, and leadership roles to influence structural change. This demonstrates that inclusion is not only received but also actively produced by SCI survivors.

Overall, the findings of this investigation align with global research identifying stigma, environmental barriers, support systems, and meaningful roles as central to social inclusion. However, this study extends the literature by developing a grounded theoretical explanation of how community acceptance unfolds as a multi-stage, interactive process in a Bangladeshi context. The results illustrate that SCI first disrupts belonging through stigma and structural exclusion; rehabilitation rebuilds capability and confidence; enabling environments allow participation; contribution generates

respect; ongoing barriers require negotiation; and inclusion stabilizes when collective networks and advocacy reshape social and structural conditions.

In conclusion, this study addresses critical gaps in existing literature by moving beyond outcome-focused frameworks and providing a process-oriented understanding of community acceptance and social inclusion among SCI survivors in Bangladesh. By centering lived experiences and contextual realities, it contributes a theoretically grounded model that explains not only what inclusion looks like, but how it is constructed, challenged, and sustained over time.

CHAPTER VI: CONCLUSION

6.1.1 Study Strength

- The Institutional Review Board (IRB) granted the study's ethical approval.
- Uses Constructivist Grounded Theory to provide rich, authentic insights into SCI survivors' lived experiences.
- Focuses on SCI survivors living in the CRP area, capturing real-life reintegration and work experiences.
- In-depth, semi-structured interviews capture unique, detailed experiences and coping strategies.
- Findings will inform policies, services, and interventions for SCI survivors' social inclusion.

6.1.2 Study Limitation

- Findings may not apply to SCI survivors in other regions or areas.
- The study involves only 15 participants, which may limit the diversity of experiences captured. This study did not include back-translation of the instrument (semi-structured questionnaire) and the collected data from Bangla to English, as per the International Test Commission (ITC) requirements.
- As a qualitative study, this study cannot be generalized.
- The researcher faced difficulty collecting the related research articles because of the lack of published research.

6.2 Practice Implication (Recommendation for Future Practice and Research)

6.2.1 Recommendation for Future Practice

This study highlights the critical role of support systems in the successful reintegration of spinal cord injury (SCI) survivors into society after rehabilitation. Based on the findings, it is essential that rehabilitation centers and community-based programs develop more personalized and comprehensive support systems for SCI survivors. These systems should include tailored job placement services, social reintegration programs, and peer support networks, all aimed at fostering long-term community participation. Furthermore, the practice of inclusive employment should be emphasized. Employers must be trained to accommodate the unique needs of individuals with disabilities, ensuring that workplaces are not only accessible but also supportive for SCI survivors. In addition, community awareness campaigns are crucial in educating the public about the challenges faced by SCI survivors. These campaigns can help reduce stigma, encourage inclusivity, and create more supportive social and professional environments. Rehabilitation programs should adopt a more holistic approach, focusing not just on physical recovery but also on the social and psychological reintegration of SCI survivors. By incorporating life skills training, social integration strategies, and workplace readiness, these programs can better prepare SCI survivors for success in their post-rehabilitation lives.

6.2.2 Recommendation for Future Research

Future research should focus on longitudinal studies that track SCI survivors over extended periods, allowing for a deeper understanding of the long-term challenges and successes in their social reintegration and community participation. Additionally,

research should explore the diverse experiences of SCI survivors from different cultural and socio-economic backgrounds, to identify how these factors influence the reintegration process. This will help improve the generalizability of findings and provide a broader perspective on the experiences of SCI survivors. The perspectives of family members and caregivers should also be explored in future research, as they are key to understanding the full scope of the support systems that contribute to successful reintegration. Intervention efficacy studies should be conducted to assess the effectiveness of specific programs, such as vocational training and community-based reintegration models, in promoting long-term social inclusion for SCI survivors. Lastly, comparative studies between SCI survivors in different environments—such as rural and urban settings—could provide valuable insights into how contextual factors shape the reintegration process and the types of support required in each setting.

CHAPTER VII: REFERENCE

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APPENDICES

Appendix A: IRB Approval Letter



বাংলাদেশ হেলথ প্রফেশন্স ইনস্টিটিউট (বিএইচপিআই)
Bangladesh Health Professions Institute (BHPI)
(The Academic Institute of CRP)

Ref: CRP-BHPI/IRB/07/2025/1090

Date: 21.07.2025

To
 Nahid Sultana Mony
 4th Year B.Sc. in Occupational
 Therapy Session: 2020-2021 Student
 ID: 122200412

Subject: Approval of the thesis proposal Community Acceptance and Social Inclusion of Individuals with Spinal Cord Injury: A Qualitative Study by ethics committee.

Dear Nahid Sultana Mony,
 Congratulations.

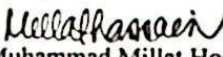
The Institutional Review Board (IRB) of BHPI has reviewed and discussed your application to conduct the above-mentioned dissertation, with yourself, as the principal investigator and Mohuya Akter Lecturer, Department of Occupational Therapy, Bangladesh Health Professions Institute (BHPI), CRP as thesis supervisor. The Following documents have been reviewed and approved:

SL No.	Name of the Documents
1	Research Proposal
2	Self-developed Interview Guide
3	Information sheet & consent form.

The purpose of the study is to explore how community acceptance and social inclusion is experienced by individuals with spinal cord injury (SCI) post-rehabilitation and identifying the key factors influencing their reintegration into society. The study involves use of a self-developed interview guide to understand how the process of community acceptance and social inclusion influences the social reintegration of individuals with spinal cord injury (SCI) post-rehabilitation that may take approximately 60 minutes to answer the Interview Guide and there is no likelihood of any harm to the participants. There is no benefit to the participants. The members of the Ethics committee have approved the study to be conducted in the presented form at the meeting held at 8:30 AM on 17 June 2025 at BHPI (50th IRB Meeting).

The institutional Ethics committee expects to be informed about the progress of the study, any changes occurring during the study, any revision in the protocol and patient information or informed consent and ask to be provided with a copy of the final report. This Ethics committee is working in accordance with the Nuremberg Code 1947, World Medical Association Declaration of Helsinki, 1964 - 2013 and other applicable regulations.

Best regards,



Muhammad Millat Hossain
 Associate Professor, Project and Course Coordinator, MRS
 Member Secretary, Institutional Review Board (IRB)
 BHPI, CRP, Savar, Dhaka-1343, Bangladesh

Appendix B: Data Collection Approval Letter

Date: 12/08/2025

To

Head of Rehabilitation wing

Centre for the Rehabilitation of the Paralysed (CRP)

Chapain, Savar, Dhaka-1343

Through: Research & Evaluation Department

Subject: Application for access to discharged patient data from the CBR Department

Sir,

With due respect I would like to draw your kind attention that I am a student of 4th Year B.Sc. in Occupational Therapy at Bangladesh Health Professions Institute (BHPI) which is an academic institute of Centre for the Rehabilitation of the Paralysed (CRP), affiliated to Faculty of Medicine, University of Dhaka and wish to conduct my thesis titled, "**Community Acceptance and Social Inclusion of Individuals with Spinal Cord Injury (SCI)- A Qualitative study**" with myself & Mohuya Akter as my thesis supervisor. The purpose of the study is to explore and understand the process of community acceptance and social inclusion and how it influences the social reintegration of individuals with spinal cord injury (SCI) after rehabilitation. The study has received ethical clearance from the Institutional Review Board (IRB) of BHPI under reference number CRP-BHPIIRB/07/2025/1090.

To fulfill the objectives of this study, I need some information such as name, age, address, contact number, occupational status, date of admission and discharge about the potential participants from SCI-database of CBR Department -CRP, Savar. I assure you that collected information that will be used solely for academic purposes and confidentiality will be maintained in accordance with ethical guidelines. As part of my study, I require information on individuals who are staying in the community for at least one year following their discharge from CRP. I am seeking your kind approval to obtain the details of the initial list of potential participants from August 2022 to August 2024.

So, I therefore, pray and hope that you would be kind enough to grant me permission to access data for my study and oblige thereby.

Sincerely yours,

Nahid Sultana-Mony

Nahid Sultana Mony

4th Year, B.Sc. in Occupational Therapy

Session: 2020-21, Student ID: 122200412

Recommendation from the Head of the Department:



Prof. Sk. Moniruzzaman

Professor & Head

Department of Occupational Therapy

Bangladesh Health Professions Institute (BHPI)

CRP, Savar, Dhaka-1343

Attachments: A Copy of IRB Approval Letter.

"Forwarded to
the Head of RW
for his Approval."

Dear CBR coordinator
Please assist Mony
for her study data
Sapna
25/8/25

Appendix C: Information Sheet and Consent Form and Withdrawal from Informed Consent Form for Patients with SCI

Study Title: Community Acceptance and Social Inclusion of Individuals with Spinal Cord Injury: A Qualitative Study

Study objectives: This study aims to understand the process of community acceptance and social inclusion among individuals with spinal cord injury (SCI). More specifically, it will a) explore how SCI survivors experience acceptance and inclusion in their communities after rehabilitation, b) identify the structures, supports, and social practices that enable inclusion, c) understand the processes through which SCI survivors re-engage with community life, d) identify key experiences and turning points that foster a sense of belonging, and e) explore how community acceptance becomes stabilized and sustained over time, including how inclusion at the individual level can contribute to broader community or structural change.

Procedures: As a participant in this study, you will be asked to take part in a face-to-face semistructured interview. The interview will focus on your personal experiences of acceptance and inclusion in your community. The interview is expected to take approximately 45 minutes. With your permission, the interview will be audio-recorded to ensure the accuracy of your responses.

Voluntary Participation: Your participation in this study is entirely voluntary. Refusal to participate will not affect your access to healthcare or any other services you are entitled to. You may also withdraw from the study at any time without providing any reason.

Confidentiality: All information you provide will be kept strictly protected and confidential. Your responses will be de-identified, meaning any information that could link you to your responses will be removed. Data will be securely stored and only

accessible to the research team. No identifying information will appear in any reports or publications resulting from this study.

Potential Benefits and Risks: Participation in this study does not provide direct personal benefits. However, your insights may contribute to a better understanding of how community acceptance and social inclusion of people with SCI can be strengthened, which may influence future services and support systems. There are no expected risks associated with participating in this interview, but if any questions make you feel uncomfortable, you may skip them or stop the interview at any time.

Consent Statement: By signing below, you acknowledge that you have read and understood this consent form and voluntarily agree to participate in this study. You also permit the interview to be audio-recorded.

Participant's Signature: _____

Date:

_____ Fingerprint for patients who are Illiterate:

Interviewer's

Signature: _____

Date: _____

If you have any questions, you can contact us through the given address:

Researcher's name: Nahid Sultana Mony

B.Sc. in Occupational Therapy,

4th year, Session: 2020-2021

Department of Occupational Therapy

BHPI, CRP, Savar, Dhaka-1343

Email: mony24.ot@gmail.com

Contact Number: 01879220716

Supervisor: Mohuya Akter

Lecturer

Department of Occupational Therapy

Bangladesh Health Professions Institute (BHPI),

CRP, Savar, Dhaka-1343

Withdrawal of consent form

Research title: Community Acceptance and Social Inclusion of SCI survivors post rehabilitation - A Qualitative Study

Student investigator: Nahid Sultana Mony

I _____(the
participant),
wish _____ to

WITHDRAW my consent to the use of data arising from my participation.

Data arising from my participation must NOT be used in this research project as described in the Information and Consent Form. I understand that data arising from my participation will be destroyed provided this request is received within four weeks of the completion of my participation in this project. I understand that this notification will be retained together with my consent form as evidence of the withdrawal of my consent to use the data I have provided specifically for this research project.

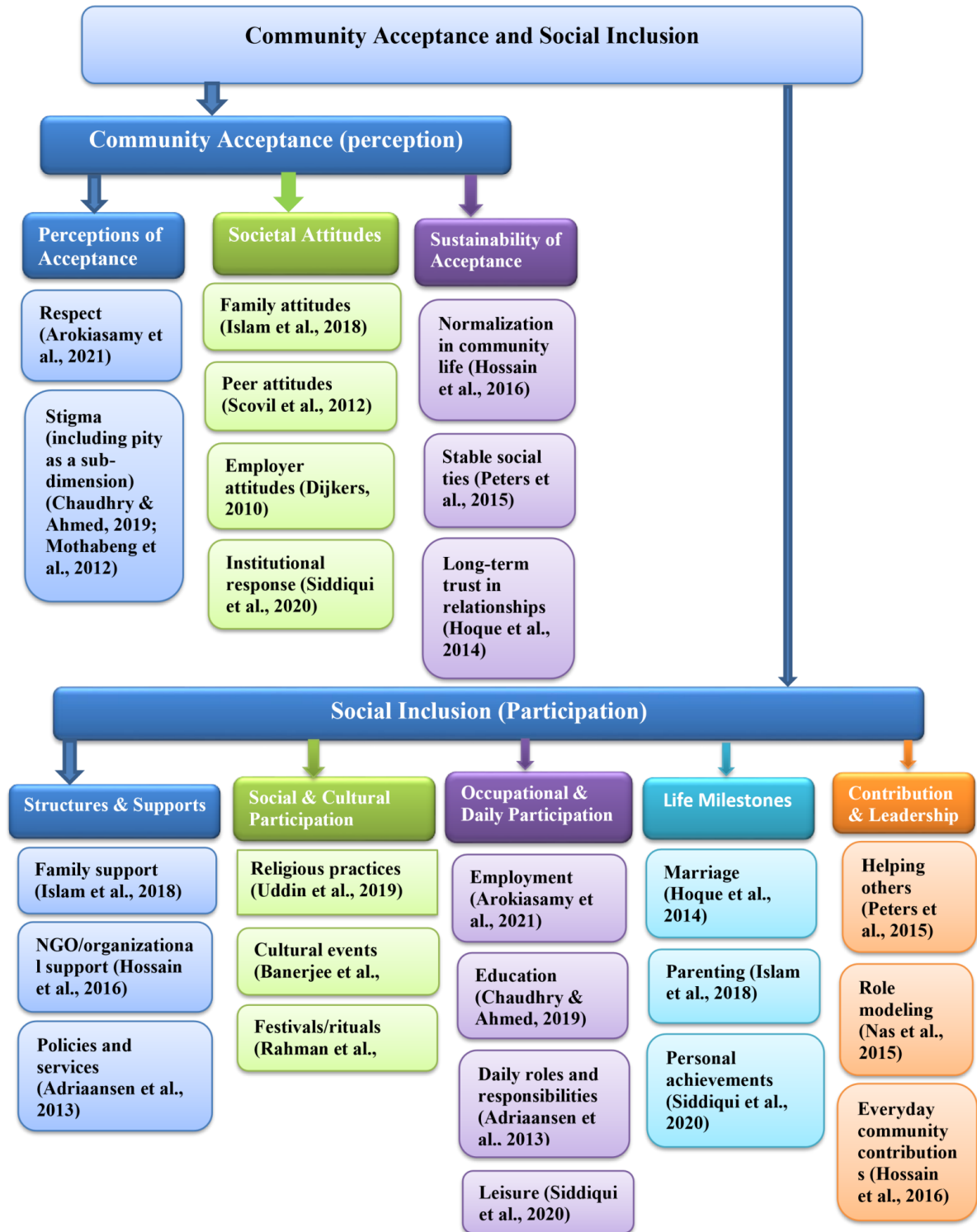
Name of participant: _____

Signature of participant/ thumb print: _____

Date: _____

Appendix D: Questionnaire (English Version)

Figure: 5 Overview of conceptual framework for semi-structured interview guide.



Section 1: Sociodemographic Information

Name:

Age:

Gender:

☐ Male

☐ Female

Marital Status:

Living Status	
<p>Living Situation:</p> <p>☐ Living alone</p> <p>☐ With family</p> <p>☐ Other: _____</p> <p>Living in community since: _____</p>	<p>Living Condition:</p> <p>☐ Urban</p> <p>☐ Semi-Urban</p> <p>☐ Rural</p>
Injury Status	
<p>Neurological Level: _____</p> <p>Duration Since Injury: _____</p>	<p>Type of Injury:</p> <p>☐ Traumatic</p> <p>☐ Non-traumatic</p>

<p>Employment Status:</p> <p>☐ Employed</p> <p>☐ Unemployed</p> <p>☐ Self- employed</p>	<p>Education Level:</p> <p>☐ No formal education</p> <p>☐ Primary</p> <p>☐ Secondary</p> <p>☐ Higher Secondary</p> <p>☐ Bachelor</p> <p>☐ Masters</p>	<p>Monthly Household Income:</p> <p>☐ <10,000 BDT</p> <p>☐ 10,000–30,000 BDT</p> <p>☐ 30,000–50,000 BDT</p> <p>☐ >50,000 BDT</p>
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Section 2: Semi-structured Interview

Warm-Up Ques.	<ul style="list-style-type: none"> • Can you tell me a little about your life after rehabilitation and how you usually spend a typical day?? • Can you tell me about your daily life in your community since living around CRP?
Objective 1: Explore how SCI survivors experience acceptance and inclusion in their communities after rehabilitation.	
1.1	<p>Main Question: Can you tell me about your experience of acceptance and inclusion in your community since rehabilitation?</p> <p><i>Probes:</i></p> <ul style="list-style-type: none"> • Where were you living before? How did people's attitudes or behaviors make you feel? • Have you ever experienced neglect, pity, or being avoided by others? • Have you faced mistreatment or discrimination (e.g., being denied responsibilities, education, job opportunities, or training)? • Do you live permanently here at CRP? If so, why? Can you describe your experiences of social life around CRP? • How has CRP changed your life, and in what ways? • Which family or community responsibilities are most important to you now? Are you able to fulfill them? Do you think your family or society is satisfied with you? Please explain.
Objective 2: Identify the structures, supports, and social practices that enable inclusion.	
2.1	<p>Main Question: What has helped you the most to adapt and feel included in your community?</p> <p><i>Probes:</i></p> <ul style="list-style-type: none"> • In what ways have your family or other friends with disabilities supported you? • How does the CRP environment influence your personal and social life? • Do housing, transportation, mobility, or public spaces in this area allow you to move around easily, or do you face challenges? What kinds of challenges? • Have NGOs, CRP, community groups, or religious institutions provided you with any support? • Are you invited to participate in community events such as meetings, weddings, or organizational functions?

Objective 3: Identify key experiences and the processes that foster re-engagement in the community and a sense of belonging.	
3.1	<p>Main Question: How have you re-engaged with your community since rehabilitation? Can you describe the steps of returning to social life after receiving rehabilitation services?</p> <p><i>Probes:</i></p> <ul style="list-style-type: none"> • Which activities or events here have helped create a place for you in the community? • Do people in your community respect you and give importance to your opinions as a person with a disability? • Despite challenges, what keeps you motivated to participate? What strategies have you used to cope? Please explain in detail. • Can you share a special moment when you felt accepted or felt that your presence was as important as anyone else's? • What does "well-being" mean to you now? How satisfied are you with yourself and your current life?
Objective 4: Explore how community acceptance becomes stabilized and sustained over time, and how inclusion at the individual level can contribute to broader community or structural change.	
4.1	<p>Main Question: In your experience, how has community acceptance and inclusion changed or developed over time?</p> <p><i>Probes:</i></p> <ul style="list-style-type: none"> • Do you feel your acceptance has become more stable and permanent? How? • Have you ever taken leadership roles, engaged in advocacy, or spoken on behalf of others with SCI? Did it benefit or inspire them? Please share examples. • Do you think community attitudes toward people with disabilities have changed compared to before? • How do you think the participation of you and others with SCI has created positive impacts in society? Do you feel your involvement inspires others? • In your opinion, how has CRP played a role in improving your quality of life or ensuring your future? Living here, are you more satisfied with life compared to before, or do you find it harder?
Closing Ques.	<ul style="list-style-type: none"> • What message would you like to give to policymakers or community leaders about improving inclusion and ensuring a secure future for people with SCI? • What are your hopes for yourself in the future within Bangladeshi society?

Quick Observation checklist:

Domain	Item (✓)	Notes (Ques. Remarks)
Emotional Expression	Facial expressions (smile, sadness, frustration, anger)	
	Tone of voice (confident, hesitant, emotional, low energy)	
	Eye contact (consistent, avoided, mixed)	
Body Language	Gestures used while speaking	
	Posture (relaxed, tense, slouched, upright)	
	Movement during emotional topics (fidgeting, pausing, sighing)	
Engagement	Willingness to share (open, brief, reluctant)	
	Emotional intensity when describing experiences	
	Consistency between words and emotions	

Interview guide (Bangla version)

প্রাথমিক প্রশ্ন

- আপনি নিজের সম্পর্কে কিছু বলুন। আগে কোথায় ছিলেন? এখন কোথায় থাকেন, কার সাথে থাকেন, আপনার দৈনন্দিন জীবন কেমন কাটে?
- পুনর্বাসনের পর এখানে (CRP) আপনার সামাজিক জীবনের অভিজ্ঞতা বর্ণনা করুন।

মূল প্রশ্ন

১. পুনর্বাসনের পর থেকে আপনার সম্প্রদায়/এলাকার মানুষের মনোভাব কেমন ছিল?

- সুস্থ হয়ে ফিরে আসার পর আপনার পরিবার ও বন্ধুদের মনোভাব কেমন ছিল? শুরুতে যেমন ছিল, এখন কেমন? কোনো পরিবর্তন লক্ষ্য করেছেন কি?
- পুনর্বাসন কেন্দ্র থেকে ফেরার প্রথম দিকের তুলনায়, এখন কি মনে হয় সমাজের মানুষ আপনাকে স্বাভাবিকভাবে মেনে নিয়েছে? কেন?
- এমন কিছু মুহূর্তের কথা বলুন যখন সমাজের মানুষ আপনাকে সম্মান দেখিয়েছে বা আপনাকে আপন মনে করেছে।
- এলাকার স্কুল, হাসপাতাল, মসজিদ/মন্দির বা সরকারি অফিসগুলো আপনাকে সম্মানের সঙ্গে গ্রহণ করেছে কি?
- এমন কিছু মুহূর্তের কথা বলুন যখন আপনার প্রতি খারাপ ব্যবহার, অবহেলা, করুণা বা অপমানজনক আচরণ করা হয়েছে? হলে তার উদাহরণ দিন।

২. এখানে কোন ধরনের সহযোগিতা, সুযোগ বা সামাজিক সেবা আপনাকে সমাজে পুনরায় অংশগ্রহণে সাহায্য করেছে? উদাহরণ দিন।

- আপনার পরিবার, বন্ধু, সহকর্মী বা অন্য ব্যক্তির আপনাকে সমাজে মানিয়ে নিতে কীভাবে সাহায্য করেছেন?
- CRP, কোনো এনজিও, প্রতিবন্ধী সংগঠন বা সামাজিক প্রতিষ্ঠান আপনাকে সমাজে অংশগ্রহণে কীভাবে সাহায্য করেছে? উদাহরণ দিন।
- আপনি কি ধর্মীয় অনুষ্ঠান, সাংস্কৃতিক অনুষ্ঠান, সামাজিক অনুষ্ঠান (যেমন—বিয়ে, সভা-সমাবেশ) এ অংশগ্রহণ করেন? সেখানে আপনার সঙ্গে কেমন আচরণ করা হয়? আপনার অনুভূতি/অভিজ্ঞতা শেয়ার করুন।

৩. ধীরে ধীরে কীভাবে আপনি সামাজিক জীবনে ফিরলেন, সেই গল্পটা শেয়ার করুন।

- কী কী চ্যালেঞ্জের (পারিবারিক, সামাজিক দায়িত্ব পালনে, ব্যক্তিগত দায়িত্ব - নিজের কাজ নিজে করা, পড়াশোনা, চাকরি, যাতায়াত করতে) মুখোমুখি হয়েছেন, সেখানে কী সহজ ছিল আর কী কঠিন ছিল? কে আপনাকে সাহায্য করেছে, আর কী কী সমস্যা হয়েছে?
- এলাকার পরিবেশ, নিয়ম-কানুন, অবকাঠামো, পুনর্বাসন সেবাগুলো কীভাবে আপনাকে সমাজে যুক্ত হতে সাহায্য করেছে?
- আপনি কীভাবে আবার চাকরি বা পড়াশোনার শুরু করলেন, সুযোগ পেয়েছেন বা কে বা কারা আপনাকে অনুপ্রেরণা দিয়েছেন? কোন চ্যালেঞ্জের মুখোমুখি হয়েছেন? উদাহরণ দিন।

৪. পুনর্বাসনের পর জীবনের কোনো বিশেষ পরিবর্তন বা গুরুত্বপূর্ণ অভিজ্ঞতা বর্ণনা করুন যা আপনাকে মনে করিয়েছে যে আপনিও সমাজের অংশ?

- পারিবারিক জীবনে যেমন: স্বামী/স্ত্রী, মা/বাবা বা অন্য কোনো দায়িত্ব পালন করতে পেরেছেন কি? পরিবার কি এতে সন্তুষ্ট? কীভাবে? বুঝিয়ে বলুন।
- আপনার ব্যক্তিগত কোনো সাফল্যের (যেমন: নিজের কাজকর্ম করা, চাকরি পাওয়া) অভিজ্ঞতা শেয়ার করুন। এক্ষেত্রে আপনার প্রতি সমাজের মানুষের দৃষ্টিভঙ্গি বদলেছে? কীভাবে?
- আপনি কি কখনও পারিবারিক বা সামাজিক বিষয়গুলোতে নেতৃত্ব দিয়েছেন বা কোনো সিদ্ধান্তে অংশগ্রহণ করেছেন? হলে উদাহরণ দিন।
- আপনার সামাজিক ও ব্যক্তিগত জীবনে আপনি কতটুকু সন্তুষ্ট? আপনার সমাজে পুনরায় মিশে যাওয়ার গল্প কি আপনার মতো এসসিআইদের (SCI) কি অনুপ্রেরণা যোগাচ্ছে? কীভাবে, তা বলুন।

৫. সমাজের কোন পরিবর্তনগুলো আপনার কাছে গুরুত্বপূর্ণ মনে হয়েছে যা আপনার মতো এসসিআইদের সমাজে গ্রহণযোগ্যতাকে আরো বেশি স্থায়ী করতে সাহায্য করে?

- এখানকার প্রতিবেশী ও মানুষের সঙ্গে আস্থার সম্পর্ক গড়ে ওঠায় সমাজে আপনার অবস্থান স্থায়ী হয়েছে? আপনার ধারণা কি?
- সমাজ ও সমাজের মানুষ আপনাকে কতটা স্বাভাবিকভাবে গ্রহণ করেছে বলে আপনি মনে করেন?
- আপনার পুনরায় সমাজে ফেরা ও মানিয়ে নেওয়ার গল্প কি অন্য SCI আক্রান্তদের অনুপ্রেরণা দিতে পারে বলে মনে হয়? কেউ কি আপনাকে কখনো অনুসরণ করেছিল?

সমাপনী প্রশ্ন

- আপনার মতে, বাংলাদেশের সমাজব্যবস্থায় এসসিআইদের ভবিষ্যৎ সুনিশ্চিত করতে একটি সহায়ক ও ভালো পরিবেশ তৈরি করতে নীতি নির্ধারক বা সমাজের নেতাদের কী কী পদক্ষেপ নেওয়া উচিত?”

Bangladesh Health Professions Institute
Department of Occupational Therapy
4th Year B. Sc in Occupational Therapy
OT 401 Research Project

Thesis Supervisor- Student Contact; face to face or electronic and guidance record

Title of thesis:

Community acceptance and social inclusion of individual with spinal cord injury - A qualitative study.

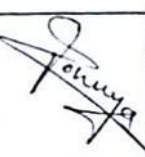
Name of student- Nahid Sultana -Mony (04)

Name and designation of thesis supervisor: Mohaya Akter
Lecturer

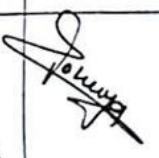
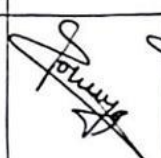
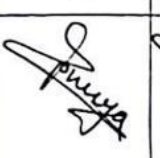
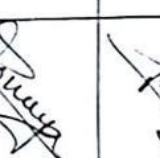
Department of Occupational Therapy, BHPI

Appointment No	Date	Place	Topic of discussion	Duration (Minutes/Hours)	Comments of student	Student's signature	Thesis supervisor signature
1	29.05.25	BHPI Room no - 306	supervision guidance discussion about title aim	2 hours	important and helpful introduction to work ahead	Nahid Sultana -Mony	
2	01.06.25	BHPI Teacher room	discussion about title methodology & participants	1 hour	clarification to apply appropriate methodology	Nahid Sultana -Mony	
3	16.06.25	BHPI Teacher room + hand therapy unit	Aim, objectives, questions of interview guide	1 hour 30 min	final clarification for IRB presentation	Nahid Sultana -Mony	

Appendix E Supervision Sheet

4	29.06.25	Teachers room	Discussed about the entire research procedure.	45 min	It was effective for my research procedure.	Many	
5	17.07.25	Classroom	Discussion about reporting guideline COREQ, Literature review.	60 min	I have received all feedback and guidance on discussion topics.	Many	
6	20.07.25	Library	For Presentation and discussion about guide with readers & supervisor.	2:30 min	I was very happy to introduce with new strategies.	Many	
7	24.07.25	Teachers room	Feedback on framework and interview guide.	1:30 min	I understand and understand my mistake and trying to solve it.	Many	
8	28.07.25	Library	Feedback on framework work	30 min	I provide my full effort on making framework but failed.	Many	
9	31.08.25	Teachers room	Feedback and discussion about interview guide	30 min	I provide my framework now I am gonna make by interview guide	Many	
10	14.09.25	Teachers room	Feedback and discussion about interview guide and framework.	1 hour 30 min	I provide my effort to make my framework but my it needs more effort	Many	

11	15.9.25	Teachers room.	Feedback about interview guide - bangla to version	30 min	I determine to make my bangla interview guide.	Many	Many
12	16.9.25	Teachers room	Feedback about bangla version interview & accept frameworks	1:30 min	I provide my afford to make interview properly	Many	Many
13	17.9.25	Teachers room	Little feedback about interview guide - check all mistakes	1:45 min	I provide my best to make interview guide	Many	Many
14	18.9.25	Teachers room	Provide permission to collect data and further checking	1:30 min	I determined to collect data properly.	Many	Many

15	20.09.25 20.09.25	Teachers Room	provide feedback on initial coding and ask to correct all mistakes	1 hour 20 min	I received proper understanding for my upcoming step. I am determined to do work.	Many	
16	29.11.25	Teachers Room	discussion and feedback on theory and result	60 min	I felt upset for doing same mistakes and mam encourage me later i felt motivated	Many Many	
17	11.01.26	Teachers Room	got final feedback on first draft and all the section of thesis writing	3 hours 30 min	Mam appreciate our work and I felt good and slowly understood my mistakes and promised to do work better.	Many	
18	13.01.26	Library	provide understanding on further work and initiate work for result correction	5 hours 30 min	I did correction of some mistakes and formatting of my result section.	Many	
19	14.01.26	Library	focused on comment and feedback and understood all the instruction	5 hours	I understand all my mistakes and determined to correct them.	Many	
20	19.01.26	Library	focused on comment on methodology part	2 hours	I understand all my mistakes and correct them	Many	

Note:

1. Appointment number will cover at least a total of 40 hours; applicable only for face to face contact with the supervisors.
2. Students will require submitting this completed record during submission your final thesis.

21	22.01.26	Library	Focused on methodology part 2,	3 hours 10 min	I determined to correct all my mistakes	Many	Many
22	03.2.26	Library	Focused on discussion & result part.	2 hours	I understand all my major, minor mistakes, correct them	Many	Many
23							
24							