Grief, anger, and relationality: The impact of a research-based theatre intervention on emotion work practices in brain injury rehabilitation

Pia Kontos, PhD, MA, BA,

Senior Research Scientist, Toronto Rehabilitation Institute-University Health Network, Toronto, Canada, Associate Professor, Dalla Lana School of Public Health, University of Toronto, Toronto, Canada

Karen-Lee Miller, PhD Candidate, MA, MSW,

Research Associate, Toronto Rehabilitation Institute-University Health Network, Toronto, Canada, PhD Candidate, Dalla Lana School of Public Health, University of Toronto, Toronto, Canada

Angela Colantonio, PhD, OT Reg, and

Professor, Department of Occupational Science and Occupational Therapy, University of Toronto, Toronto, Canada, Senior Research Scientist and Saunderson Family Chair in Acquired Brain Injury Research, Toronto Rehabilitation Institute-University Health Network, Toronto, Ontario

Cheryl Cott, PhD, Dip.Ger., BPT

Professor, Department of Physical Therapy at the University of Toronto, Toronto, Canada, Senior Research Scientist, Toronto Rehabilitation Institute-University Health Network, Toronto, Canada

Introduction

Therapeutic emotion work (Bone, 2002) is performed by health care providers as they manage their own feelings as well as those of colleagues and patients as part of efforts to improve the physical and psychosocial health outcomes of patients. Emotion work practices involve organizationally mandated emotional displays as well as feelings of vocational altruism, and issues of professional autonomy and interprofessional skirmishes (Dingwall & Allen, 2001; Miller et al., 2008). Emotional strain and burnout, as well as feelings of professional satisfaction and esprit de corps are associated with engagement in emotion work for therapeutic purposes (Bartram, Casimir, Djurkovic, Leggat, & Stanton, 2012; Hunter, 2001; Miller et al., 2008).

Therapeutic emotion work has been used to insightfully examine relations amongst health care providers (Lewis, 2008; Miller et al., 2008). It has also been used to examine relations between patients and practitioners, most notably in nursing (Mann, 2005), but increasingly across a range of clinical areas including dentistry (Sanders, 2005), medically assisted reproduction (Fitzgerald, Legge, & Frank, 2013), and paramedical services (Williams, 2012). There are profound differences in the emotion work demands placed upon health care

staff across clinical specialties due to patient conditions or associated behaviours towards staff. For example, an excited new mother on a maternity ward and an aggressive psychiatric inpatient present vastly different patient-provider interactions, care burdens and rewards; these, in turn, influence the emotion work efforts required of staff (see for example Grandey, Foo, Groth, & Goodwin, 2012; Hunter, 2001). Yet the therapeutic emotion work of health care providers has yet to be fully examined in the context of traumatic brain injury (TBI) rehabilitation (for a preliminary investigation see Kontos et al., 2012). This is a significant omission given the emotional impacts of TBI on patients and their family members (Carroll & Coetzer, 2011; Kreutzer et al., 2009; Verhaeghe, Defloor, & Grypdonck, 2005), including family care partners (Dupuis & Gillies, 2014) who provide unpaid, non-professional, informal care. These impacts are suggestive of high emotional management demands upon staff.

TBI is defined as physical damage to brain tissue caused by an external and mechanical force. It is typically caused by blunt force (i.e., motor vehicle crash) or a penetrating wound (i.e., gunshot wound) (Phyllis & Farls, 2000). Neuropsychological, cognitive, and physical impairments are common; reasoning, relating, walking, and working may all have to be relearned to some degree (Menon, Schwab, Wright, & Maas, 2010). Neurorehabilitation staff have been found to exclude clients from full participation in decision-making because of these neuropsychological and cognitive impairments (Toglia & Kirk, 2000), which is contrary to client centred best practice guidelines (Sumsion & Law, 2006).

In other clinical specialties, educational initiatives have been proposed to address health care practitioners' more troubling perceptions of patients/clients (Cott, 2004; Pegg et al., 2005). Because of its strength in communicating best practices in an emotive and embodied manner (Rossiter et al., 2008), theatre holds particular potential for educational interventions in the health field. Dramatic performances have successfully increased practitioners' empathy in specialties such as schizophrenia (Mieniczakowski, 1992), substance abuse (Mieniczakowski & Morgan, 1993), prostate cancer (Gray, Fitch, Labrecque, & Greenberg, 2003), and Alzheimer's disease (Jonas-Simpson et al., 2012; Kontos, Mitchell, Mistry, & Ballon, 2010). To date, drama as a pedagogical strategy is largely neglected in neurorehabilitation. An exception is *After the Crash: A Play about Brain Injury* (Gray et al., 2011). Previous evaluations of the play demonstrated its success as an educational intervention to bridge the gap between client centred care (CCC) and brain injury rehabilitation (Colantonio et al., 2008; Kontos et al., 2012). Nevertheless, these evaluations overlooked many pre-intervention and post-intervention emotion work practices. Such oversight is critical to redress because TBI-associated injuries arguably present among the most profoundly distressing affective challenges for patients, families, and health care providers (Carroll & Coetzer, 2011; McLaughlin & Erdman, 1992). Thus, our objective was to return to the empirical data to analyze previously unexplored emotion work practices by TBI practitioners in the context of our evaluation of *After the Crash*.

We begin first with overviews of therapeutic emotion work, TBI, and neurorehabilitation. Next, we provide a brief description of research-based theatre as a background to the intervention study from which our data is drawn. We then describe emotion work practices from the pre- and post-intervention stages of the study. Excerpts from the *After the Crash*

script are provided to identify the specific scenes that sustained existing, or prompted new, emotion work practices. We discuss the implications of our findings for the well-being and physical and emotional safety of clients, and their intimate partners and families. We conclude by noting the importance of an alliance of the performance paradigm, emotion work praxis, and health services research.

Therapeutic Emotion Work

The study of emotions has become increasingly central to sociology, with particular engagement by the sub-disciplines of work, medical sociology, and health geography (Davidson & Milligan, 2004; Miller et al., 2008; Rafaeli & Worline, 2001). A cross-cutting concern is with the regulation of individual emotions via cultural norms and social structures, and the ways in which this regulation affects individuals, groups, and organizations (Wharton, 2009). Current scholarship builds on the concept of “emotional labour” developed by Hochschild (1983). Hochschild (1983) drew on dramaturgical principles such as method acting to describe how feelings may be manipulated to present a demeanour compliant with the “feeling rules” and “display rules” of commercial organizations. In the context of health care, the concept has been since broadened. Now termed emotion work, it includes autonomous and discretionary affective practices that are undertaken by health care practitioners in a variety of settings (Bone, 2002; Fitzgerald et al., 2013; Miller et al., 2008) in relation to the management of a range of types (e.g. anger) and expressions (e.g. verbal abuse) of emotion (Grandey et al., 2012; Skjørshammer, 2003). Emotion work within and beyond therapeutic spaces has been characterized as having a particularly gendered, as well as racialized nature (Mirchandani, 2003; Pierce, 1995; Wharton, 2009). Women as wives, mothers, and nurses are often engaged in what could be characterized as emotion work during the physical and social care of chronically ill and disabled family members at home as well as in hospital (Dyck, 2005; McKeever, O’Neill, & Miller, 2002). Emotion work is also undertaken by women in non-caring professions such as law (Pierce, 1995), strip work (Fogel, 2007), and sex work (Sanders, 2005), often in ways not required of their male counterparts who are generally not expected to provide emotional sustenance or support as part of contractual obligations (Pierce, 1995). Emotion work is also often racialized because, as Mirchandani (2003, p. 737) explains, “immigration histories, racial backgrounds and class resources often effect the nature of the emotion work” undertaken by women of colour. The daily emotion work of dealing with inequity also applies to lesbian and bisexual women of colour in multiple spatial locations including the home, workplace, and bar scene (Kawale, 2004).

Therapeutic emotion work also has a spatial quality (Kontos, Miller, Cott, & Colantonio, Forthcoming; Lewis, 2008; Miller et al., 2008). Setting-specific practices of emotion work exist, mutually structured by the clinical and social presentations of patients (Grandey et al., 2012; Hunter, 2001), as well as practitioner perceptions of the extent to which the environment is therapeutic (Holmes, 2005). For example, forensic psychiatry nurses’ consoling efforts have been found to be shaped by whether the care setting is a correctional facility or a civic hospital (Holmes, 2005).

Traumatic Brain Injury and Client Centred Rehabilitation

Globally, TBI is the most common cause of death and disability for those younger than 45 years of age (Caro, 2011). It is typically caused by falls, motor vehicle crashes, or assault. Approximately 5.3 million Americans and 7.7 million people in the original European Union States live with a TBI-related disability (Roozenbeek, Maas, & Menon, 2013). Across the lifespan, TBI is more common in men (Colantonio et al., 2010). Young men are at twice the risk of TBI than are women, and due to youth and lifestyle in the “testosterone years” (Bruns & Hauser, 2003, p. 7), often present with limited education, sparse work histories, and forensic or drug histories (Carpenter, 2008). TBI in women is often associated with male violence (Farley, 2004; Wilson, 2009) with 74–77% of women residing in emergency shelters displaying symptoms consistent with TBI (Wilson, 2009).

Following a TBI, impairments in physical functioning (e.g. walking, coordination), sensory processing (e.g., difficulty recognizing what is seen), communication (e.g., difficulty speaking), and cognition (e.g., memory loss) may occur (National Institute of Neurological Disorders and Strokes, 2002). Personality change is the most “consistent feature of mental change after blunt head injury” (Jennett & Teasdale, 1981, p. 44) giving rise to disinhibition, impulsivity, irritability, and agitation. Of these, agitation is the most frequently observed (31–71%) in the post-acute stage (Kim, 2002). It may range in presentation from mild (e.g. repetitive, aimless movements) to more severe (e.g. physical aggression or violence) (Kim, 2002). Further, the nature of brain injury often results in significant losses for an individual (Blackmer, 2003), which causes anxiety (Al-Adawi et al., 2007), depression (Al-Adawi et al., 2007; Jorge et al., 2004), and posttraumatic stress (Bryant, Marosszeky, Crooks, Baguley, & Gurka, 2001). These changes affect the entire family system since they disrupt relationships and the sharing of responsibilities (Wood, Liossi, & Wood, 2005).

Post-acute inpatient rehabilitation in Canada is on average seven weeks long (Colantonio et al., 2011) wherein the goals are to regain competence in self-care, mobility, and independence (Cullen, Chundamala, Bayley, & Jutai, 2007). CCC is the care philosophy of most institutional rehabilitation centres (Cott, 2004; Maitra & Erway, 2006), and is predicated on client autonomy in goal setting, and optimized therapeutic partnerships (Law, Baptiste, & Mills, 1995). The principles of CCC—choice, autonomy, and negotiation between clients and providers (Law et al., 1995)—prove particularly challenging to implement in TBI rehabilitation given practitioners’ lack of understanding of the personal and social implications of TBI (Jumisko, Lexell, & Soderberg, 2005) and the misperception that its sequelae are incongruent with rational choice making (Toglia & Kirk, 2000).

Research-Based Theatre

The use of the arts (e.g. drama, dance, music) for educational initiatives is advocated for their ability to foster critical reflection, nurture empathy, and challenge dominant assumptions (Dupuis et al., 2011; Kontos & Poland, 2009). Theatre contributes significantly to medical education because it has “a uniquely compelling emotional quality, making it difficult to avoid or intellectualize the struggles and suffering portrayed” (Shapiro & Hunt, 2003, p. 923). While there is increasing empirical support for the effectiveness of research-

based drama for learning about illness and humane patient care in various clinical areas (Gray et al., 2003; Gray et al., 2000; Kontos, Mitchell, et al., 2010; Shapiro & Hunt, 2003), it is used with surprising infrequency in educational interventions to improve the quality of brain injury rehabilitation (for exceptions see Colantonio et al., 2008 and Kontos et al., 2012).

The Intervention: *After the Crash*

After the Crash was based on focus group research with survivors of TBI, their families, and health care practitioners (for full methodological details of the play, see Colantonio et al., 2008 and Rossiter et al., 2008). The play portrays the complexity of TBI rehabilitation through presentation of clients' medical and social needs including access to information, goal-setting, and re-integration strategies. It also translates the principles of CCC into practice exemplars that address those needs such as the use of plain language by staff, the provision of emotional support, and the tailoring of therapy to the life history of the client.

The intervention is a 1-hour, 24-scene play with two interrelated storylines. The first is that of Elliott, a young heterosexual married lawyer who sustains a brain injury following a car accident. Next is Trish, a young heterosexual unmarried occupational therapist first introduced as a member of Elliott's rehabilitation team. After bicycling home one day, Trish is struck by a car and incurs a brain injury. The play is staged simply, and has few props beyond four chairs and a wheeled wooden plinth that transforms from hospital bed to kitchen table. In addition to dialogue-driven exchanges, dance and music are incorporated to capture the content and emotional dimensions of the focus group research that forms the play's basis. For example, Scene 6 depicts Elliott's transition from vegetative state and acute care to early responsiveness and rehabilitation. Nurses first repetitively wash, reposition, and assess a limp, rag doll-like Elliott while a soulful blues tune plays in the background. Their movements become absurdly exaggerated as they pull his legs to drag him to the bottom of the bed, abruptly prop him up, and then lift and pivot the newly awakened, confused Elliot to a wheelchair, which signals his readiness for rehabilitation.

Methods

The study took place over a three year period (2008–2011) in urban central Canada. It was approved by the research ethics boards of the two participating inpatient rehabilitation hospitals and the research team's host institution. *After the Crash* was performed live by a professional acting troupe, and open to all staff, patients, and families. Data collection was undertaken in the neurorehabilitation units (Facility A, 32 beds; Facility B, 27 beds) of the two participating inpatient rehabilitation hospitals.

Participants

Informed consent by proxy (Karlavish, 2003) was obtained for clients assigned to health care practitioner caseloads; informed consent was obtained from participating staff. Criterion-based selection (Le Compte & Preissle, 1993) was informed by a literature search that identified the health care disciplines most commonly associated with inpatient TBI rehabilitation settings (Turk & Scandale, 2007). We consequently purposively sampled

(Patton, 1990) TBI staff (N=33) with the most and least years' experience from nursing (registered nurses [RNs; n=8] and registered practical nurses [RPN; n = 3]), psychology (PSY; n = 1), occupational therapy (OT; n = 5), physiotherapy (PT; n = 5), speech language pathology (SLP; n = 6), social work (SW; n = 3), recreational therapy (RT; n = 1), and chaplaincy (CHAP; n = 1). The health care practitioners were predominantly female (91%) and ranged in age from 27 to 63 years (mean 39.91; standard deviation 9.85); 73% had worked in the facility for 4 years or more. They consented to viewing *After the Crash*, and to being observed and interviewed at pre-intervention, and at 3 and 12 months post-intervention (hereafter abbreviated as 3PI and 12PI); 72.73% participated in all data collection points.

Data Collection

The intervention study was qualitative. Naturalistic observations (N=204.5 hours) and semi-structured interviews (N=87) were conducted across both hospital sites pre-intervention, 3PI and 12PI.

Naturalistic observations of structured and unstructured interactions

Naturalistic observations were conducted of a range of structured and unstructured intraprofessional and interprofessional health care activities (Miller & Kontos, 2012; Miller et al., 2008) in both public (hallways, nursing stations) and private areas (client or treatment rooms). Structured activities included nursing reports (30-minute meetings held twice daily by nurses at the completion of morning and evening shifts to discuss client status); rounds (weekly 45-minute meetings involving the interprofessional team to discuss client progress); case conference planning meetings (30-minute meetings involving the interprofessional team to prepare for future discharge planning or family meetings); and discharge planning or family meetings (1-hour meetings involving the interprofessional team, client, family care partners, and often a legal representative and insurance adjuster to discuss discharge and post-discharge care, or client progress). Unstructured activities included practitioner-client care activities, or practitioners working together intraprofessionally or interprofessionally for information sharing and/or to provide client care. Two research associates, each responsible for data collection in one of the two rehabilitation hospitals, conducted observations across all time points (pre-intervention, 3PI, and 12PI). Observations were documented in field notes, and captured the ways in which therapeutic care activities, goals setting, and communication strategies were consistent or inconsistent with the principles of CCC.

Interviews

Ninety audiotaped, semi-structured interviews lasting approximately 60 minutes each were conducted in a private room in each hospital by the same research associates responsible for the naturalistic observations. Interviews explored the social, spatial, and organizational characteristics of rehabilitative practice. Specifically: 1) impacts of injuries on clients' relationships, routines and quality of life from the staff's perspective; 2) the institutional environment including social climate and clinical practice; and 3) factors that constrained and enabled CCC. Post-intervention interviews additionally explored impacts of the play on practitioners' knowledge, attitudes, and practices.

Analysis

In our earlier evaluation of the intervention (Kontos et al., 2012), our focus was on practices associated with the key tenets of CCC. In that context, a few therapeutic emotion work strategies associated with professional display rules (Hochschild, 1983) that promoted or inhibited CCC were identified. These included: emotional disengagement to prevent burnout; restraint of personal judgment to prevent inequitable care; false cheeriness to promote patient motivation; and staff discomfort with client sexuality (Kontos et al., 2012).

While our initial CCC evaluation explored emotion work only tangentially, it was the first to examine such practices in the context of TBI rehabilitation. Given that affect and emotion in inpatient TBI care remain woefully under-examined, we returned to the raw data using therapeutic emotion work as a sensitizing concept (Bowen, 2008). Category formation began with identification of emotional expressions (e.g. frustration) and emotional management (e.g. the control of outbursts) during interactions between staff, family members, and clients. These categories were then condensed, investigated for inter-relationships, and organized according to thematic content, moving from lower-order to higher-order themes. Through an iterative process, higher order themes were developed to capture points of intersection and disconnect between emotional expressions and management (e.g. staff-client interactions involving client grief were identified as a practice of emotional suppression, and further linked to staff's own fears of brain injury).

At present, consensus does not exist on how best to specify quality in qualitative research (Mays & Pope, 2000; Tracy, 2010). We implemented Lincoln and Guba's (1985) four-point criterion: credibility, dependability, confirmability, and transferability. Credibility was ensured by, for example, decreasing the potential for reactivity during observations using strategies such as acclimatizing staff to researcher presence and the establishment of good rapport (Gold, 1997; Spano, 2005). Dependability and confirmability were established through the use of a dependability audit (Miyata & Kai, 2009) to ensure accounts were supported by the data. Finally, transferability was addressed with the provision of sufficient detail such that the range and applicability of the extrapolation of findings (Miyata & Kai, 2009) could be assessed.

Findings

Our analysis identified important emotion work practices. Pre-intervention analysis indicated staff emotion work practices were characterized by staff control of client emotions, specifically, staff suppression of the grief of clients, family care partners, and other family members, and their proficient management of clients' anger. In turn, these practices were associated with staff's stringent self-management of empathy, self-protective practices and 'similar fate fear,' and their discomfort with the involvement and reactions of family. Post-intervention analysis indicated that the play evoked significant changes in a "relationality" orientation (Dewing, 2008; Nolan, Ryan, Enderby, & Reid, 2002) by staff. That is, improvements were observed in how staff related to family care partners and other family members, and in how they supported clients' sexual orientations and their needs for intimacy expression and sociability. However, no improvements were demonstrated in staff's ability to undertake grief support, or in the management of their own 'similar fate fear.'

Pre-intervention

Controlling emotions: the suppression of grief and proficient management of anger—In our findings, as with the TBI literature in general (Al-Adawi et al., 2007; Blackmer, 2003; Bryant et al., 2001; Jorge et al., 2004), the sequelae of brain injury had profound emotional consequences. Staff classified clients' responses to injury as one of two primary emotions: grief when injury and loss of function were correctly self-identified; or anger and/or extreme frustration when cognitive impairments interfered with the recognition of the logic of, and the need to follow, rehabilitative directives. Staff's differential approaches to clients' expressions of grief and anger are discussed individually below.

The suppression of grief—Staff were very aware that clients' responses to their TBIs were associated with grieving or mourning the losses of abilities and livelihoods:

They've lost their life, maybe not physically, but they've certainly lost their life that they knew, and that's a big grief issue. [CHAP Interview]

One day you're able to do things, the next you're not able to...Like somebody that's in mourning, [clients] go through a grief process. Basically it's the same thing. [RPN Interview]

[S]ome [clients]...are going through like a mourning period...Realizing that..."My life's not what it was before. It never will be." [OT Interview]

Staff interpreted the enormity of clients' losses within the context of their own lives, and imagined the impacts that such losses would have. Many staff articulated worried fantasies, what we have termed 'similar fate fear,' about the possibility that they or their loved ones would incur a TBI. The following comments were typical:

Well I think as a wife, and a nurse...the feeling you get, the panic attack...that, "Oh my God! It could be me, my husband, my son." You know? I know what it is to have a head injury. I see it here every day. So it's panic to think it could be my family. [RPN Interview]

Well sometimes [there] is family around, like to help [the TBI client]. And then...there's family around, but they're unavailable for day-to-day support. And I think about that all the time. Because, say something happened to one of my parents, I work every day. Like, if they need 24 hour care [due to a TBI], I wouldn't be able to provide that to them. [OT Interview]

The most common response to the emotional distress that 'similar fate fear' evoked was emotional self-protection, which was accomplished with strategies such as emotional distancing:

I feel that sometimes I have to put up a bit of a wall with the patient because it's hard to be empathetic all the time, because you just get so overwhelmed with what they must be going through. [SLP Interview]

At their core, self-protective strategies involved the suppression of empathy. When directed inwardly, this suppression of empathy led to staff's passive but wilful overlooking of the client *in situ*.

I don't really want to know [the client's life]...I think it's just your instinct [to protect] your emotions. Like, you're gonna feel for the mom who has three kids and now can't even brush her own teeth. [RN Interview]

When directed outwardly towards clients, staff's self-protective strategies led to their active suppression of clients' grief reactions. In order to do so, staff actively discouraged clients from crying, redirected those in distress, and avoided topics that might provoke upset. The following instances are illustrative:

The client, seemingly out of nowhere, begins crying and says that she doesn't want to be here. The RPN says, "Don't cry." The food tray finally arrives. The RPN takes the lid off the plate to reveal mashed potatoes, mashed carrots, and gravy... then adds a bit of protein powder on top and mixes it into the food. She tells the client that this is good for her body. The client, again out of nowhere says, "If I don't talk to my daughter every day..." and begins to cry again, unable to finish her sentence. The RPN says in a calm voice, "It's okay. Let it go. You talk to her every day." The client, who is still crying, replies that her daughter is not coming in today. The RPN [ignores this comment] says, "Wipe your eyes... You won't be able to eat if you're crying." [RPN Unstructured Observation]

...[Staff] don't want [clients] to focus on despair issues. I mean, he had a girlfriend, he loved her, and I will tell him, "yes, [names client], I'm sure you love her. But right now, this is why you're here...[Y]ou can focus on the other things later on. You know, when you leave here, when you get better." [RN Interview]

These suppression strategies appeared quite effective at inhibiting clients' expressions of distress. Overt grief expressions by clients were kept to a minimum:

It's amazing how we don't see people crying that much. Like, we may see the odd family member, but the client themselves [no]... We won't, or we don't, allow them to cry... [RPN Interview]

Often, even non-teary displays of grief or upset by clients were responded to with reticence and physical withdrawal by staff:

The client appears to be getting upset, and is looking depressed. She asks the SLP to come a little closer. She then holds onto one of the SLP's hands. The SLP jokes that she wants her hand back... The SLP holds her hand briefly, but taps the client's hand with her free one and lets go. [Case Conference Structured Observation]

Practitioners from multiple professions referred to their lack of professional training to justify the lack of attention to clients' sadness. Poor preparedness gave rise to palpable unease when clients broached grief-related emotional issues:

If they're grieving about their communication [deficits] then that's one thing, but if they're grieving about their life and, you know, their sense of self and they're depressed...I think that's bigger. [SLP Interview]

I sometimes feel like I am put in a little bit of a social worker role where I'm offering support to people or just kind of, someone to listen...but I don't have the

training to provide strategies or plans ...[S]o I feel a little bit out of my element there. [PT Interview]

After the Crash highlighted the emotional distress and unique care challenges that were raised by family care partners during the focus group research that informed the play. Similar research indicates that families experience significant difficulties managing TBI sequelae during inpatient rehabilitation, and often long after clients have been discharged (Kreutzer et al., 2009; Verhaeghe et al., 2005). The behaviour-related challenges faced by families are effectively portrayed in Scene 5 when a bedside physician describes the injuries of a comatose Elliott. An interlocutor perched on Elliott's hospital bed cheekily translates the medical terminology into colloquial terms for the audience:

Dr. Jeffreys: The patient may also exhibit extreme or difficult behaviour. This results in a mix of challenges including irritability, impatience, loss of temper, emotional volatility...

Translator: He may lash out.

Dr. Jeffreys: ...egocentrism, impulsiveness.

Translator: He may be self-centred.

Dr. Jeffreys: ...anxiety, and anhedonia.

Translator: He may get depressed.

Dr. Jeffreys: In the absence of effective intervention, over time this behaviour can cause loss of friendships, increase the burden for daily care and support on families, and result in a threat to the safety of others.

Translator: This is totally going to affect his family, big time.

Despite that TBI disabilities are known to affect the entire family system (Kreutzer, Sander, & Fernandez, 1997), pre-intervention data found staff often downplayed or ignored families' expressions of distress. Staff also interpreted the involvement of family members as intrusive:

We do probably 10% of what should be done [with family], you know, getting them on board. We blame the families all the time [when] they don't get it. Or we almost make them seem stupid or [that] they just are not interested...We're giving them so much education, why aren't they getting it? Well, it could be they're not ready for it...or it's just they haven't dealt with the actual emotions of things yet. Meanwhile, we're expecting them to be able to back off, you know, because now [that the client is] in rehab [not acute care], you've gotta see what [the client] can do. Well, no. And so, you know, we're not helping the family deal with things. [PSY Interview]

At times, this downplaying of family distress was masked by an emphasis on education about injury presentation. In one example, a speech language pathologist described how she emphasized to distressed family members the normalcy, in the context of Wernicke's aphasia, of their relative's fluid torrent of nonsensical, often unrecognizable words:

[H]is wife kept *bawling* her eyes out in here...every time she saw him...And, [during treatment] I would sit there and I'd talk to the daughter and the wife..."It's okay. This is normal. Everything." [SLP Interview, original emphasis]

The management of anger—Up to 45% of individuals with moderate to severe TBI demonstrate deficits in awareness (Freeland, 1996). Lack of self-awareness or reduced insight is associated with the overestimation of competencies, and underestimation of impairments (Prigatano & Klonoff, 1998). In turn, these are associated with poor treatment motivation and outcomes (Lam, McMahon, Priddy, & Gehred-Schultz, 1988), and difficulty in modifying behaviours based on feedback or generalizing to other situations (Sohlberg, Mateer, Penkman, Glang, & Todis, 1998). Staff were highly cognizant that many clients' cognitive injuries prevented a correct assessment of the loss of functional abilities. Comments included:

Lack of awareness is inherent in almost all brain injuries. It's very unusual for us to get somebody that says, "I can't do this anymore," [or] "I'm really bad at this." Most of them say, "Yeah, yeah" [dismissive tone]... [RT Interview]

[A]nother example would be a grocery outing or a kitchen assessment, and there's obvious impairment or safety risk [but] the person doesn't have the awareness to realize that. They say, "...Like, what do you mean? Of course I can do it!" [M]eanwhile you have to tell them, "You're not safe...Don't use the stove unsupervised because you forgot it on twice, and you burnt your food." [Mimics client's reply,] "I didn't burn it. That was just the butter frying." Like, they'll a lot of times come up with reasons why it happened. [OT Interview]

Alongside the overestimation of competencies (Sherer et al., 2003), lack of awareness of deficits often culminates in feelings of being unfairly restrained by family members and practitioners, and hence results in anger and irritability (Prigatano, 1991). As noted by the Chaplain during an interview:

And I've seen where some of the patients...get quite annoyed with their therapist, you know, when they are told the truth and the reality. And there's lots of anger issues, because they think they are the same way they were before.

This comment was echoed by many allied health practitioners who indicated that during therapy sessions, clients often lashed out because of directives:

[T]hey don't have that [cognitive] awareness [of deficits] so they [are] acting out in anger because well, "Why am I here?" You know, "I'm normal. Why can't I leave?" [OT Interview]

So a patient might say, "I don't need the seatbelt [on the wheelchair] 'cuz I can get up and walk." And you know their Berg [balance] scale might be like 12 out of 56 [high fall risk], and if they get up they're falling. But they don't know that, or they don't understand or internalize that...So that would be an instance where we can't always comply to the patient's desires or wants, and then they are furious. And that one happens a lot. [PT Interview]

In marked contrast to staff's discomfort with client grief, observations revealed that staff were adept at handling aggression. Nurses in particular demonstrated unique proficiency with the management of aggression through such techniques as bargaining or compromising, which McLaughlin and Erdman (1992) have found typifies the interventions of nurses in brain injury rehabilitation. In the following illustrative examples, nurses utilized behavioural management techniques such as rule explanation, positive reinforcement, limit setting, task redirection, and non-threatening eye contact in order to achieve and sustain therapeutic alliance. Nursing staff also engaged in self-care soothing techniques:

[The client] asks [RPN] why she has to be here to watch him eat. The RPN replies, "It's my job." The client, showing some [negative] attitude, asks her, "When you gonna quit?" The RPN joking replies, "In another a couple of years, I hope!" The client sharply says, "You're a pain in the ass." The RPN [referring to his eating] says, "You're doing good." In a sarcastic tone, the client says, "Are you happy now, Princess?" The RPN smiles and says, "I am."...The client says to the RPN, seemingly out of the blue, "I'm frustrated with you." She asks why, and he responds, "You're too much!" The RPN replies, "I do it [referring to supervising his eating] 'cuz - " The client finishes her sentence, and says, "- you care." The RPN says, "Yes." The client replies, "Well, I don't." The RPN offers some pudding to the client. He declines it, but the RPN reminds him that it's important to eat. The client...turns to her and says, "You bitch."...The RPN leans back in her chair, slightly shakes her head, and breathes in and out in an apparent attempt to calm herself down. She quickly sits up again, and watches him while he continues to eat. She reminds him to take small bites of food. He then gives her an 'evil eye' look. [RPN Unstructured Observation]

The client tells the RPN that he wants coffee from Tim Hortons™ [Canadian owned coffee franchise] which has a kiosk in the hospital lobby. She tells him that she can't leave the ward right now [to accompany him] but she can check if someone else can...The client says, "I'll go by myself. Call the cops - I don't give a shit!"...She tells him that she needs to make sure that he is safe. He replies, "Safe?! Are you fucking kidding me?" He exits the room to go to the elevators. The RN at the nursing station sees him walking by, and asks him to come join her....She adds, "I haven't seen you all day." The client says, "You'll get over it!" and continues down the hallway. The RPN follows him and asks, "You don't want Watchmate™ [an electronic wander prevention system that activates an alarm if the wearer approaches a door] anymore, right?" The client says, "No." She warns him that he is going to need to wear one if he does not follow instructions. He is now at the elevators, and the RPN tries to block him from pressing the buttons. He throws his hands up in the air and yells to the RPN, "Fuck Fuck you! Go home!"...The RN says that they are going to have to call security if he persists...He says "Fuck off!" to the RN. She looks at him and says, "Don't talk like that. C'mon, nurses are the fun ones." He says, "Screw yourself." The RN then asks him to say it again, and to look into her eyes when he says it. He says it again at her, but not with the same gusto. She says to him calmly, and with solid eye contact, "This is [says her own name]." She explains that they don't have nurses on the floor available to go with

him...She asks him to hang out with her again, and suggests that he make some phone calls...Turning away from the elevator...he tells her “No” quietly...He goes back to the direction of his room. [RPN and RN Unstructured Observation, original emphasis]

Unlike with grief expressions, staff did not experience the same degree of discomfort with their lack of qualifications when it came to addressing clients’ outbursts or other behaviours that could be traced directly to TBI cognitive impairments. For example, a client’s inappropriate sexual behaviour towards young female nursing assistants was deftly managed through the provision of emotional support to the client’s distraught wife, and the request by senior nurses for additional training for their junior colleagues who were unfamiliar with the clinical presentation of sexual disinhibition. Nurses also explained that intraprofessional mentorship was key to managing clients’ overt and subtle forms of aggression, and providing support to neutralize the fears or frustrations that may arise during client care:

So, when I came here, I saw [clients], like, some could be aggressive. Holy cow. You know, like, it was scary. It was very scary. I didn’t know how to approach [the clients]. [Names two senior nurses], so they’re the ones who would say, “Just get in there. And you tell [the clients] that they have to get up, and it’s not like, ‘Oh, okay’ [if they don’t want to]”...You just learn, you know. Yeah, your peers, really they help [teach you]. [RN Interview]

See, a lot of [new staff] take what the TBI patient will tell you very to heart...But you have to remember that that’s a new, learning brain. They’re learning new skills. ...And yes, [the client] might have swore at you right at this moment, but just leave him be and come back in five minutes, you’ll have a totally different person...I can give [new staff] a lot of information if I’m here while the situation’s happening... [RPN Interview]

Post-intervention

Still no place to grieve—Because an important tenet of CCC is the empathic capacity of the therapist to achieve an emic or insider understanding of the client’s and family’s perspective (Jamieson et al., 2006), it was intended that *After the Crash* assist the audience to identify with the characters. Staff identification and empathy with clients was deliberately cultivated through providing the play’s main characters with relatable backstories as educated professionals. Further, Trish morphed from an earnest care provider like themselves to a profoundly injured client. However, Trish’s backstory was so effective at evoking identification that, for some practitioners, it appeared to reinforce the ‘similar fate fear’ that was expressed prior to the intervention:

What about the physio...turning into a brain injury? Is that not our greatest fear?... We all think we’re gonna turn into our patients, it’s gonna happen to us...That’s very frightening. [RT Interview]

I could identify with the OT [in the play], almost slip into the character’s skin, and it was disturbing. Really. Like, terrifying. It’s a terrifying feeling to realize that tomorrow it could be you. It was *very* emotionally taxing. [OT Interview, original emphasis]

Although it was anticipated that staff identification would foster empathy and hence positive care relations, post-intervention data instead suggested that staff continued to deploy the same emotional distancing strategies that were identified pre-intervention. While they recognized the enormity of clients' losses, staff continued to stop short of empathizing:

When you see a play ...you will be temporary aware in your own practice. Yeah, I feel sorry, I feel sorry for that scenario, for the patient, but I know how realistically...how hard it is...to apply that to your job sometimes, and be always there and supportive...And you sometimes cannot deal with it yourself, and you have to protect yourself too. [RN Interview]

I mean the way I look at it is like, unless you're in the shoes of the patient or the wife, ...at the end of the day, [therapists] kind of pack our bags and go home. Thank goodness [nervous laughter]. [PT Interview]

Relationality—A relationality orientation attends to client interdependencies and reciprocities (Dewing, 2008; Nolan et al., 2002). In this study, the intervention effected a notable shift in staff's responses to relationality, operationally associated here with issues such as post-discharge familial relations, and sexual intimacy and friendship.

Familial relations—Post-discharge, families are often more distressed by the client's residual emotional impairments than by physical and language difficulties (Kreutzer, Gervasio, & Camplair, 1994). Tensions often arise during the re-establishment of family homeostasis and social routines due to clients' disinhibited behaviours or aggressiveness (Kreutzer et al., 1994). Thus, familial post-discharge struggle was an important theme captured in Scene 12, as Elliot plays Scrabble^{TM} (a crossword board game) with his wife Jane, and his brother and sister-in-law:

Celia: Ok. I'm pulling out the thirty-second rule. Thirty, twenty-nine, twenty-eight ...

Elliott: (*overwhelmed*) Can we just play the game?

Pete: Sure, yeah, Ok, here. (*puts down one letter*)

Celia: "AT"? That's your word?

(Laughter.)

Jane: Pete, that's seriously all you had?

Pete: Hey man, you took my spot, OK?

Jane: Yeah, that's it, go blaming your problems on someone else.

Celia: And the score is...[*holding up two fingers*]

Jane: (*to Elliott*) Elliott, do you need any help?

Elliott: I farted.

(Pause [Pete snickers].)

Jane: Elliott, it's your turn.

.... (*Elliott places some letters on the board.*)

All: (*looking at the board—all have a huge intake of breath*) Gasp!

Pete: “Penis.”

....Celia: Um, no, no, that’s ...

Pete: You can’t—it’s right beside the ...

Jane: It’s fine, you guys.

Pete [*joking*]: Elliott, you can’t put your “Penis” there.

Jane [*frustrated and embarrassed*]: It’s fine.

Pete [*acquiescing*]: Ok. How much do you get for “Penis”?

Jane: [*grabbing the pencil from Celia with frustration*] Ten points. [*writing the score*]

...Jane: I’m next ... All I got is “Penises.” And I get the whole word. Double score, so that makes it...

Celia: Double score! You’re evil.

Pete: Seems hardly fair that you benefit so much from “Penises.” (*begins to shake and move in a circular motion in his chair, absurdly, in false hilarity*) Of all words.

Jane: (*CELIA and JANE join in PETE’s shaking and moving in false hilarity*) Of all words? “Penises” is a perfectly legitimate word.

Pete: Yes, it’s LEGITIMATE, but...

Elliott [*shouting excitedly*]: (*trying to get in on the fun*) DOUBLE COCK!!

(PETE, CELIA, and JANE release from their absurd movements, as if they had been “natural” all along. Pause. They feel awkward.)

Jane [*chiding*]: Elliott...

The play’s portrayal of post-discharge family dynamics was cited as revelatory by staff. It was noted that social reintegration is beyond the remit of inpatient rehabilitation:

...That [family] stuff we don’t necessarily see here [in rehabilitation]. So we don’t see the beginning of the picture, we don’t see the end, we [only] see the middle. But I think this play brings into effect what happens in the beginning of acute care, and also what happens once the person’s out of our hospital system. [SW Interview]

While staff did not show an improvement in emotional support for TBI clients, staff did show significantly increased empathy regarding families’ experiences and struggles:

Like [in the play when] the wife took the husband home...She tried to get back into a normal routine playing that card game with the friends, or board game, whatever it was, and then, uh,...I guess in her world she was trying to normalize everything but then meanwhile, he’s not coping with this. And then you can see just her face

like, “Oh my God.” Like it was almost a realization, “Our lives are not the same anymore.” That hit me a little bit...just what they’re gonna go through in the community, after. [RN Interview]

And brain injury is socially isolating enough for the patient but, it must be *horribly* socially isolating for the caregiver because they’re totally cognitively intact, and now they’re carrying this extra burden and now their friends are probably leaving them behind. ...Seeing the uncomfortableness on the brother’s face [in Scene 12], and I think they even had this sidebar discussion, the [sister-in-law] to the brother saying, “I don’t want to come back here. This makes me so uncomfortable. Can’t handle this.” And knowing that they weren’t going to be coming back, or at least not as frequently, or at least when they did it was going to be under duress. And then, seeing how the wife was trying to make everything okay, you know, trying to keep them there, trying to just hold it together... [OT Interview, original emphasis]

Some practitioners used this new empathetic identification to mitigate earlier frustrations with the ways in which some family members and family care partners were behaving. It enabled staff to have greater patience:

...[T]he [client’s partner]...is starting to drive me crazy! Because this person is so so *so* super anxious that they’re sending their head injured partner off in a tantrum. And I can feel some of my emotions starting to get a little bit boiling under the skin. So what I do is I take a nice deep breath and realize that [the partner] is gonna need a *lot* more time [with health care providers] because when [the client] goes home, if that’s the way [the partner is] *here* now in our artificial, safe, and secure environment, it’s gonna be H-E-double toothpick when [the client] gets home. So if I can try...and appreciate what this [client] and the partner’s going through. [SW Interview, original emphasis]

...When you see family members being sometimes um, “What are you talking about!?” and “How come the [food] tray is late?” and like, really emotional statements and halfway angry statements...If it’s a one time thing, maybe it was just that day, who knows what kind of day they had? But if it’s repetitive...I try to check. Maybe there’s more to the whole patient-family scenario going on. [RN Interview]

Others practitioners were moved to provide family members and family care partners with individual supports following weekend passes. The following noteworthy example was provided by a registered nurse:

RN: Well, I’m asking them more often, like, “How are you doing?” Like especially when maybe the patient is not there, after they drop them off and they’re ready to leave. You just pull them aside, like, “How did [the weekend at home] really go?” Because a lot of times they don’t want to talk in front of the patient. So maybe just a bit more emotional contact with them.

Interviewer: And why do you feel that you’re tending more to their emotional needs?

RN: The big emotions the wife [in the play] had, it's like a lot. It's almost like a death, you know, because the person changes so much that she has to start coping with all of this new change, and so I think she really needed emotional support...I just remember how emotionally distraught she was. So...that makes me think more of the family side, of the emotional side.

Sexual intimacy and friendship—Trish's storyline was intended to demonstrate the struggles faced by TBI clients as they reestablished social relationships, as well as to critically expose institutionally-associated constraints against physical intimacy including the perceptions of practitioners as disapproving. In Scene 18, Trish's boyfriend, Alex, visits her in hospital. Although Trish has regained use of her arms, she is paralyzed from the waist down, and drools and slurs noticeably because of partial facial paralysis:

Trish [*coily patting the bed*]: The nurses aren't coming back for another half an hour. You want to climb in?

Alex [*resisting*]: I don't think I'm allowed.

Trish [*crestfallen, mouth drooping*]: I'm not exactly hot like this.

Alex [*moving further away*]: Um, I'm not exactly thinking about that right now.

Trish [*angry*]: You're not even looking at me.

Alex [*angry*]: Trish, you're in the hospital.

Trish [*pleading*]: Look, I'm not asking you to have sex with me, just hold me.

Alex [*anguished*]: I just don't want to...I just can't.

In response to this scene, post-intervention data evidenced new awareness of the importance of sexual intimacy for recovery, as well as the expression of clients' sexual identities. The awareness fostered acceptance and professional facilitation of the consensual sexuality of both gay and heterosexual clients:

Other parts of the play really stood out for me, but the part that *really* [stood out] was about the sexual intimacy. I think really and truly because we're seeing a lot of that on the floor. Especially with um, um homosexual patients. We're not used to seeing that, right?...[A client] was a Black person, and you rarely ever see - I'm going to stir this up right now, right? [laughs] - you rarely ever see, like, a Black gay person. That's not really common, right? And so after watching the play, I started like, whenever I go into a room and I see like a couple, you know, I show more respect. I'm not thinking "Okay, what is he doing here?" You know? Sometimes I'll see people lying in the bed together and I think "Oh, that's great! This is something that should be happening." [RN Interview, original emphasis]

Yet, despite evidence of normalizing the consensual sexuality of clients, staff were not observed to engage with clients about post-injury sexual dysfunction despite its noted frequency in other studies (see for example Miller, 1994). To illustrate, an observation of a social worker's pre-discharge session revealed that the practitioner solicited and addressed information regarding the client's ongoing physical and cognitive concerns. Yet, once he

received a positive response about the continuation of the client's relationship with his girlfriend, he did not enquire about any sexual functioning or performance issues that the client may have had:

[The client] is a young male with short spiky hair, and one obviously dilated eye. He has a deep scar on one side of his forehead from two bone flap surgeries that have left a large bony protrusion jetting out from his frontotemporal region. The SW says, "Your discharge date is one week today...How have things gone for you since you began rehab?" The client describes, haltingly, some persistent issues with vision, recall, and concentration. The SW responds that this is "normal" for someone who has sustained head trauma. He adds, "Some things will get better, and some things will need to be worked on with different strategies," and reviews the compensatory strategies the client has already learned such as writing things down. The SW comments that the patient's girlfriend has visited him on several occasions on the unit. He asks, "So, how are things with your girlfriend since your injury?" The client replies, "Things are going good." [There are no follow-up questions]...The SW then takes a few moments to summarize the client's progress in PT, OT and SLP...and with a smile on his face, jokingly concludes, "You have successfully graduated from the [names hospital] Hotel!" [SW Structured Observation]

Post-intervention, positive changes in facilitation of clients' non-sexual friendships and sociability with peers in hospital were also observed:

The SW asks the client about her friends. The client lights up a little and has a slight smile and brighter tone as she tells the SW that she has a great friend that visits her. The SW tells her that she's happy that she has a close friend, and lets her know that if she ever needs it, there is actually a quiet room that they could use if they ever want to talk privately. She tells the client that she can show her where the room is. [SW, Structured Observation]

Facilitating clients' sociability with friends also extended to discharge planning by multiple members of the rehabilitation team. When asked to elaborate on her claims to post-intervention practice change, a SLP replied,

An example is to ask [clients], "What can you not do now that you could do before that you want to do?" Then I usually get back responses, like yesterday, "Uh, I wanna go to Java Joe's^{TM} [Canadian owned coffee franchise], and I wanna talk to my friends again. Uh, and I can't get the words out. And I just wanna socialize and be with them." So I try to make that happen. In terms of the discharge planning process, I'm talking to the social worker and saying, "This is really important to him, that he goes to Java Joe's^{TM}." So, we have found him a new apartment close to Java Joe's^{TM}. He's gonna get a communication book [a picture or symbol book to assist with verbal expression] to help him. So I recognize better now why that's important. Who would have known that Java Joe's^{TM} is so important?

Discussion

This evaluation is the first to fully examine emotion work practices in the context of TBI specifically, and rehabilitation more generally. We surmise the novelty of our work is a consequence of rehabilitation's longstanding affinity with the biomechanical view of the body (Hammell, 2006) which precludes attention to emotional concerns.

We found that neurorehabilitation nurses and allied health practitioners alike suppressed the grief of clients, and expressed 'similar fate fear' that led to the suppression of empathy. These findings make a significant contribution to the emotion work field that has largely focused on the practices of nurses (Mann, 2005). Further, they challenge most nursing emotion work studies that herald nurses for their skills in emotional engagement, including addressing issues of loss, providing solace, or supporting emotional disclosures (see for example McCreight, 2005; Miller et al., 2008; Smith & Gray, 2000). The similarities in therapeutic emotion work practices amongst nursing and allied health practitioners in this study may be suggestive that there exists a unique climate (Coeling & Simms, 1996) or therapeutic landscape (Kontos et al., Forthcoming) specific to interprofessional brain injury rehabilitation that warrants further exploration.

Research has demonstrated that increased readiness to cry, what is termed "emotional lability" or "emotional incontinence" (McGrath, 2008, p. 262), is characteristic of neurological patients including those with TBI (McGrath, 2008). The volatile emotionalism of clients with TBI "can often be seen as a normal response to an abnormal situation" (McGrath, 2008, p. 262). It has also been found that TBI clients commonly fail to disclose distress to therapists, or to present with behaviours congruent with the seriousness of their distress (McGrath, 2008). In our study, staff responded to clients' emotionality by actively suppressing grief, discouraging or ignoring evidence of distress, and failing to enquire about emotional status in asymptomatic clients. Alone or in combination, these practices are concerning anti-therapeutic. As Mann (2004) notes, there are critical implications for the care relationship, as well as the well-being of the patient, when a care provider fails to display the appropriate emotion or displays an inappropriate one. It is likely such practices prevail given rehabilitation's embeddedness in the biomedical model, which emphasizes physical functioning and not emotional needs (Hammell, 2006; Papadimitriou, 2008), and reduces individuals to a catalogue of cognitive deficits and behaviour disorders (Kontos, 2003). Our findings suggest that the culture of rehabilitation needs to change in order to better support the emotional needs of clients. Contra Coetzer (2003), who identifies psychotherapy as the ideal profession within the rehabilitative field to help clients come to terms with grief and loss, a culture change of the nature we propose would require a collaborative effort amongst all rehabilitative staff. This needs to be an important focus for interprofessional education.

In this study, we suggest a link between staff suppression of the grief of clients and suppression of their own feelings of empathy. It is possible this is similar to the high levels of "self-monitoring" engaged in by US nurses who, in the context of managed care, opted for disengagement since resources to support emotion work were scant (Bone, 2002, p.146). In Canada, the enormity of clients' unmet rehabilitative and psychiatric needs under

inadequately publicly funded rehabilitative care (Kontos et al., Forthcoming; Kontos et al., 2012) may render staff unable to incorporate grief-related emotion work given existing demands of practice. It is also possible that practitioners' suppression of empathy is, as other studies have shown, a consequence of individual-level behaviours such as compassion fatigue (Robins, Meltzer, & Zelikovsky, 2009), discipline specific training (Papadimitriou, 2008), or institutional policy directives (Kontos et al., Forthcoming). However, our study is unique in linking the suppression of empathy by staff to their distress of identification with the fates of brain injured clients. This fear, which we term 'similar fate fear,' appeared to beget the suppression of client grief in order that staff protect themselves from further identification and consequent emotional harm. Indeed, similar fate fear was so pronounced that our theatrical strategy of fostering audience identification – by having Trish transition from earnest occupational therapist to brain injured client – served only to reinforce the already present fears of staff, and failed to prompt their empathetic connection with clients.

Research on cultural assumptions of loss due to cognitive impairment (Kontos, 2004, 2005, 2006; Kontos & Naglie, 2007a; Kontos, 2012) can inform our understanding of the nature of this fear. As Kontos has argued (2004, 2005), Alzheimer's disease and its kindred dementias are presumed to signal the erasure of selfhood, and to carry a sentence of social death. The loss of self so widely assumed to be a consequence of dementia has similarly been associated with TBI-related impairments in cognition, sensory processing, communication, and behaviour (Myles, 2004). Thus, it is likely that practitioners' fear of the enormity of their clients' losses is rooted in a much deeper cultural narrative about the erosion of selfhood, which, according to Western culture, defines our humanness. 'Similar fate fear' shares some kinship with the exaggerated worries of dementia care practitioners who envision themselves becoming cognitively impaired as they age (Beck, 1996). In dementia practitioners, however, placing themselves or a close relative in the 'shoes' of their care recipients, has not been found to suppress empathy (Kontos, Miller, & Mitchell, 2010; Kontos & Naglie, 2007a). The reasons for such profoundly different responses to fate-linked identification require further exploration. It is quite possible that educational interventions designed to address dominant narratives of loss of self in dementia practice (see for example Kontos, Mitchell, et al., 2010; Kontos & Naglie, 2007a, 2007b) could be an important resource for TBI practitioners.

Had 'similar fate fear' been raised during the original focus group study that informed the development of *After the Crash*, the play could have been scripted to address the cultural sources of such fear. We can only surmise that 'similar fate fear' was not discussed by focus group participants because of its taboo nature. Contrary to Kitzinger (1995), who suggests that focus groups can facilitate the discussion of taboo topics, we found that practitioners only disclosed 'similar fate fear' during interviews. This suggests that one-on-one interviews with staff might be a better data collection strategy than focus group discussions for exploring troubling perceptions of brain injury and their consequences for rehabilitative care practices.

The suppression of empathy for clients was in striking contrast to staff's post-intervention development of increased empathy for family and family care partners. *After the Crash* effectively raised awareness of the issues that families face when TBI clients reintegrate into

the community. Post-intervention emotion work practices included concern over the care responsibilities of family care partners, and better handling of family dynamics. The difference in staff response to family and family care partners may be attributable to their identification with them as burdened carers. Similar caregiver burdens have been found across formal and informal sectors (Noelker, 2001). This focus on care burden enabled staff to circumvent the examination of family members' grief concerning their relative or their own changed circumstance, and thus did not re-trigger 'similar fate fear.' Though such identification was positive in its facilitation of empathy, it is important to highlight the problematic nature of viewing clients as burdensome. Again tied to the biomedical model, notions of 'burden' restrict care and caring to the narrow parameters of task performance and the management of behaviours (Dupuis, Wiersma, & Loiselle, 2012).

Client anger and/or frustration was identified as another primary emotion that was highly implicated in the therapeutic emotion work undertaken by staff. Since staff attributed anger to poor insight, therapeutic emotion work strategies necessarily focused on rule explanation and limit setting rather than on exploring alternative aetiologies of anger. While the adeptness with which staff deescalated client anger was admirable, it does however suggest a denial of clients' tacit knowledge and personal agency that might otherwise be acknowledged if neurological deficits were not the sole explanatory framework for interpreting client responses. This is concerning given recent research that suggests that client outbursts can be a logical, predictable consequence of the poor environmental simulacra of 'home' within inpatient rehabilitation settings (Kontos et al., Forthcoming). Here, advances in dementia research may offer important insight regarding person-environment interaction, and the elicitation of embodied knowledge through environmental familiarity (Kontos, 2006; Kontos & Martin, 2013; Kontos & Naglie, 2009).

Sherwin and O'Shanick (2000) note that rehabilitation staff rarely broach with TBI clients issues of interpersonal relationships, intimacy or sexuality. Yet our post-intervention data revealed staff acceptance and facilitation of clients' consensual sexual activities, including those of sexual minority clients of whom some staff had commented they were previously unaware. This is significant given that many staff presume brain-injured clients are heterosexual, and that even benign neglect of sexual orientation can negatively impede rehabilitation progress (Mapou, 1990). Such new awareness should go a significant way in ameliorating the spatially-mediated emotion work undertaken by lesbian, gay, bisexual, transgender and intersex individuals (Currah, Juang, & Minter, 2006; Holmes, 2009; Kawale, 2004), who may find the rehabilitation environment yet another unsafe or heterosexist space.

While our post-intervention data revealed that staff newly accommodated clients' sexual needs, they failed to holistically support the emotional, relational, and identity issues associated with relationship intimacy. Yet since most individuals sustain TBI injuries during late adolescence and early adulthood (Crowe, 2008), holistic interventions are particularly critical to address the resolution of age-normative issues involving gender identity, sexual orientation, and relationship establishment that may be impaired by the neuropsychological and psychosocial impacts of TBI (Mapou, 1990). Nonetheless, in the face of organizational

barriers to facilitating sexual expression (White, 2002), it is significant that the intervention affected the shift that it did.

While the newfound facilitation of client sexuality is positive, neurorehabilitative therapeutic emotion work must also incorporate proactive concerns around coercive acts that may occur in the context of pre-existing intimate partner violence, including intimate partner sexual violence (Farrer, Frost, & Hedges, 2012; Miller, In press). This is particularly pressing since TBI is the most frequent emergency department presentation by female victims within two years of domestic homicide (Corrigan, Wolfe, Mysiw, Jackson, & Bogner, 2003; Wadman & Muelleman, 1999). Appropriate assessments and interventions that address clients' interpersonal safety needs may be critical to breaking the cycle of violence and abuse in heterosexual as well as homosexual relationships in hospital and community (Kwako et al., 2011; Langlois et al., 2008; Miller & Du Mont, 2000). It would also address some of the high-risk legal and moral conundra that rehabilitation facilities identify in relation to intimate contact by clients (Banja, 1993; Davis & Schneider, 1990). Staff cautionary surveillance should also apply to intimate partners in previously non-abusive relationships, since they have been shown to be at increased risk of verbal abuse, threats of physical violence, and overt aggression due to clients' TBI-related increases in irritability levels, temper outbursts, or alcohol use (Farrer et al., 2012).

Conclusion

Jamieson et al. (2006) argues that the foundation of CCC is the capacity of health care workers to empathize with clients and families. Although *After the Crash* had little impact on the empathy felt by staff, it was particularly effective at improving their responses to issues involving relationality. The demonstration at 12 months post-intervention that staff continued to reflect on the portrayal of the struggles around familial dynamics, friendship, and client sexuality provides important evidence of the long-term efficacy of theatre as an education strategy for interprofessional neurorehabilitation practitioners in the realm of relationality and clients' post-discharge functioning.

This study demonstrates that the dramatic arts are well positioned to improve therapeutic emotion work, and thereby foster cultures of best practice. Emotion work practices have yet to be the focus of initiatives to improve the quality of health care. Thus, an important direction for future inquiry in brain injury rehabilitation specifically, but also more generally in other clinical areas, is an alliance of the performance paradigm, emotion work praxis, and health services research.

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References

- Al-Adawi S, Dorvlo AS, Al-Naamani A, Glenn MB, Karamouz N, Chae H, Burke DT. The ineffectiveness of the Hospital Anxiety and Depression Scale for diagnosis in an Omani traumatic brain injured population. *Brain Injury*. 2007; 21(4):385–393. [PubMed: 17487636]
- Banja JD. Moral sensitivity, sodomy laws, and traumatic brain injury rehabilitation. *Journal of Head Trauma Rehabilitation*. 1993; 8(1):116–119.
- Bartram T, Casimir G, Djurkovic N, Leggat SG, Stanton P. Do perceived high performance work systems influence the relationship between emotional labour, burnout and intention to leave? A study of Australian nurses. *Journal of Advanced Nursing*. 2012; 68(7):1567–1578. [PubMed: 22384981]
- Beck CT. Nursing students' experiences caring for cognitively impaired elderly people. *Journal of Advanced Nursing*. 1996; 23(5):992–998. [PubMed: 8732528]
- Blackmer J. The unique ethical challenges of conducting research in the rehabilitation medicine population. *BMC Medical Ethics*. 2003; 4(2) Retrieved from <http://www.biomedcentral.com/1472-6939/4/2>.
- Bone D. Dilemmas of emotion work in nursing under market-driven health care. *International Journal of Public Sector Management*. 2002; 15(2):140–150.
- Bowen G. Grounded theory and sensitizing concepts. *International Journal of Qualitative Methods*. 2008; 5(3):12–23.
- Bruns J, Hauser WA. The epidemiology of traumatic brain injury: A review. *Epilepsia*. 2003; 44(S10): 2–10.
- Bryant RA, Marosszeky JE, Crooks J, Baguley IJ, Gurka J. Posttraumatic stress disorder and psychosocial functioning after severe traumatic brain injury. *The Journal of Nervous and Mental Disease*. 2001; 189(2):109–113. [PubMed: 11225683]
- Caro DH. Traumatic brain injury care systems: 2020 transformational challenges. *Global Journal of Health Science*. 2011; 3(1):19–29.
- Carpenter, KN. Acute neuropsychological rehabilitation services. In: Tyerman, A., King, NS., editors. *Psychological approaches to rehabilitation after traumatic brain injury*. Malden, MA: BPS Blackwell; 2008. p. 17–38.
- Carroll E, Coetzer R. Identity, grief and self-awareness after traumatic brain injury. *Neuropsychological Rehabilitation: An International Journal*. 2011; 21(3):289–305.
- Coeling HE, Simms LM. Understanding work group culture on rehabilitation units: The key to facilitating group innovation and promoting integration. *Rehabilitation Nursing*. 1996; 21(1):7–12. [PubMed: 8577983]
- Coetzer BR. Grief following traumatic brain injury. *Grief Matters: The Australian Journal of Grief and Bereavement*. 2003; 6(2):31–33.
- Colantonio A, Gerber G, Bayley M, Deber R, Yin J, Kim H. Differential profiles for patients with traumatic and non-traumatic brain injury. *Journal of Rehabilitation Medicine*. 2011; 43(4):311–315. [PubMed: 21347507]
- Colantonio A, Kontos P, Gilbert J, Rossiter K, Gray J, Keightley M. After the Crash: A research-based theatre approach for knowledge translation on traumatic brain injury. *Journal of Continuing Education in the Health Professions*. 2008; 28(3):1–6. [PubMed: 18366124]
- Colantonio A, Saverino C, Zagorski B, Swaine B, Lewko J, Jaglal S, Vernich L. Hospitalizations and emergency department visits for TBI in Ontario. *The Canadian Journal of Neurological Sciences*. 2010; 37(6):783–790. [PubMed: 21059539]
- Corrigan JD, Wolfe M, Mysiw WJ, Jackson RD, Bogner JA. Early identification of mild traumatic brain injury in female victims of domestic violence. *American Journal of Obstetrics and Gynecology*. 2003; 188(5):S71–S76. [PubMed: 12748454]
- Cott C. Client-centred rehabilitation: Client perspectives. *Disability and Rehabilitation*. 2004; 26(24): 1411–1422. [PubMed: 15764361]
- Crowe, SF. *The behavioural and emotional complications of traumatic brain injury*. New York, NY: Taylor & Francis; 2008.

- Cullen N, Chundamala J, Bayley M, Jutai J. The efficacy of acquired brain injury rehabilitation. *Brain Injury*. 2007; 21(2):113–132. [PubMed: 17364528]
- Currah, P.Juang, RM., Minter, S., editors. *Transgender rights*. Minneapolis, MN: University of Minnesota Press; 2006.
- Davidson J, Milligan C. Embodying emotion sensing space: Introducing emotional geographies. *Social & Cultural Geography*. 2004; 5(4):523–532.
- Davis DL, Schneider LK. Ramifications of traumatic brain injury for sexuality. *The Journal of Head Trauma Rehabilitation*. 1990; 5(2):31–37.
- Dewing J. Personhood and dementia: Revisiting Tom Kitwood's ideas. *International Journal of Older People Nursing*. 2008; 3(1):3–13. [PubMed: 20925884]
- Dingwall R, Allen D. The implications of healthcare reforms for the profession of nursing. *Nursing Inquiry*. 2001; 8(2):64–74. [PubMed: 11882204]
- Dupuis S, Wiersma E, Loiselle L. Pathologizing behavior: Meanings of behaviors in dementia care. *Journal of Aging Studies*. 2012; 26:162–173.
- Dupuis SL, Gillies J. Learning as a vehicle for individual and social transformation: Re-thinking leisure education. *Therapeutic Recreation Journal*. 2014; 48(2):113–134.
- Dupuis SL, Gillies J, Mitchell GJ, Jonas-Simpson C, Whyte C, Carson J. Catapulting shifts in images, understandings, and actions for family members through research-based drama. *Family Relations*. 2011; 60:104–120.
- Dyck I. Feminist geography, the 'everyday', and local–global relations: Hidden spaces of place-making. *The Canadian Geographer/Le Géographe Canadien*. 2005; 49(3):233–243.
- Farley M. "Bad for the body, bad for the heart": Prostitution harms women even if legalized or decriminalized. *Violence Against Women*. 2004; 10(10):1087–1125.
- Farrer TJ, Frost RB, Hedges DW. Prevalence of traumatic brain injury in intimate partner violence offenders compared to the general population: A meta-analysis. *Trauma Violence Abuse*. 2012; 13(2):77–82. [PubMed: 22467643]
- Fitzgerald RP, Legge M, Frank N. When biological scientists become health-care workers: Emotional labour in embryology. *Human Reproduction*. 2013; 28(5):1289–1296. [PubMed: 23508251]
- Fogel C. Presenting the naked self: The accumulation of performative capital in the female strip trade. *Gender Forum Issue*. 2007; 17:1–17.
- Freeland J. Awareness of deficits: A complex interplay of neurological, personality, social and rehabilitation factors. *Magazine*. 1996; 4:32–34.
- Gold R. The ethnographic method in sociology. *Qualitative Inquiry*. 1997; 3(4):387–402.
- Grandey A, Foo SC, Groth M, Goodwin RE. Free to be you and me: A climate of authenticity alleviates burnout from emotional labor. *Journal of Occupational Health Psychology*. 2012; 17(1):1. [PubMed: 21875210]
- Gray J, Rossiter K, Colantonio A, Kontos P, Gilbert J, Keightley M, Prince M. After the Crash: A play about brain injury. *Canadian Theatre Review*. 2011; 146:66–86.
- Gray R, Fitch M, Labrecque M, Greenberg M. Reactions of health professionals to a research-based theatre production. *Journal of Cancer Education*. 2003; 18(4):223–229. [PubMed: 14766333]
- Gray R, Sinding C, Ivonoffski V, Fitch M, Hampson A, Greenberg M. The use of research-based theatre in a project related to metastatic breast cancer. *Health Expectations*. 2000; 3:137–144. [PubMed: 11281920]
- Hammell, KW. *Perspectives on disability & rehabilitation: Contesting assumptions, challenging practice*. Edinburgh, Scotland: Churchill Livingstone; 2006.
- Hochschild, AR. *The managed heart: Commercialization of human feeling*. Berkeley, CA: University of California Press; 1983.
- Holmes, Dave. Governing the captives: Forensic psychiatric nursing in corrections. *Perspectives in Psychiatric Care*. 2005; 41(1):3–13. [PubMed: 15822847]
- Holmes, M., editor. *Critical intersex*. Farnham, Surrey, United Kingdom: Ashgate Publishing, Ltd; 2009.
- Hunter B. Emotion work in midwifery: A review of current knowledge. *Journal of Advanced Nursing*. 2001; 34(4):436–444. [PubMed: 11380710]

- Jamieson M, Krupa T, O’Riordan A, O’Connor D, Paterson M, Ball C, Wilcox S. Developing empathy as a foundation of client-centred practice: Evaluation of a university curriculum initiative. *Canadian Association of Occupational Therapists*. 2006; 73(2):79–85.
- Jennett, B., Teasdale, G. *Management of head injuries*. Philadelphia, PA: F.A. Davis Co; 1981.
- Jonas-Simpson C, Mitchell GJ, Carson J, Whyte C, Dupuis S, Gillies J. Phenomenological shifts for healthcare professionals after experiencing a research-based drama on living with dementia. *Journal of Advanced Nursing*. 2012; 68(9):1944–1955. [PubMed: 22082306]
- Jorge RE, Robinson RG, Moser D, Tateno A, Crespo-Facorro B, Arndt S. Major depression following traumatic brain injury. *Archives of General Psychiatry*. 2004; 61:42–50. [PubMed: 14706943]
- Jumisko E, Lexell J, Soderberg S. The meaning of living with traumatic brain injury in people with moderate or severe traumatic brain injury. *Journal of Neuroscience Nursing*. 2005; 37(1):3–58. [PubMed: 15794438]
- Karlawish JHT. Research involving cognitively impaired adults. *New England Journal of Medicine*. 2003; 348(14):1389–1392. [PubMed: 12672869]
- Kawale R. Inequalities of the heart: The performance of emotion work by lesbian and bisexual women in London, England. *Social & Cultural Geography*. 2004; 5(4):565–581.
- Kim E. Agitation, aggression, and disinhibition syndromes after traumatic brain injury. *NeuroRehabilitation*. 2002; 17(4):297–310. [PubMed: 12547978]
- Kitzinger J. Qualitative research: Introducing focus groups. *British Medical Journal*. 1995; 311(7000): 299–302. [PubMed: 7633241]
- Kontos P. ‘The painterly hand’: Embodied consciousness and Alzheimer’s disease. *Journal of Aging Studies*. 2003; 17:151–170.
- Kontos P. Ethnographic reflections on selfhood, embodiment and Alzheimer’s disease. *Ageing & Society*. 2004; 24:829–849.
- Kontos P. Embodied selfhood in Alzheimer’s disease: Rethinking person-centred care. *Dementia: The International Journal of Social Research and Practice*. 2005; 4(4):553–570.
- Kontos, P. Embodied selfhood: An ethnographic exploration of Alzheimer’s disease. In: Cohen, L., Leibing, A., editors. *Thinking about dementia: Culture, loss, and the anthropology of senility*. New Brunswick, NJ: Rutgers University Press; 2006. p. 195–217.
- Kontos P, Martin W. Embodiment and dementia: Exploring critical narratives of selfhood, surveillance, and dementia care. *Dementia*. 2013; 12(3):288–302. [PubMed: 24336852]
- Kontos, P., Miller, KL., Cott, C., Colantonio, A. Therapeutic landscape: Rethinking ‘place’ in client-centred brain injury rehabilitation. In: McPherson, K., Gibson, B., editors. *Rethinking theory and practice in rehabilitation*. Australia: Elsevier; Forthcoming
- Kontos P, Miller KL, Mitchell GJ. Neglecting the importance of the decision making and care regimes of personal support workers: A critique of standardization of care planning through the RAI/MDS. *The Gerontologist*. 2010; 50(3):352–362. [PubMed: 20026525]
- Kontos P, Mitchell GJ, Mistry B, Ballon B. Using drama to improve person-centred dementia care. *International Journal of Older People Nursing*. 2010; 5:159–168. [PubMed: 20925717]
- Kontos P, Naglie G. Bridging theory and practice: Imagination, the body, and person-centred dementia care. *Dementia: The International Journal of Social Research and Practice*. 2007a; 6(4):549–569.
- Kontos P, Naglie G. ‘Expressions of personhood in Alzheimer’s disease’: An evaluation of research-based theatre as a pedagogical tool. *Qualitative Health Research*. 2007b; 17(6):799–811. [PubMed: 17582022]
- Kontos P, Naglie G. Tacit knowledge of caring and embodied selfhood. *Sociology of Health & Illness*. 2009; 31(5):688–704. [PubMed: 19392935]
- Kontos P, Poland B. Mapping new theoretical and methodological terrain for knowledge translation: Contributions from critical realism and the arts. *Implementation Science*. 2009; 4(1) Retrieved from <http://www.implementationscience.com/content/pdf/1748-5908-4-1.pdf>.
- Kontos PC. Rethinking sociability in long-term care: An embodied dimension of selfhood. *Dementia: The International Journal of Social Research and Practice*. 2012; 11(3):329–346.

- Kontos PC, Miller KL, Gilbert JE, Mitchell GJ, Colantonio A, Keightley ML, Cott C. Improving client-centered brain injury rehabilitation through research-based theater. *Qualitative Health Research*. 2012; 22(12):1612–1632. [PubMed: 22941919]
- Kreutzer J, Rapport LJ, Marwitz JH, Harrison-Felix C, Hart T, Glenn M, Hammond F. Caregivers' wellbeing after traumatic brain injury: A multicenter prospective investigation. *Archives of Physical Medicine and Rehabilitation*. 2009; 90:939–946. [PubMed: 19480869]
- Kreutzer J, Sander A, Fernandez C. Misperceptions, mishaps, and pitfalls in working with families after traumatic brain injury. *Journal of Head Trauma and Rehabilitation*. 1997; 12(6):63–73.
- Kreutzer JS, Gervasio AH, Camplair PS. Primary caregivers' psychological status and family functioning after traumatic brain injury. *Brain Injury*. 1994; 8(3):197–210. [PubMed: 8004079]
- Kwako LE, Glass N, Campbell J, Melvin KC, Barr T, Gill JM. Traumatic brain injury in intimate partner violence: A critical review of outcomes and mechanisms. *Trauma Violence Abuse*. 2011; 12(3):115–126. [PubMed: 21511686]
- Lam CS, McMahon BT, Priddy DA, Gehred-Schultz A. Deficit awareness and treatment performance among traumatic head injury adults. *Brain Injury*. 1988; 2(3):235–242. [PubMed: 3251475]
- Langlois JA, Hall J, Breiding M, Reichard AA, McDonnell A, Wald M. Breaking the silence: Violence as a cause and a consequence of traumatic brain injury. *Brain Injury Professional*. 2008; 5(1):8–12.
- Law M, Baptiste S, Mills J. Client-centred practice: What does it mean and does it make a difference? *Canadian Association of Occupational Therapists*. 1995; 62(5):250–257.
- Le Compte, MD., Preissle, J. *Ethnographic and qualitative design in educational research*. San Diego, CA: San Diego Academic Press; 1993.
- Lewis P. Emotion work and emotion space: Using a spatial perspective to explore the challenging of masculine emotion management practices. *British Journal of Management*. 2008; 19(S1):S130–S140.
- Lincoln, YS., Guba, EG. *Naturalistic inquiry*. Thousand Oaks, CA: Sage Publications; 1985.
- Maitra K, Erway F. Perception of client-centered practice in occupational therapists and their clients. *American Journal of Occupational Therapy*. 2006; 60(3):298–310. [PubMed: 16776397]
- Mann S. 'People-work': Emotion management, stress and coping. *British Journal of Guidance & Counselling*. 2004; 32(2):205–221.
- Mann S. A health-care model of emotional labour: An evaluation of the literature and development of a model. *Journal of Health Organization and Management*. 2005; 19(4/5):304–317. [PubMed: 16206916]
- Mapou RL. Traumatic brain injury rehabilitation with gay and lesbian individuals. *Journal of Head Trauma Rehabilitation*. 1990; 5(2):67–72.
- Mays N, Pope C. Assessing quality in qualitative research. *British Medical Journal*. 2000; 320(7226):50–52. [PubMed: 10617534]
- McCreight BS. Perinatal grief and emotional labour: A study of nurses' experiences in gynae wards. *International Journal of Nursing Studies*. 2005; 42(4):439–448. [PubMed: 15847906]
- McGrath, JC. Fear, anxiety and depression. In: Tyerman, A., King, NS., editors. *Psychological approaches to rehabilitation after traumatic brain injury*. Malden, MA: Blackwell Publishing; 2008. p. 260-293.
- McKeever P, O'Neill S, Miller KL. Managing space and marking time: Mothering severely ill infants in hospital isolation. *Qualitative Health Research*. 2002; 12(8):1020–1032. [PubMed: 12365586]
- McLaughlin AM, Erdman J. Rehabilitation staff stress as it relates to patient acuity and diagnosis. *Brain Injury*. 1992; 6(1):59–64. [PubMed: 1739853]
- Menon DK, Schwab K, Wright DW, Maas AI. Position statement: Definition of traumatic brain injury. *Archives of Physical Medicine and Rehabilitation*. 2010; 91(11):1637–1640. [PubMed: 21044706]
- Mieniczakowski, J. *Syncing out loud: A journey into illness*. Brisbane, Australia: Griffith University Reprographics; 1992.
- Mieniczakowski, J., Morgan, S. *Busting: The challenge of the drought spirit*. Brisbane, Australia: Griffith University Reprographics; 1993.
- Miller KL. Relational caring: The use of the victim impact statement by sexually assaulted women. *Violence and Victims*. In press.

- Miller KL, Du Mont J. Countless abused women: Homeless and inadequately housed. *Canadian Woman Studies*. 2000; 20(3)
- Miller KL, Kontos PC. The intraprofessional and interprofessional relations of neurorehabilitation nurses: A negotiated order perspective. *Journal of Advanced Nursing*. 2012
- Miller KL, Reeves S, Zwarenstein M, Beales JD, Kenaszchuk C, Conn LG. Nursing emotion work and interprofessional collaboration in general internal medicine wards. *Journal of Advanced Nursing*. 2008; 64(4):332–343. [PubMed: 18990112]
- Miller L. Sex and the brain-injured patient: Regaining love, pleasure, and intimacy. *Journal of Cognitive Rehabilitation*. 1994; 12(3):12–20.
- Mirchandani K. Challenging racial silences in studies of emotion work: Contributions from anti-racist feminist theory. *Organization Studies*. 2003; 24(5):721–742.
- Miyata H, Kai I. Reconsidering evaluation criteria for scientific adequacy in health care research: An integrative framework of quantitative and qualitative criteria. *International Journal of Qualitative Methods*. 2009; 8(1):64–75.
- Myles SM. Understanding and treating loss of sense of self following brain injury: A behavior analytic approach. *International Journal of Psychology and Psychological Therapy*. 2004; 4(3):487–504.
- National Institute of Neurological Disorders and Strokes. Traumatic brain injury: Hope through research. 2002. Retrieved July 23, 2010, from http://www.ninds.nih.gov/disorders/tbi/detail_tbi.htm
- Noelker LS. The backbone of the long-term-care workforce. *Generations*. 2001; 25(1):85–91.
- Nolan M, Ryan T, Enderby P, Reid D. Towards a more inclusive vision of dementia care practice and research. *Dementia*. 2002; 1(2):193–211.
- Papadimitriou C. ‘It was hard but you did it’: The co-production of ‘work’ in a clinical setting among spinal cord injured adults and their physical therapists. *Disability and Rehabilitation*. 2008; 30(5):365–374. [PubMed: 17852300]
- Patton, MQ. *Qualitative evaluation and research methods*. Newbury Park, CA: Sage; 1990.
- Pegg PO, Auerbach S, Seel R, Buenaver L, Plybon L, Kiesler D. The impact of patient-centered information on patients’ treatment satisfaction and outcomes in traumatic brain injury rehabilitation. *Rehabilitation Psychology*. 2005; 50(4):366–374.
- Phyllis R, Farls K. Pathophysiology of traumatic brain injury. *Critical Care Nursing Quarterly*. 2000; 23(3):14–25. [PubMed: 11852935]
- Pierce, JL. *Gender trials: Emotional lives in contemporary law firms*. Berkeley, CA: University of California Press; 1995.
- Prigatano, GP. Disturbances of self-awareness of deficit after traumatic brain injury. In: Prigatano, GP., Schacter, DL., editors. *Awareness of deficit after brain injury: Clinical and theoretical issues*. New York, NY: Oxford University Press; 1991. p. 111–126.
- Prigatano GP, Klonoff PS. A clinician’s rating scale for evaluating impaired. Self-awareness and denial of disability after brain injury. *The Clinical Neuropsychologist*. 1998; 12(1):56–67.
- Rafaeli A, Worline M. Individual emotion in work organizations. *Social Science Information*. 2001; 40(1):95–123.
- Robins PM, Meltzer L, Zelikovsky N. The experience of secondary traumatic stress upon care providers working within a children’s hospital. *Journal of Pediatric Nursing*. 2009; 24(4):270–279. [PubMed: 19632504]
- Roizenbeek B, Maas AIR, Menon DK. Changing patterns in the epidemiology of traumatic brain injury. *Nature Reviews Neurology*. 2013; 9:231–236. [PubMed: 23443846]
- Rossiter K, Gray J, Kontos P, Keightley M, Colantonio A, Gilbert J. From page to stage: Dramaturgy and the art of interdisciplinary translation. *Journal of Health Psychology*. 2008; 13(2):277–286. [PubMed: 18375632]
- Sanders T. ‘It’s just acting’: Sex workers’ strategies for capitalizing on sexuality. *Gender, Work and Organization*. 2005; 12(4):319–342.
- Shapiro J, Hunt L. All the world’s a stage: Theatrical performance in medical education. *Medical Education*. 2003; 37(10):922–927. [PubMed: 12974849]

- Sherer M, Hart T, Nick TG, Whyte J, Thompson RN, Yablon SA. Early impaired self-awareness after traumatic brain injury. *Archives of Physical Medicine and Rehabilitation*. 2003; 84(2):168–176. [PubMed: 12601646]
- Sherwin ED, O'Shanick GJ. Subject review - The trauma of paediatric and adolescent brain injury: Issues and implications for rehabilitation specialists. *Brain Injury*. 2000; 14(3):267–284. [PubMed: 10759044]
- Skjørshammer, Morten. Anger behaviour among professionals in a Norwegian hospital: Antecedents and consequences for interprofessional cooperation. *Journal of Interprofessional Care*. 2003; 17(4):377–388. [PubMed: 14763341]
- Smith, P., Gray, B. The emotional labour of nursing: How student and qualified nurses learn to care; A report on nurse education, nursing practice and emotional labour in the contemporary NHS. London, United Kingdom: South Bank University, Faculty of Health; 2000.
- Sohlberg MM, Mateer CA, Penkman L, Glang A, Todis B. Awareness intervention: Who needs it? *The Journal of Head Trauma Rehabilitation*. 1998; 13(5):62–78. [PubMed: 9753536]
- Spano R. Potential sources of observer bias in police observational data. *Social Science Research*. 2005; 34(3):591–617.
- Sumsion T, Law M. A review of evidence on the conceptual elements informing client-centred practice. *Canadian Journal of Occupational Therapy*. 2006; 73(3):153–162.
- Toglia J, Kirk U. Understanding awareness deficits following brain injury. *NeuroRehabilitation*. 2000; 15:57–70. [PubMed: 11455082]
- Tracy SJ. Qualitative quality: Eight “big-tent” criteria for excellent qualitative research. *Qualitative Inquiry*. 2010; 16(10):837–851.
- Turk, MA., Scandale, J. Training and certification of care providers for persons sustaining TBI. In: Zasler, ND, Katz, DI., Zafonte, RD., editors. *Brain injury medicine: Principles and practice*. New York, NY: Demos Medical Publishing; 2007. p. 27-32.
- Verhaeghe S, Defloor T, Grypdonck M. Stress and coping among families of patients with traumatic brain injury: A review of the literature. *Journal of Clinical Nursing*. 2005; 14:1004–1012. [PubMed: 16102152]
- Wadman MC, Muelleman RL. Domestic violence homicides: ED use before victimization. *The American Journal of Emergency Medicine*. 1999; 17(7):689–691. [PubMed: 10597091]
- Wharton AS. The sociology of emotional labor. *Annual Review of Sociology*. 2009; 35:147–165.
- White, I. Facilitating sexual expression: Challenges for contemporary practice. In: Heath, H., White, I., editors. *The challenge of sexuality in health care*. Malden, MA: Blackwell Science, Inc; 2002. p. 243-263.
- Williams A. Emotion work in paramedic practice: The implications for nurse educators. *Nurse Education Today*. 2012; 32(4):368–372. [PubMed: 21640449]
- Wilson, SR. Traumatic brain injury and intimate partner violence. In: Mitchell, C., Anglin, D., editors. *Intimate partner violence: A health based perspective*. New York, NY: Oxford University Press; 2009. p. 183-200.
- Wood RL, Liossi C, Wood L. The impact of head injury neurobehavioural sequelae on personal relationships: Preliminary findings. *Brain Injury*. 2005; 19(10):845–851. [PubMed: 16175844]