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Pushed to the Margins and Pushing Back: A Case Study of One Adult's Reflections on Social Interactions After a Traumatic Brain Injury Sustained as an Adolescent

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Abstract

Traumatic brain injury (TBI) is a worldwide chronic health problem. Current empirical approaches to defining factors that contribute to a meaningful life after TBI have been limited to the biomedical perspective. Such a limited paradigm fails to address how people with TBI find meaning and act on and are acted on by the world in which they live. Between 2005 and 2007 an in-depth qualitative case study was conducted. The primary data source was a man's retrospective journal writings about his life after sustaining a severe TBI. The qualitative perspective of symbolic interactionism framed this case study analysis. Meaning is strongly influenced by the ways in which the social world interacts with the injured person. Despite an accumulation of negative social experiences, a traumatically brain-injured person can also assign positive meanings to the quality of his or her life. This has been ignored or explained away as a defense mechanism in previous investigations. More studies that include unbiased methods able to capture subjective experiences and what they mean to individuals with TBI are needed. This information will lead to more relevant interventions and better outcome instruments for use with this population.

Neurological impairments resulting from traumatic brain injury (TBI) are a chronic health problem around the world for both children and adults (Centers for Disease Control and Prevention, 2006; Tagliaferri, Compagnone, Korsic, Servadei, & Kraus, 2005; World Health Organization, 2004). To some degree, these impairments can explain each person's appraisal of his or her quality of life after a TBI. However, most investigations and the scholarly discourses that follow assume that the functional changes resulting from impairments can solely explain social life after TBI (Donnelly, Donnelly, & Grohman, 2005; Hammond, Hart, Bushnik, Corrigan, & Sasser, 2004; Hoofien, Gilboa, Vakil, & Donovan, 2001). A smaller number of published qualitative investigations document individuals' subjective appraisals of social life after a TBI (Jumisko, Lexell, & Söderberg, 2005; Nochi, 1998a, 2000; Shotton, Simpson, & Smith, 2007). In the qualitative studies that have been published, investigators may have biased their explanations of participants' experiences because their choice of methods allowed introduction of extant theories when conceptualizing the problem and designing the investigation. The use of interpretive phenomenology in these studies also positioned the investigators, or other clinicians who worked with the population, as equal experts on the experience of life after TBI (rather than considering the people who have lived with TBI as the only experts on that experience). Although these small flaws in the studies were not intentional, they do present philosophical limitations that may have constrained what

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Kevin Van Liew was an adult survivor of traumatic brain injury as an adolescent.

parts of participants' narratives were given attention and what parts were overlooked. Had investigators approached their studies without preconceived notions to explain what it is like to be a TBI survivor when designing the study and analyzing their participants' narratives, their conclusions about the nature of social life after TBI (viewed from the subjective perspective) might have been different. In another qualitative investigation, Morris and colleagues (2005) did not identify the method they used to gather their information. Qualitative methods are numerous and they differ considerably in their philosophical underpinnings. Withholding that information makes critiquing their investigation difficult and limits their findings.

Most professional discourses describing life after TBI imply that third-party persons (TPPs) with whom the person with TBI interacts do not contribute in any way to the faulty social interactions or the resulting isolation that people with TBI often experience. The small number of studies investigating subjective perspectives of people with TBI may imply that they are unreliable witnesses and informants of their social world. Thus, significant others in the traumatically brain-injured person's social environment are instead solicited for their viewpoints, pushing the viewpoint of the person who experiences life after TBI into the background. Because of this fundamental flaw in our philosophical beliefs and our data-gathering methods, healthcare providers' conceptualizations of life after TBI may be very limited concerning the true range of contributing factors to quality of life after TBI, as evidenced by the conceptualization map of Donnelly and colleagues (2005). In order for us to design effective and relevant research investigations and future clinical interventions, it is important to first understand and consider the factors for health and well-being as seen through the eyes of the people who have experienced a TBI.

Purpose

The purpose of this in-depth qualitative case study was to highlight one man's personal writings about his life after experiencing a severe TBI. His narratives provide a preliminary understanding of the nature of social interactions for people who experience a TBI. Using a qualitative case study to initially describe and explore in-depth the subjective perspective of health in a person's natural life setting has implications for future research designs (Keen & Packwood, 1995; Luck, Jackson, & Usher, 2006). This case study contributes to a better understanding of one man's experiences; however, evidence of the same themes discussed by this man was later found in a literature review of previously published qualitative investigations of young adults and adults after TBI. Interestingly, the investigators of these studies came to different conclusions. This disparity in their conclusions could be explained by investigator bias in their studies' designs.

Background

Mead (1934) described the theoretical reflective and interactive processes a person uses to create meaning in relation to his or her self and his or her interactive social world. This process involves a subjective version of the self in which there is no influence from others (the person's "I"). The person also sees an objective version of his or her self through others' behaviors toward him or her during daily social interactions (the person's "Me"). Both the subjective and objective versions of the self continuously converse with each other, and this inner dialogue ultimately formulates the person's meaning regarding his or her social self. The person's social self is his or her perceived status among the others he or she interacts with every day and the personal behaviors he or she will tend to present to others in future social interactions based on that perception.

TBI causes a range of heterogeneous cognitive impairments. Published reports have pointed out that some of these impairments can affect the person's appraisal of others' mental states and the social cues given by others (Bibby & McDonald, 2005; McDonald & Flanagan,

2004). Thus, it has been assumed in professional discourses that these resulting impairments in people with TBI are largely the cause of their altered social interactions and the social isolation they experience. Professional discourses about life after TBI often fail to consider or may minimize any TPP's role in this interactive process (Draper, Ponsford, & Schönberger, 2007; Horneman, Folkesson, Sintonen, von Wendt, & Emanuelson, 2005; Winkler, Unsworth, & Sloan, 2006). It is assumed that the TPPs are reacting normally because the person with the TBI cannot interact socially in a normal fashion (McDonald & Flanagan; Milders, Ietswaart, Crawford, & Currie, 2006). It is believed, therefore, that TPPs present a more reliable perspective on social experiences. However, Blumer (1969) clarified that when either party in any social interaction misinterprets the other party's behaviors or meanings, a breakdown in social interaction occurs. Thus, both parties play a role in the final outcome of any social interaction. This case study allows us to see social interactions after TBI from the point of view of the person who has experienced TBI.

Methods

The first author was contacted by a 35-year-old man named Kevin. The author was recruiting for an investigation of children's experiences in the first 3 years after TBI. Kevin stated that he wanted to participate because he had experienced a TBI at the age of 18. It was explained to him that he was not eligible to participate because at that time it had been 15 years since his injury; he insisted that he had already written about his life in a journal, and he felt this information would be useful to the author's understanding of life after TBI. He said he wanted to share his experience so that others could learn from it. The institutional review board was consulted to see whether a separate case study could be conducted with Kevin. The board believed no institutional review was necessary because the journal was already written, unsolicited, and freely offered by Kevin, and the information could not be generalized. Written informed consent was obtained from Kevin to publish this case study, and he requested to be identified and listed as a coauthor of the resulting publication. After reading his journal, the first author thought that Kevin's narratives presented a different perspective of social interactions, contrasting with what had been commonly discussed in the professional discourses surrounding life after TBI. It should be pointed out that Kevin's journal narratives were written retrospectively during the (approximately) 5 years before he contacted the author, and they covered periods spanning more than 17 years of his life. In-person and phone discussions in 2005 and 2006 were also used as sources for this case study. Thus, this case study covers Kevin's reflections as an adult on the 18-year period since his adolescence, when he experienced a severe TBI and a second TBI.

The first author read Kevin's writings several times to gain a sense of his whole story, which he was telling without any preconceived notions or theories to frame it. After reading Kevin's descriptions and coming to a conclusion about the general sense of what Kevin was describing, the first author chose George Herbert Mead's (1934) writing on the formation of self as the appropriate theoretical framework from which to see and tell Kevin's perspective. Mead's philosophical writings are the basis of the theoretical perspective known as *symbolic interactionism* (Blumer, 1969). The perspective of symbolic interactionism was later developed into the qualitative method known as grounded theory (Glaser & Strauss, 1967). A philosophical underpinning of symbolic interactionism is the belief that a person assigns meaning to his or her experiences as a result of social interactions and that the person's experiences and the meanings he or she makes of them are enmeshed in the person's history and culture (Blumer). Using symbolic interactionism as the framework for this case study, the first author asked the research question, "What are the social processes that occurred after Kevin's TBI that influenced his individual assignment of meaning to his life?" Understanding how a person frames his or her health and overall well-being is an important tenet of the discipline of nursing because it allows us to "understand events as they have meaning in the

life of the other,” which also allows us to engage in relevant research questions and nursing interventions (Swanson, 1993, p. 355).

In addition to using Kevin’s writings, the first author spoke with him on the phone four times and also met him in person twice for several hours each time. The purpose of these additional interactions was to validate the use of Mead’s theoretical framework, discuss more details of his journal writings and his life, and validate the final interpretation made by the first author, to ensure that this manuscript would truly reflect Kevin’s perspective of his life after his TBI.

Kevin’s Background Story

Kevin was 18 years old and had just completed his freshman year at a community college, where he also played on the baseball team. It was summer, and he was playing baseball for a summer league and working a job that was approximately 1 hour from his parents’ house. Kevin was playing baseball games many nights each week and had to drive long distances to both the games and his summer job. He wrote about how he had gotten very little sleep in the days leading up to his car accident. He was coming home from his job and he dozed off:

I started to go off of the right side of the road and I grabbed the steering wheel and jerked the Isuzu across the road. ... Once the Isuzu went on the other side of the road I must have jerked the steering wheel back in the other direction because I was told that the Isuzu rolled one time into a tree and was facing the road on the left-hand side of the highway.

Kevin was airlifted to a level I trauma hospital, where he was in a coma for approximately 7 days, and then spent 9 weeks in inpatient rehabilitation. He also continued several outpatient therapies after discharge.

After this accident Kevin had short-term memory impairment; his speech was slurred, slower, and sounded as if he worked hard to make sounds (dysarthria); he struggled with concentration and attention difficulties; and he had right-sided weakness (hemiplegia) and balance problems, so he was prone to falls.

Approximately 1 year after this first accident, Kevin was in a second car accident as a passenger in a small pickup truck. He admitted that he and his friends had been drinking. The driver didn’t successfully negotiate a curve on a windy mountain road and swerved to compensate. The pickup truck rolled over, and Kevin was ejected from the car onto the grass. He was conscious at the scene and was again transported to the same level I trauma hospital he’d stayed at after his first accident, but he was not comatose. This time his primary injury was his right hip, which continued to give him problems for the rest of his life. After this hip injury Kevin walked more awkwardly. He continued to have problems with this hip and needed two more surgeries when he was 35 and 37. Kevin had no other major health problems.

Kevin’s “I,” or How He Saw Himself Uninhibited by Others

Excerpt 1

One thing that I did not lose when I received the head injury is my extraordinarily vivid memory and my sense of humor. If I had lost my sense of humor, having to go through these traumatic experiences probably would have been impossible.

Excerpt 2

I also will look at pictures of myself from when I was in high school and compare those pictures to pictures of me now. I feel that I am way better looking now; certainly I’m in way better shape.

Kevin was an attractive man who had a very strong, uninhibited sense of self. He liked to be social and had tried many different social avenues over the last 18 years to keep his social life active. He finished 2 years of college after his injury, insisted on living independently, and worked to support himself despite his limitations. He also traveled a great deal, joined social groups, and went out to clubs. Throughout his journal writings and our subsequent talks, he prided himself on his sense of humor and his charming social qualities.

Kevin's "Me," or How He Saw Himself Through Others

The following excerpts from his journal illustrate various events that continued to influence his notion that others rejected him or at the very least did not see him as he saw himself.

Excerpt 3

I feel that because of the head injury other people, mostly relatives and those who don't know me or just met me, treat me like a small child. I feel that some of my older relatives think of me as "little Kevin." ... I notice people who work with the elderly or small children will raise the pitch in their voice. I notice people who do not know me very well will talk to me with a high pitch. ... Those same people will explain to me what I need to do as if I am a 3-year-old.

Excerpt 4

I went to a shopping mall in Kent to see a movie with [friend's name]. He walked up to a female whom he had never seen before and said, "You are beautiful." The girl responded like something was wrong with [friend's name]. Afterward, I realized the reason that the girl had an awkward response was because the time was shortly after the car accident that I was in and I was using a metal, hospital-issued cane. I feel that the girl felt that something was mentally wrong with [friend's name] because he was with me.

Excerpt 5

I was waiting for the bus at the bus stop on the corner of E. Laurel and Indian St[reet]. Two girls walked past me and made me feel a little uncomfortable. One of the girls then looked over her shoulder like there was something wrong with me.

Excerpt 6

[One of my friends] did tell me to pre-think, i.e., whenever I have a thought, think of what I'm going to say first, then speak, to avoid sounding "retarded." The only problem was [he] never "taught" me, [he] "told" me how I should act in certain situations. I think that [he] thought that I could somehow control my body and how I acted.

Excerpt 7

Whenever I ate at WWU I would eat at the student diner. The student diner overlooked Bellingham Bay and I must say that the view was magnificent. I would always sit at a table, usually by myself, overlooking the bay. I feel that the reason that most of the other students seldom sat next to me was that those kids were afraid. Only a couple of times when the diner was really full and there was no place else for other students to sit, would other students come and join me at the table where I was sitting. Otherwise, I would sit and have dinner by myself.

In these narratives, Kevin attributes his loss of social status to the physical impairments or a symbol of disability (e.g., a cane), both of which he felt were obvious to others before they

even interacted with him. They made him walk and talk awkwardly. He felt that these things contributed to people's inability to see the person rather than the disability. He concluded that others thought he was less than everyone else now. He clarified in our talks that he felt these attitudes were strong contributors to his social isolation because the few people who took the time to get to know him really liked him.

The next two excerpts highlight how TPPs who were strangers to Kevin sometimes completely misinterpreted his behaviors to mean something very different (e.g., speech patterns and movements that had different meanings to them). Again, these experiences were very demeaning:

Excerpt 8

I was pulled over by a motorcycle cop. The motorcycle cop who pulled me over came to the passenger side of the car. The officer immediately asked if I had been drinking to which I emphatically said no, that I was on my way to an appointment with a doctor in Seattle, but I first was going to meet my mom at my sister's house in Woodinville. I gave the officer my registration along with a doctor's note that says I have a disability that causes me to appear like I have been drinking when I am actually sober. A different officer who had just pulled up in his state patrol car then gave me a modified field sobriety test. I was then taken to sit inside the squad car of the Snohomish County State Patrol that came once I was pulled over. I was then given a Breathalyzer test and I blew triple zeros that showed that there was no alcohol in my system. I was then taken to the police department in Seattle so that I could not possibly still get to the appointment with Dr. [name]. I was taken into a caged-in area with a bunch of common criminals. I was dressed in a shirt and tie for my appointment with Dr. [name] and I felt really out of place. I asked what the time was and I realized that there was no way that I was going to get to my appointment. I was visibly upset but I kept my cool. I was then taken to another place and given a blood test. I did not blow up into a fit of rage until the following day when I took out all of my anger and aggression on my dad. Fortunately, my dad and I did come to some agreement and made up with each other.

Excerpt 9

I went to an orientation at [name of a daycare center] at the location on [street name]. I was reading through some of the literature. ... One part said that the daycare had a no smoking policy. Since I like to "burn a duke" every once in awhile, I was concerned about possibly being seen in public smoking a cigarette. I told the director at the job [that I like to burn a duke every once in a while] and she thought that I said "doobie." The director then told [name], the job developer who was working on finding me employment. [Developer's name] then spoke to me on the phone and I believe initially thought that I did, in fact, say "doobie." Like I would say, "I smoke doobies sometimes" to the director of the place that I work. Possibly the job developer works "all day" with morons, or people who aren't very smart. I feel like [developer's name] does talk to me like I'm not very smart.

These TPPs lacked experience interacting with people with TBI, and this may have caused them to make assumptions or categorize Kevin's behaviors incorrectly. According to Kevin, situations such as these happened often and were hard for him to forget because they caused him immense embarrassment and distress.

Social Self After His TBI

The most common theme from Kevin's narratives illustrated that his objective sense of self (his "Me") struggled to be seen and heard by others the same way as Kevin saw his self (his "I"). In his journal he speaks very little about the impairments constraining his life, except in relation to how others treated him after his TBI because of these impairments. He described others not recognizing his capabilities or his good qualities, and he experienced many messages that he felt expressed rejection from others before they took any time to interact with him. He also illustrated through his narratives the social embarrassment he experienced from others' misinterpretations of behaviors that were normal for him because of his TBI but were misread by others to mean he was a social deviant. According to Kevin, it was not each individual act but rather the successive and similar nature of others' reactions that made him feel he was being pushed to the margins of society.

However, Kevin did not want anyone feeling sorry for him. "Respect is the one thing that I want most from other people," he wrote. In fact, it was perhaps because he had such a strong subjective sense of self (his "I") that he did not give in or get depressed. During the 18 years after he sustained a TBI, he continued to fight misperceptions by "pushing back." He pushed back by attempting to overcome the impairments or minimize their influence on his social functioning: "I always kept myself ultra busy. ... I took all kinds of different therapies in order for me to overcome this disability." Kevin hoped that if he worked harder, these efforts would change how others perceived him. This theme of working hard to overcome others' perceptions was also echoed by the participants in previously published qualitative studies with people who had experienced TBI (Jumisko et al., 2005; Morris et al., 2005; Nochi, 1998a, 1998b, 2000; Shotton et al., 2007).

In the following passage Kevin describes an important spiritual aspect that influenced his appraisal of his life after he began working with children in a daycare center:

Excerpt 10

I find that I really enjoy working with the children. In addition, I would like to teach and instill in those youngsters the things that I wish I had learned when I was their age. I can tell that the children really like me a lot. Children are kind of a "blank slate." The children do not have a lot of preconceived notions about the way that I am. I find that the children are just more accepting of me the way that I am than most adults are.

Kevin explained to me that having the children's acceptance and feeling as if he could influence their lives gave him hope and inspiration in his life. Victor Frankl summarized a statement originally made by Nietzsche and clarified, "He who has a why to live can bear with almost any how" (Frankl, 1984, p. 12; Nietzsche, 1964). Another previously published qualitative investigation found that gaining acceptance from children could be an important way to alleviate feelings of isolation that many people can experience after TBI (Jumisko et al., 2005). This highlights the importance of a match between a person's subjective self and objective self and how important a social ecology where acceptance and caring exist is to human beings.

Finally, Kevin's comparison of how others treated him before his TBI (his past social self) and how they treat him now (his new social self) caused Kevin to conclude that it was his obvious outward impairments (e.g., slurred and slower speech patterns, hemiparesis, awkward ambulation) that caused other people to make inappropriate assumptions about who he was. He felt that this explained why most other people did not even want to get to know him more intimately or treated him as if he were more cognitively impaired than he actually was:

Excerpt 11

Presently, due to my disability, I feel like girls that I show the slightest bit of interest in will still not even get a chance to know me. I get the feeling that whenever I ask a girl to meet me somewhere one on one, and give the girl a chance to know the real me, the girl seems like she always has an excuse to avoid the situation, or “date.” Even if the reason for not being able to show up were valid, the girl not showing up would never have happened before my disability.

In 2005, Kevin began experiencing new-onset seizures, which caused him to “black out” and become confused. He felt that the effects of these seizures profoundly magnified the misconceptions, fears, and prejudices of others in areas that were very important to him:

Excerpt 12

I was at work [the daycare center] one day cleaning up tables and straightening up while my coworkers weren’t working so hard. I passed out [had a seizure] at work, but stayed at work, then went home and went right to bed. I woke up at 1 pm 2 days later. I was flustered, but thought it was 1 pm the next day. I called into work and told my boss what happened and I said “I’m on my way in.” My boss told me “No don’t worry.” I replied, “Don’t you worry I’ll make it in.” He never said anything about me missing the previous day’s work [on the phone] and I didn’t realize it ‘till much later. I tried to drive in to work a back way, but I got disorientated and went out towards Ferndale, which was in the wrong direction. “This isn’t right.” I backed up and ended up backing up into a ditch. A police officer came and asked if I had been drinking. “No, I’m on my way into work.” He could tell something was wrong and he asked, “Do you want me to take you to the hospital?” I replied, “Yes.” Then I was in the hospital for 16 days and I hardly remember any of it. I had to give up my driving license and get on seizure medications. Then a few months later, I was playing basketball with one of the kids at work when I fell and broke my wrist and had a cut over my left eye. The new childcare director wanted to call my mom, who didn’t even live in the same area of the state. He wanted her to come and take me to the emergency room. I said, “No!” The director insisted that my mom come and take me to the ER. I later got a release form in order to return to work and worked for the next 3 days. Then the daycare owner’s wife told me to take that Thursday, Friday, and Monday off and to call the owner on Monday. I met with the owner that Monday and he told me I didn’t have the updated version of a required course for childcare workers. I had taken it once, but needed to renew it. No one ever told me it expired and I needed to do that. I would have if they did. The owner then told me they had to let me go. I knew it had nothing to do with the expired course, because all they had to do was tell me to take it and I would have. I was a hard worker and the kids loved me. I think he was just afraid of having me work there because he thought I was a liability to them.

Kevin told me (the first author) this story after our last in-person meeting. He had been visibly upset and down the day we met in person but hadn’t explained why. The next day he called to explain why, and after telling the story, he summarized this final experience as “having the rug yanked out from underneath” him. He said he didn’t even know what he would do in the future because he couldn’t believe his boss had just forgotten about his hard work or how good he was with the kids. It turned out to be the last time we met or talked. Kevin died approximately 4 weeks later, during his sleep in bed at home. He was recovering from his second hip replacement surgery but was doing very well according to his parents. The cause of his death was undetermined. Approximately 1 year later, I met with his parents, and they gave informed written consent to publish this case study and to continue to identify Kevin as the coauthor. Kevin had made them aware of our work together, and they knew it was Kevin’s fervent desire to help people better understand what it felt like when others didn’t recognize your capabilities,

see you as a complete human being, or realize that we all have a basic need to belong and contribute. His parents read the final manuscript and agreed that it fit with how he explained his experiences to them. Kevin's mother said she had noticed that something had changed about Kevin during his last couple of years. She explained:

Early on he had so many ideas about what he was going to do with his life, but he finally said that he realized that God had used him in His way. He became more accepting of other people's reactions because he realized that God had used him in other people's lives.

Discussion

The belief that a person's cognitive impairments alone can completely explain the social isolation that people with TBI experience may be flawed, especially as time progresses. The notion that people with TBI cannot always assess the factors that contribute to their impaired social relations or social isolation may also be flawed. Investigations that evaluate the post-TBI person's ability to assess another's thoughts or intentions (theory of mind) are most often performed under very controlled conditions, using methods that do not simulate the totality of assessment that can occur in a social environment, and they are often conducted in the early years after the participants' TBI (Bibby & McDonald, 2005; Havet-Thomassin, Allain, Etcharry-Bouyx, & Le Gall, 2006; McDonald & Flanagan, 2004; Milders et al., 2006). Therefore, these investigations may not accurately reproduce the person's natural social settings. Within a person's natural social settings, even after a TBI, the person has many more social and behavioral cues, which allow him or her to make accurate assessments of TPPs' behaviors and intentions (Hall, 1973). It is true that early after TBI people often have difficulty assessing their environment. However, Kevin was intuitive and intelligent and I (the first author) had no reason to distrust his retrospective appraisals any more than one might question any other person's appraisals. Kevin did not deny that at times he said something inappropriate or stared at a girl in a way that might make someone self-conscious or nervous, but he reported that this was more infrequent in the last 10 years, and he felt that in most cases people avoided him before any of these types of interactions had a chance to occur.

It is seldom discussed within professional discourses that few TPPs have experience interacting with people diagnosed with a severe TBI and assessing the meaning of their behaviors. Therefore, investigators may not be recognizing that these inexperienced people could also be providing unreliable information about the true nature of social interactions with people who have experienced a TBI. TPPs may filter out their own reactions and how they subsequently behave toward the person with the TBI when describing their interactions (Blumer, 1969; Hall, 1973; Mead, 1934). Relying on the TPP's perspective of how a person with TBI behaves does not provide a complete picture of what occurs during social interactions. This limits investigators' understanding of social interactions and the ability to improve social reintegration for people after TBI.

Most people judge another's intentions and meanings based on their social experiences and the cultural meanings they have been exposed to (Knapp & Vangelisti, 1996). It is important to recognize that most people are guided by an underlying able-bodied philosophy and culture, which holds that people who function in certain ways are normal, and those who cannot function in that manner are abnormal, sick, or disabled. When one is part of the group that is considered normal, one is unlikely to question how such a conceptualization might be biased or may marginalize and oppress others (Wendell, 1996). Able-bodied people may unknowingly attribute incorrect meanings to the behaviors of a person with a TBI. Thus, TPPs may misinterpret many behaviors of the person with TBI and react to him or her in a way that also contributes to the faulty social interactions and the ultimate isolation people often experience after a TBI (Blumer, 1969; Mead, 1934). Furthermore, a TPP may choose not to interact at all

with people who have impairments from a TBI because the TPP has false beliefs about their capabilities, such as that they are more intellectually impaired than they actually are, they are dangerous, or they are weird or embarrassing to be around (Goffman, 1963; Wendell). Neurological impairments, especially when they distort the body's appearance or its functioning, have a history of negative social connotations and reactions. It is possible that the social isolation that may occur after a TBI actually occurs after minimal interaction with others within the person's social ecology. It may result from the ignorance and prejudices of others when they observe different walking patterns, different speech patterns, assistive aids, disfigurement, or a difference in functioning of any kind (Goffman; Wendell). According to the previously published narratives of people who have experienced TBI, many able-bodied people are simply unprepared to understand and accept the person who is different from them in functional capacity (Jumisko et al., 2005; Morris et al., 2005; Nochi, 1998a, 1998b, 2000; Shotton et al., 2007). It is a part of human nature to feel closer to those whom we believe are like us and distanced from those whom we observe to be different from us (Flavell, 1999; Goffman). Considering these underlying philosophical beliefs in future research designs and clinical interventions would change how we as healthcare professionals might understand and interact with patients after TBI.

An interesting finding from this case study (that was either overlooked or disregarded in previous published investigations exploring subjective versions of life after TBI) is that despite the many negative objective messages he received, Kevin did not always conclude that his life had only negative meaning:

Excerpt 13

I have had many experiences and been to many places that I never would have gone through or places I never would have been to had I not been in the car accident in 1988. I also have met a lot of people that I never would have met had the life-changing event never occurred. I guess that's a positive way of looking at things that have gone on in my life. But [I also] think of all the people I didn't get to meet and the places I didn't get to go to because of the car accident. Certainly, my life has not turned out the way I had anticipated. I never in a million years would have thought that I would be single, never married or have any kids, and living alone in a small, one-room apartment at 35 years of age. ... However, I also will still, every now and then, have that feeling of excitement and anxiety come over me just before going to bed. I almost feel at those times like I can't wait for the next day to arrive.

Kevin's journal passages highlight the complexity and temporal nature of the process whereby humans evaluate their everyday life and assign meaning to it. Previously published subjective investigations presented their participants' summaries of their experiences after TBI as having primarily negative meaning by focusing on only the negative comments. They ignored the intricacy with which balancing the negatives and positives in a person's life helps them to continuously assign and reassign meaning to the quality of their life. This process is not unique to people diagnosed with TBI but occurs in all people. It involves people's spiritual dimension as well as their thoughtful and emotional dimensions. Spirituality, defined as a person's awareness of his or her self and his or her connection to others through a power outside himself or herself, can be a filter by which people view the world and their interactions within it (Martsof & Mickley, 1998). If we see our purpose as something larger than ourselves, then we can ignore some of the negative interactions we have experienced (Frankl, 1984). Kevin's pushing back occurred because he could not accept how others defined his self and his being in the world. He showed them who he was by living and enjoying life despite the fact that it went against others' conventions of what it meant to be a disabled person. He felt his limitations did not define him. Instead, it was his appreciation of life, sense of humor, and stubbornness that defined Kevin.

When investigators evaluate subjective experiences and highlight only the negative experiences, they may inadvertently ignore the holistic nature of a person's appraisal of his or her quality of life. For instance, previously published investigations explained their participants' positive evaluations of their new life as a coping mechanism for avoiding the emotional pain of loss. Their account for these positive evaluations was "to avoid the experience of loss-of-self-by-comparison in some respects" (Nochi, 1998a, p. 873), and "the participants consoled themselves by saying that sustaining a TBI is a way of finding out who your true friends are" (Jumisko et al., 2005, p. 44). These conclusions imply that positive sentiments are not valid appraisals, but they may instead reflect the investigators' preconceived biases surrounding the true nature of giving meaning to life experiences, especially experiences that to an able-bodied person might seem to have only negative meaning. These investigators explained reactions unusual to their worldview using extant psychological theories that describe the appraisal process as occurring in the individual's mind alone. They ignored that their participants were telling them (through their narratives) that they had arrived at their meaning through their social interactions and their spiritual reflections.

Adapting to any form of life change is a normal part of the human experience that often involves emotional pain and loss. Adaptation and acceptance often involve a reflective process of comparisons whereby the person can see both the positive and negative aspects of his or her experiences over time. Marris (1974) points out that the person's sense of self can be restored only when the person detaches "the familiar meanings of life from the relationship in which they were embodied" before the person's life-changing situation (p. 37). In other words, once people can recognize and find a new relationship between their self and their world, which is independent of the old meaning, they can move on to make new meaning. Both Kevin's narratives and the narratives presented in previously published qualitative investigations demonstrate that input from others in the person's social environment may cause the person to experience continuous conflicting objective input about his or her self, which makes the person feel as if he or she is pushed away and marginalized. Together they highlight that people can continue to experience feelings of loss and emotional pain long after TBI because of their social interactions (Jumisko et al., 2005; Morris et al., 2005; Nochi, 1998a, 1998b, 2000; Shotton et al., 2007). These negative messages may make the person's transition to detaching the "social" meanings associated with his or her impairments a daunting or impossible process.

In Keagan's (1982) conceptualization of the evolving sense of self, he states, "What is most important for us to know in understanding another is not the other's experience, but what the experience means to him or her" (p. 113). However, understanding the meaning of daily life after TBI without understanding how it is formed has led to conceptualizations across healthcare professions that focus interventions only on improving the patients' impairments or emotionally supporting them to accept their functional changes and loss. Few interventions are geared toward educating TPPs in the general public about the capabilities or needs of people diagnosed with a TBI and preparing them to be supportive. Additional evidence suggests that many TPPs outside the family avoid people with TBI and prevent them from participating in social activities because of misconceptions (Pierce & Hanks, 2006; Swift & Wilson, 2001; Van Baalen et al., 2006). Healthcare providers fail to recognize and challenge the public to accept the person with a TBI as an integral part of society and realize that he or she has something to contribute to society that would otherwise be missing (Hauerwas & Vanier, 2006).

In fact, this case study highlights that a person can become comfortable with his or her functional changes after TBI, have a strong sense of self, and still struggle with negative input from people or structures in the social environment. This input makes it difficult for the person to feel comfortable with his or her new social self. Because few qualitative investigations have consistently connected the processes and the meaning given to a person's experiences after

TBI without imposing extant theories on the participant's narratives, few interventions have comprehensively been aimed at TPPs in the community setting. These are the people who will ultimately interact with the person after TBI. Their interactions will be a part of this cocreative process in which meaning is assigned to the person's quality of life. Furthermore, no descriptive phenomenological inquiries of life after TBI have included children, despite the fact that their subjective sense of self may be particularly vulnerable to their environmental influences and could have lifelong implications for their psychosocial well-being.

Limitations

A major limitation of this case study is the fact that it presents only Kevin's view of the social interactions being discussed. He also could have misinterpreted the intentions or meanings of people he interacted with or observed. He could have also filtered out any of his own behaviors when describing these events. However, the perspectives of TPPs were not closely scrutinized, and because the themes Kevin discusses are also replicated in the other published qualitative investigations, there was no reason to question them.

The findings from this case study are not intended to be generalized to all people with severe TBI. However, the findings from this case study and the critical evaluation of previous qualitative studies with people after TBI make a plausible argument for clinicians and researchers to consider the notion that interactions with others in society have a significant impact on the well-being of people after TBI. Understanding this notion when planning future interventions or research studies with this population will allow more relevant and caring interventions and research studies.

Clinical and Research Implications for Nursing

More qualitative investigations with people who are diverse (i.e., different ethnicity, gender, age, social demographics) are still needed to gain a better understanding of the individual and social factors that affect a person's appraisal of life after TBI. Clinicians need to consider the viewpoints of their patients and the factors they feel contribute to their quality of life without interjecting their own explanations. An open-minded approach could help healthcare providers develop more relevant and caring interventions within the social environments of people after TBI (Swanson, 1993).

Conclusion

Because experiences and meaning can be strongly influenced by the way an individual's social world interacts with them, subjective accounts of experiences and their meaning must be included in conceptualizations of life after TBI. This case study highlights that a person's impairments after TBI may continue to influence how others define that person more than his or her impairments define the person's appraisal of self. However, it is also possible that the person's new impairments indirectly influence his or her appraisal of quality of life by influencing the quality of the person's social interactions. People who have experienced TBI continue to be whole people, with physical, emotional, thoughtful, and spiritual capacities, each of which influences a person's ongoing interpretations of social experiences and result in his or her assignment of meaning to the quality of life. This case study and the critical analysis of previously published investigations highlight that interventions after the acute care phase fail to help people integrate into meaningful relationships within society. Nurses can play a vital role in supporting patients after TBI by advocating for these needs and providing interventions that not only support the patient's emotional struggles but also help educate the public.

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