

# Social Capital and the Political Economy of Recovery from Injury

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## Abstract

*Injury has long been recognized as a contributor to disability, but there is little data on how processes related to social capital, may influence the emergence of disability. This article aims to present findings from the qualitative arm of a multi-method Prospective Outcomes of Injury Study (POIS), which was established to examine factors influencing recovery following injury in New Zealand. A maximum diversity sample of nineteen injured people, aged 18-64, was chosen from 2856 participants in the quantitative POIS study (Butler, Derrett & Colhoun, 2009). Participants in the study were all on the New Zealand Accident Compensation Corporation's (ACC's) injury entitlement register. Interviews were carried out at six and twelve months after injury, which offered a unique insight into the unfolding impact of the injury on social networks. The findings describe a political economy of social capital that reflects the inverse care law (Hart, 1971). This can be summarised by the observation that those with higher levels of social capital were able to ask for care in ways that maintained the invisibility of the labour involved and also contributed to the growth of social capital. Those with lesser degrees of social capital used strategies to make their needs less visible in order not to lose face and this contributed to the erosion of social capital. The findings indicate the utility of Bourdieu's (1986) conceptualisation of social capital to elucidate the dynamics implicit in the practice of giving and receiving resources following an injury.*

**Keyword:** social capital, Bourdieu, injury.

## Introduction

Injury has long been recognized as a contributor to disability (World Health Organization, 2011). In New Zealand, injuries are given as a cause of disability for approximately one-third of all those with a disability (Statistics New Zealand, 2006). It is known that disability outcomes can be mediated by the social supports available to the injured person (Flaherty, 2008), and this study sets out to study the processes through which these supports are given following an injury. The dramatic nature of an injury means that a person can move from independence to dependence instantaneously, with little or no opportunity to prepare social networks. The person is therefore forced to draw on whatever social capital they have available to them at the time of the injury. In this paper we describe social capital as a factor within the trajectory of recovery, starting the examination from a point close to the injury event and continuing for a year after the event. This data comes from the qualitative arm of the multi-method Prospective Outcomes of Injury Study (POIS) and uses a framework for analysis that is informed by Bourdieu's concept of social capital.

## Key concepts

Social capital makes access possible to a wide range of resources through contacts with competent others (Barrett, Hale & Butler, 2014). Two main strands within the social sciences build on the notion of social capital – the macro (ecological) and micro (individual) approach. The macro approach analyses the social capital of communities regarding shared identity and interests, trust and extent of collaboration (Putnam, 2000) and it is touched on briefly in this paper. The micro approach was defined by Bourdieu as:

*"...the aggregate of the actual or potential resources which are linked to possession of a durable network of more or less institutionalized relationships of mutual acquaintance or recognition" (1985, p.248).*

The volume of the social capital possessed by a given agent depends on the size of the network of connections he can effectively mobilize and on the volume of capital possessed in his right by each of those to whom he is connected. Bourdieu identified other kinds of capital (cultural and symbolic) and emphasised their fungibility and capacity to

be ultimately reduced to economic capital, defined as accumulated human labour (Portes, 1998).

Much of Bourdieu's interest in elucidating social capital was to describe the mechanisms that produce and reproduce inequality. He coined the term 'habitus' (Bourdieu, 1984) to describe the way that culture is transmitted through durable dispositions and practices that are developed in daily life. The individual agent develops dispositions in response to the objective conditions he/she encounters, making habitus a form of 'embodied capital' (Bourdieu, 1986), which cannot easily be changed. Through habitus, culture becomes experienced as second nature. Therefore individual identities and understandings of what is appropriate and possible are a response to the social field that has shaped them over a lifetime (Rankin, Backett-Milburn, & Platt, 2009).

Carpiano (2008) points out the need for empirical research based on Bourdieu's original theory of social capital. He pointed out that the current emphasis on communitarianism and social cohesion associated with Putnam's approach has been criticised across several disciplines including social epidemiology (Muntaner & Lynch, 2002) and sociology (Lin, 2001). The strength of Bourdieu's approach is its capacity to emphasise the actual and potential resources that may be used for action and the power dynamics that underpin how people access – or are denied access to – these network-based resources. Although Bourdieu is highly cited, there are only a handful of qualitative studies that have explicitly drawn upon his work to provide the orientation to their analysis (Baum & Palmer, 2002; Campbell, Cornish, & McClean, 2004; Ziersch, Baum, Darmawan, Kavanagh, & Bentley, 2009). This paper, therefore follows Portes' (1998) suggestion, that a systematic consideration of social capital should distinguish between a) the possessors of social capital (those making a claim); b) the sources of social capital (those donors agreeing to the claim); and c) the resources themselves.

#### **Claimants and social capital**

Social and cultural norms work to the advantage of those with high levels of social capital, enabling them to appropriate the labour time of others without having to acknowledge it. Such a dynamic is described by Bourdieu (2001): "...the particularity of the dominant is that they are in a position to ensure that their particular way of being is recognised as universal" (p.62). Those who are among the privileged regarding social capital can, therefore, demand care without even seeming to ask for it. Social and cultural norms disadvantage those with lower levels of social capital. Regarding Bourdieu's concept of habitus, they are in a situation where their expectations have been conditioned to be lower. For example, they must consider whether their independence will be undermined by a particular request for help (Boneham & Sixsmith, 2006). They are also forced to

consider whether asking will make them feel like a burden (McPherson, Wilson, & Murray, 2007), or whether the help given would carry too great a cost regarding intrusion on privacy (Friesen, Krassikouva-Enns, Ringaert, & Isfeld, 2010).

#### **Donors of social capital**

There is a dark side to social capital, where the claims made become burdensome to donors. For instance, Portes (1998) pointed out the restricted individual freedom often associated with strong community networks and shared normative values. Donors can become burdened when their response to a request leads them towards provision that exceeds their capacity. Such expressions of burden have long been recognised in the literature on caregiving in general, and in particular following brain injury (Allen, Linn, Gutierrez, & Willer, 1994; Livingstone & Brooks, 1988; Marsh, 1998; Nabors, 2002). The situation of caregivers who become socially, financially and legally marginalised through giving (Kittay, 1999; Schofield et al., 1998) is a demonstration of the political economy of social capital. The potential for the carer to collapse under the burden of care is an indication of how fragile the mechanisms of social capital can be, both within a community and at the societal level (Barrett, Hale & Butler, 2014).

#### **Resources**

The political economy of the flow of resources between claimant and donor can be theorised in terms of bridging or bonding social capital (Woolcock, 2001). The review that enables a person to 'get by' is described as bonding social capital, while the resources that enable the person to 'get ahead' is described as bridging social capital (Briggs, 1998; Putnam, 2000). Bonding social capital is characterised by strong, long-lasting relationships between people of equal standing. These networks are denoted by ties between people in similar situations, such as immediate family, close friends and neighbours. Bridging social capital, on the other hand, is characterised by complex and fluctuating contacts between people from different social strata and environments.

At a micro level, it is possible to distinguish at least three main types of social support accessed through these types of individual social networks (Gele & Harslof, 2010). Emotional supports involve the provision of intimacy, attachment, caring and concern; informational supports involve the giving of advice, guidance or information relevant to the situation; and instrumental supports denote the provision of concrete aid or assistance. From a macro perspective, resources evolve within communities that are bounded by effective internalised norms (Coleman, 1988). For example, this can make it possible to walk freely outside at night in the city; or to get loans (because there is no fear

around repayment), or to send the children into the street to play without concern.

The Accident Compensation Corporation (ACC) in New Zealand was founded in 1974 on the principles of community responsibility and no-fault compensation (Woodhouse, 1967). The no-fault nature of the system means that the entitlements available through the ACC system are provided regardless of age, employment status or type of injury. Entitlements may include: hospital and medical expenses, rehabilitation costs, injury-related transport costs (e.g. provision of taxis), childcare, earnings-related compensation (80% of the average weekly salary of the injured person prior to injury to a threshold income), lump sum payments for permanent loss or impairment, or for pain and suffering (Armstrong, 2008).

ACC has been described as a source of social capital (Price Waterhouse Cooper, 2008). New Zealanders have come to trust they will be cared for, no matter how an injury is caused or how serious it is (Price Waterhouse Cooper, 2008) and this trust is a form of social capital. The advantage of 'no-fault' insurance is that people do not have to spend time and money proving negligence following an injury, possibly eroding relationships in the process. However, this study examines whether and how, even in a no-fault compensation system, the care that people receive still depends on their level of social capital.

## **Methodology**

The quantitative POIS study included 2856 participants from across New Zealand who were followed for two years after injury (Derrett et al., 2011). The inclusion criteria for the larger study incorporated: being of working age (18-64 years) and on ACC's entitlement claims register. This paper reports on data from the qualitative arm of the study at one year. A previous paper analysed some of the data from interviews at six months (Butler, et al., 2009). To understand the lived experience of injury, nineteen participants were purposively chosen from the quantitative cohort (nine men and ten women). These represented a maximum diversity sample, across gender, age, economic status, location, injury type and the existence (or not) of pre-existing conditions. Injured Māori (New Zealand's indigenous population) are not participants in this study because a separate qualitative study was undertaken with Māori (Wyeth, Derrett, Hokowhitu, Hall & Langley, 2010). A degree of homogeneity within the sample was obtained through the commonalities of injury experience and the relationship with ACC. A sample of nineteen was sufficient to reach theoretical saturation about the concept of social capital.

Participants completed a structured (quantitative) interview three months after injury. This meant that the choice of the qualitative sample benefited from insights obtained at this

three-month quantitative interview, particularly about whether people had completely recovered from their injury or not. Those who reported complete recovery at this three-month point were not included in the possible sample because the study was interested in examining ongoing dynamics around social capital in relation to the needs created by the injury and the possible emergence of disability.

This paper reports on qualitative interviews that were undertaken six and twelve months after injury. The numbers after the quotes (below) indicate whether they are taken from the first (1) or the second (2) interviews. Such 'serial' interviews are suitable for research that aims to explore evolving and complex processes, such as social capital (Murray et al., 2009). Attrition can be problematic in longitudinal research and the establishment of rapport through face to face interviews was a factor in ensuring that all participants remained in the study.

Descriptive phenomenology (Giorgi & Giorgi, 2004) was used to access the essence of the social capital underpinning the lived experience of injury. Each individual was interviewed in a setting of their choice, usually at work or at home. A question schedule was developed during pilot interviews, and this was used to guide the following interviews. Participants were encouraged to elaborate on details of their story to obtain clarity and to stay close to the lived experience. Coding and thematic analysis was guided by the framework provided by Braun & Clarke (2006). The analysis was primarily an iterative, inductive process of decontextualization through coding and recontextualization around central themes arising from the narrative (Van Manen, 1990). The early analysis resonated with Bourdieu's work on social capital and this insight guided the final analysis. A reflexive process, aimed at maintaining a stance that was faithful and open to the material, was achieved by the separate coding of a large percentage of the transcripts, which became a basis for consultation and checking. There were also a series of seminars to colleagues, which provided feedback on the evolution of the ideas and concepts (Finlay, 2002). The study received ethical approval from New Zealand's Multi-region Ethics Committee. Precise details of participants have been changed to protect their anonymity.

## **Findings**

The longitudinal approach over the course of a year allowed insight into the fluidity of social capital in people's lives. Three themes are developed to describe the dynamics underpinning social capital after injury: a) a description of the types of resources that were made available through social capital including the concepts of timeliness, flexibility and competence; b) an analysis of the dynamics

associated with maintaining resources, including the sense of power and control, the need to 'maintain face' and the concept of reciprocity; and c) a description of the lack of resources associated with low levels of social capital including disappointed expectation and the erosion of social capital.

### 1. Getting Resources

The study uncovered a wealth of material where the injured person was given competent, practical assistance in ways that palpably demonstrated the depth of social capital available to them through individual social networks. These supports were both emotional and instrumental. For example, husbands described standing in the shower while their wives washed them; wives went to the gym while husbands looked after the children; children tucked their mothers into bed and did the housework; while friends brought in the washing, mowed the lawns and brought baking into the house every week. Expressions of formal civic involvement, which would be associated with a macro perspective, were less common but they did exist. These included church groups which had a roster for bringing meals every second day; or the local sports club that brought food to the house. These examples suggest a blending of micro and macro forms of social capital. Resources available in the workplace varied but tended to involve accommodations that enabled productivity to be maintained.

To be effective these practical resources needed to be delivered promptly, with a degree of flexibility and competence. The extent of social capital available to a person was therefore marked by their capacity to access resources promptly, with some degree of flexibility that responded to their situation, and with a high level of competence in the delivery. The subthemes focus on timeliness, flexibility and competence associated with the resources made available through social capital.

#### 1.1 Timeliness as a resource

Of all the resources that social capital make available, not having to wait for help is possibly the key. Injury, after all is a crisis, that leaves no time for preparation, so timeliness in accessing services is particularly indicative of the availability of social capital. For example, Robert was in senior management and was able to access bridging capital in the form of personal connections in the medical world where he had previously worked. This helped him to gain useful information and also instrumental supports. It meant that he was able to rapidly move from the back injury to surgery, without any of the attendant delays that the system might have otherwise created:

*I started making some phone calls to ACC at that time to try and get approval to fast track it... it was a bit confusing as to who was responsible for making the decision to approve. I did not feel I was*

*getting anywhere, so I rang through to the surgeon who got the CEO of the hospital to progress and get approval from ACC. So it all happened within a week (1).*

The social capital in the form of high-level connections available to Robert meant that he was not forced into a waiting pattern. Complaints about delays in the provision of essential services after discharge from hospital were common. For example, when Hugh had a hip fracture he was at some risk of re-injuring himself because of an underlying degenerative neurological condition. His wife was working full time, but she had enough flexibility to be able to help him. So, although he says here that 'personal care' did not happen, what he means is that ACC did not provide it:

*The critical time that personal care is needed is when you come out of the hospital, not two weeks later. By that time you should be reducing the hours for personal care or not needing them at all. So the personal care side did not happen at all.(1)*

In contrast to Robert who had access to high-level contacts in the health service, other people had narratives of learning about resources too late. For example, Joan had multiple leg fractures and was convinced that her leg would have healed much more quickly had she known about the physiotherapy pool where she could have done exercises. Unfortunately, it was time to go back to work by the time she learned about it

#### 1.2 Flexibility

There is a strong association between flexibility and timeliness because a flexible support system is able to provide the resources that are needed when they are needed. One example of real flexibility was where ACC was prepared to pay a young adult to care for his mother. When Joan badly fractured her leg, she was living alone with four children ranging in age from 18 to 6 years of age. Her eldest son was unemployed, and ACC agreed to pay him to provide 20 hours of home help and personal cares for his mother. The flexibility of this approach meant that Joan was able to get the help that she needed when she needed it. The social capital element of this arrangement was the fact that the son was living in the house, and had been well enough trained to be able to provide real assistance.

*I mean you have got someone in the house, and the washing needs in because it is raining. You cannot wait for someone to come back at four o'clock especially with me having the younger kids as well. It made a huge difference having him on hand (2).*

It was the invisibility and seamless quality of care that was most notable for those with high levels of social capital. This was embodied in the easy expectation of support, for

example: “This is what a family does” (1) or, “Of course they are fine about doing it” (2).

Flexibility when returning to the workplace was more evident with higher skilled workers. Robert was a senior manager who managed to keep working, almost without a break, despite needing back surgery following his injury. The accommodations included having meetings at his home, which involved travel for the management team:

*I held meetings at home, and I interviewed people at home, and my deputy team met at home and so some of the work aspects just happened at home (1).*

There is a seamless unselfconscious fit between such accommodations and the ability of the person to maintain their productivity as part of the healing process. These kinds of workplace accommodations were not available for those in manual positions.

### 1.3 Competence

Trying to find competent skilled carers is not a straightforward process in the context of New Zealand, which has a small, widely-dispersed population leading to shortages of skilled services in rural areas. In one example, Kylie had recently left home and was living in a flat at some distance to her family. She had a severely fractured leg, and her plaster cast was changed nine times, frequently causing her discomfort and alarm when she did not have the prescience and skills to assert her needs more strongly:

*The first one they put on was just the plaster of Paris one. For some reason that didn't go hard, it just stayed wet and soggy and so I had to get that replaced. Then the first fibreglass one they put on, the cylinder one, from my thigh to my ankle, and by day two, I was in absolute agony (2).*

## 2. Maintaining a balance

In the following sections, the focus is on the dynamics between the claimant and the donor. There was a sense of power and control articulated by those with the highest levels of social capital when they reflected on their privileged access to resources. For others, there was a complex negotiation with themselves and others about the ways that they expressed their sense of need. They knew that forcing the issue was likely to bring about a loss of face, so they often avoided asking for help.

### 2.1 Sense of power and control

Thomas was from a rural background and had worked his way up the system, to middle management. Possibly this contributed to his awareness of privilege:

*Having enough control to get other people to do the things you needed them to do to help you, I guess did make it easy (1).*

There was a similar deep consciousness of privilege evinced by Sridhar, who was a migrant with a strong civic sense of responsibility to his adopted country. When he had a sporting injury, the local team rallied around him to such an extent that he felt strongly affirmed and valued. Implicit in his enjoyment of this support, there is also an ongoing narrative of involvement with the club and the growth of social capital:

*After this injury, they have put me right at the top, like one of those presidents...a very respected person (1).*

Kylie was a young woman who demonstrated a remarkable capacity to inspire warmth and support from those who cared for her. However, by the time she was facing a second round of surgery on her broken knee, she was undeniably concerned about the pressure that this was going to put on her relationship with her boyfriend. She was all too aware that he was also dealing with his life issues and that this surgery could overwhelm him. However, at the time of the second interview they were closer than ever:

*I am really scared about it. I do not want to put that extra pressure on him, but there is not a lot I can do (2).*

### 2.2 ‘Keeping face’ and maintaining social capital

The issue of ‘keeping face’ was an important component in the maintenance of social capital for those who did not have their needs met with ease. This was particularly the case in situations where the imposition on potential donors went on for much longer than was comfortable. It was permissible to ask for help immediately after the injury, and Susan stayed with a friend for a week after discharge from hospital with multiple injuries, including a significant brain injury. However, beyond this she was very reluctant to ask for help from friends and family, as though this would weaken her resolve to survive:

*It was like looking for the sympathy vote, so I did not. ...It is quite nice, (lots of laughs), but then it makes me feel sorry for myself (1).*

Her van had been destroyed in a crash, where the person at fault had no car insurance and no resources to pay for a replacement. Susan had a strong network of business friends who helped her with transportation. However, she was acutely aware of the obligation for reciprocity and felt uncomfortable about the ongoing need for help:

*People have been really kind to me but I just can't keep going like that. I cannot keep running my business on other people's kindness (1).*

Even those who had long established relationships and who had lived in the same area for decades could not assume that adequate support would be forthcoming. It seemed that Julie was in an ideal position to get support when she broke her ankle. She had lived in the same rural community for decades, and ACC assessors assumed that her husband and neighbours would help her. Such assumptions were a source of intense embarrassment for Julie because they articulated dynamics that were carefully left unsaid. Julie knew that her husband could not help her because he had twice as much work to do on the farm when she was not helping him. There had also been a painful break in her long-term relationship with a religious group shortly before her injury, so she could not expect any support from this source. The economic climate meant most of her women neighbours had outside employment also further reduced the pool of available donors:

*There weren't neighbours who could drop in because everyone works around here. We do not have that kind of a community (1).*

The way that the injury revealed her community as essentially unsupportive was so shocking that Julie seriously considered leaving the area. It was deeply shaming for Julie to ask for help because asking exposed the reality of how little support was available.

### 2.3 Reciprocity

This focus on the need to reciprocate was a common thread in the second interview. Part of the price of social capital was the necessity of paying greater heed to the donor's concerns. At the home level, for example, Robert was willing to give more attention to his wife's concerns about his well being:

*Sometimes I would not do something knowing that my wife would be worried, where otherwise I would have done it (2).*

The growth in social capital was also demonstrated when the culture of sympathetic response that arose around the needs of one person began to filter down to others in the work situation. Having learned to accommodate Robert's back pain, the workplace became attuned to responding to others who were similarly vulnerable. For example, a couch was made available to someone with health problems during a lengthy management meeting:

*When he expressed being awkward, somebody said, 'Oh yeah, but do you remember when Robert had that back injury he was lying down. So if he can do*

*it, you certainly can. Be quiet; we are fine about this' (2).*

### 3. Not getting resources

There were also those who simply could not access resources through social capital, and these situations are examined in this section.

#### 3.1 Disappointed expectations

Nancy had a brain injury prior to an injury that left her with a broken shoulder. There had been a steady erosion of social capital for Nancy over many years or negotiating the effects of the brain injury. Her husband had left and she was living alone in a rural environment. ACC again assumed that family would come to the fore, but the nearest family was living 15 miles away. Nancy's daughter was a solo parent and was already struggling, so did not have any spare capacity to help Nancy.

*ACC still expected my daughter to come over here every day and help me get into bed and help me to the appointments in town...in the end, she came here crying one day and said 'Mum, I cannot do this anymore, I just can't do it' (1).*

#### 3.2 The erosion of social capital

Brain injury is classically associated with the erosion of the kinds of resources associated with social capital (Arango-Lasprilla et al., 2008; Boyle & Haines, 2002). This became evident in the case of Josh who had a brain injury. It was abundantly clear in the first interview just how supportive his family and wider community were, and much of this support was intact at one year. However, his mother bore the brunt of his changed behaviour, and by the time of the second interview, she had gone back to work, largely to escape from this dynamic. Once the tape recorder was turned off, and her son was no longer in the room, she tearfully described how hard it was for her.

Brent was someone who had a pre-existing brain injury, compounded by another serious and painful physical injury. He was a solo father, with a strong sense of devotion to his children and his partner. Between the first and second interviews, he suffered a series of events that led to a catastrophic loss of social capital. It was apparent from what he said at the outset that his partner was not able to give him much support, even when he needed it immediately after the injury:

*She does things if she has to do it, but otherwise, it is my responsibility, the meal cooking and the dishes and all of that. I do get a bit pissed off with her sometimes for not chipping in as much as I would like her to (1).*

By the time of the second interview, this relationship had ended, and Brent was living on his own. He was targeted by local thugs, till he had to move from the area where he had lived since he was a child. His workplace had initially seemed very supportive, but by the time of the second interview there was such a decline in his relationships with workmates that he felt victimised:

*I just wasn't being treated like a human being basically. I just was treated like a bit of scum, that is how I felt most of the time (2).*

He went to a counsellor who advised him to leave his job, which reduced the level of stress in his work-life. Unfortunately, he failed to notify ACC that the trial of full-time work had not been successful and this meant he lost his entitlement to financial support from ACC. Brent did not seem to understand the implications of how such poor advice might have contributed to his consequent extreme poverty and social distress at the time of the second interview. There was a similar pattern for several other respondents of being ostensibly welcomed back to work and then finding that the circumstances at the job were made untenable:

*I just felt completely inefficient and absolutely useless working there. I applied for several different positions in the company for non-physical activity. I didn't get them and then I said well no, I cannot stay in this position because of what is required of me. I have been working here long enough to know what I need to be doing and when I am trying to do it, it is just not happening (1).*

## Conclusion

Bourdieu's construct of social capital has been utilised in the study of social capital and health. This paper contributes to an emerging literature that acknowledges the explanatory potential of his approach to elucidate the ways that people access care after an injury. A political economy of care problematises the dynamics of receiving care after an injury.

The participants of this study are described as claimants, which refers both to their claims towards ACC and their claims for care by their network. It is useful to remember that social capital is not always 'claimed' when it is invoked. In many instances social capital is brought into play on a non-conscious level, whereas a claim would seem to be something that is done at a conscious level. The more conscious form of capital-claiming was less relevant in this paper than the non-conscious invocation of care, particularly among those with higher levels of social capital.

The person with high levels of social capital is indeed able to access practices of care that seem to be natural through

the process of doxic relationships, which Bourdieu (1977) used to denote the experience by which "the natural and social world appears as self-evident" (p.164). Such relationships inevitably maintain the invisibility of the labour involved, enabling the growth of social capital even after a period of vulnerability created by the injury. Access to high levels of social capital can make care appear natural. It makes it possible to 'graft the substance of another onto oneself' (Kittay, 1999, p.35), enabling the "dis-appearance" of the body (Leder, 1990) so that the lived body can resume its career as the background of everyday tasks (Kugelman, 1999). The example of 'Robert' in this study pinpoints Bourdieu's theories: Robert's connections in the medical world enabled timely access to resources and timeliness was of great value in an injury situation; a competent wife maintained the home, and a flexible work environment ensured that he was able to continue his work. This example also demonstrated that the level of social capital is not only defined by how many people you know or have in your network but just as importantly which resources these people hold. High levels of social capital translate into supports that are timely, flexible and competent. Social capital in this case also includes the ways that ACC responded to particular participants.

Those participants who experienced the loss of social capital over the course of the study period fell into one of three groups: those with brain injury; those living in a rural area; and those who had difficulty returning to work. In this study, it was a source of deep shame to have ACC draw attention to potential donors, family members who were unwilling or unable to give support. There was a strong preference among rural participants to avoid drawing attention to their need, which then precluded disappointment. Much of their discourse was about finding ways of excusing these donors so that they could maintain their social capital in that relationship. For injured workers, on the other hand, there was anger expressed at workplaces that made them feel incompetent and therefore redundant. This was accompanied by a strong tendency to walk away from the situation without challenging it.

Those with brain injury appeared to have the lowest levels of social capital and the least capacity to hide from the situations where they were forced to recognise the erosion of social capital. These were sometimes adults who had made large investments in social capital, regarding caring for others. In this sense, people like Brent who continued to give and to care for his children and his partner reflect Bourdieu's (1986) recognition of potential violations in the reciprocity of social capital resources. They also reflect the conundrum of all carers who are forced to care for vulnerable members of society, who do not have access to social capital in their own right (Kittay, 1999).

This study has been primarily focused on the 'claimants' of social capital, but it is worth drawing attention to the many types of donors that were involved. These included family members, friends, co-workers, employers and ACC. One could imagine a situation where someone might have low levels of support from family members, but high levels from co-workers. However, in this study, the holders of high levels of social capital tended to be able to draw on care from all of these potential donors. In fact, there was a secure connection between social capital and cultural and economic capital in this study.

The findings from our qualitative research have some implications. In particular, they point to the fact that easy access to resources is only available to those with the highest levels of social capital. For all others, it seems to be essential to identify whether social capital is, in fact, available over time. It is not enough to pay tribute to human resilience. Instead, it is necessary to understand the social capital that underpins such resilience and to make targeted investments that can enhance that capacity in those who have not been among the initially privileged.

One prominent area where such a targeted investments could be made is through the ACC system. At the time this study was carried out, the management of the system suggested that there were substantial expectations on the part of 'case managers' that individuals would have access to social capital. The imposition of this expectation can shape the experience of social capital in both positive and negative ways for individual claimants. Those at risk of an adverse experience tended to have moderate levels of social capital and a strong desire to protect their relationships with potential donors. Those groups identified as having the lowest levels of social capital, seldom recognised that this was the case in the first interview. Such a lack of insight or narrow perspective of the social capital available to them at the outset hints at the mechanisms by which disability may be foreshadowed in the spaces that people have not identified in their social relations. We know that disability is frequently associated with injury and this study points to the need for styles of questioning in health care that elicit more contextual information and different ways of viewing the problems presented by the injury (Brown, 1997). This could be most usefully targeted at those identified as being particularly vulnerable regarding social capital.

One of the strengths of this study is the second follow-up interview, which was able to demonstrate shifts in the political economy of social capital over time. There are few studies that examine social capital as anything other than a static phenomenon. Serial interviews were able to demonstrate the dynamics underpinning both the growth and the loss of social capital. The demands made by the injury were sufficient to cause deterioration in the fragile economy

of labour for those with low levels of social capital. On the other hand, those with high levels of social capital were able to access labour time in ways that did not seem to incur a debt, yet the growth of social capital meant that they were in an excellent position to pass on the benefits to others. The second interview was often an occasion for expressing a deep sense of gratitude for how much had been given to them.

The relevance of these findings reaches beyond the personal consequences of the injury experience because it suggests an aetiological link between the embodied capacity to claim social capital and inequalities concerning the psychosocial origins of disability. All the participants operated in the same injury compensation and treatment/rehabilitation environment, but the extent to which a person was able to accommodate themselves to impairment was in large part determined by the social capital resources that were available to them. This included their capacity to make effective use of the provisions of the state through ACC. In making decisions about allocating resources, it is therefore essential to consider the nature and extent of the social capital available to the injured person.

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