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

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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 across clinical specialties in the emotion work demands placed upon health care staff 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 and care burden and rewards, and 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 efforts by staff have 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 lapse given the emotional impact that TBI has on both the survivor and family members (Carroll & Coetzer 2011; Kreutzer et al. 2009;
which is 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 consequence, educational initiatives have been proposed to address health care practitioners’ perceptions of 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 (Mienczakowski 1992), substance abuse (Mienczakowski & 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 script are provided to identify the specific scenes that sustained 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 between the performance paradigm, emotion work, 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 since broadened to ‘emotion work’, which includes autonomous and discretionary affective practices that are undertaken by 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 their contractual obligations (Pierce 1995). Emotion work is also often racialized since as Mirchandani (2003, p. 737) comments, “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 Centered Rehabilitation
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. Globally, it is the most common cause of death and disability for those younger than 45 years of age (Caro 2011). 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 as 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. 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), causing anxiety (Al-Adawi et al. 2007), depression (Al-Adawi et al. 2007; Jorge et al. 2004), and posttraumatic stress (Bryant, Marosszey, 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 an exception see Colantonio et al. 2008; 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).
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 basis for the play. 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 participating neurorehabilitation units (Facility A, 32 beds; Facility B, 27 beds) of two inpatient rehabilitation hospitals.

Participants

Informed consent by proxy (Karlawish 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), informed by a literature search that identified those health care disciplines most commonly associated with inpatient TBI rehabilitation settings (Turk & Scandale 2007), was used to purposively sample (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 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 sites pre-intervention, 3PI and 12PI.

Naturalistic observations of structured and unstructured interactions

Naturalistic observations were conducted of a range of structured and unstructured activities (Kontos 2004; 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 interdisciplinary team to discuss client progress); case conference planning meetings (30-minute meetings involving the interdisciplinary team to prepare for future discharge planning or family meetings); and discharge planning or family meetings (1-hour meetings involving the interdisciplinary team, client, family, and often a legal representative and insurance adjuster to discuss discharge and post-discharge care, or client progress). Unstructured activities included practitioners working together or with clients for care or information sharing. 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, capturing the ways in which therapeutic care activities, goal setting, and communication strategies were consistent or inconsistent with the principles of CCC.

Interviews

Ninety audiotaped, semi-structured interviews lasting approximately 60 minutes 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 institutional practice. Specifically: 1) injury impacts on clients’ relationships, routines and quality of life from the staff’s perspective; 2) the rehabilitation 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 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 expression (e.g. frustration) and emotional management (e.g. the control of outbursts) within staff, family, and client interactions. These 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 expression 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, for example, by 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 data. Finally,
transferability was addressed with the provision of sufficient detail 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 the controlling of client emotions, specifically the suppression of client and family grief, and the proficient management of client 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 and spouses. Post-intervention analysis indicated the play evoked significant changes in a “relationality” (Dewing 2008; Nolan, Ryan, Enderby, & Reid 2002) orientation by staff, specifically, improvements in relating to family care-partners, and in supporting 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 to manage 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’ injury responses 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 recognition of the need for, or logic of, rehabilitation directives. Staff’s differential approaches to clients’ 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 loss of ability and livelihood:

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 of themselves or their loved ones incurring 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’ invoked was **emotional self-protection**, which included 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 teeth. [RN Interview]

When directed outwards towards clients, staff’s self-protective strategies led to their active suppression of client’s grief reactions. To do so, staff actively discouraged clients from crying, redirected those in distress, and avoided topics that might provoke upset in clients. 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 at 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 disciplines justified their lack of attention to client sadness by reference to their lack of training. Lack of 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* was also intended to highlight the emotional distress and unique care challenges experienced by family care-partners. Research indicates that care-partners experience significant difficulty managing TBI sequelae during inpatient rehabilitation and often long after the client has been discharged (*Kreutzer et al. 2009; Verhaeghe et al. 2005*). This is 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 (*Kreuter, Sander, & Fernandez 1997*), pre-intervention data found staff often downplayed or ignored families’ expressions of distress. Staff also found intrusive the involvement of family:

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 members deal with things. [PSY Interview]

At times, this downplaying of family distress was masked with an emphasis on education about injury presentation. For example, a speech language pathologist described how she would emphasize to distressed family members the normalcy – in the context of Wernike’s aphasia – of their relative’s fluent, nonsensical use of 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 care 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 families and practitioners, and hence anger, and irritability (Prigatano 1991). As noted by the Chaplain:

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

(S)ome of them are going through anger because…they don’t understand why they’re here. (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?”

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.

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. They 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 jokingly 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, overt sexual behaviour towards young female nursing assistants was deftly managed through the provision of emotional support to the client’s wife, and additional training for nurses unfamiliar with the clinical presentation of 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 [them]. [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, [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. So effective was Trish’s backstory in evoking identification that for some practitioners it appeared to reinforce the ‘similar fate fear’ that was expressed prior to the start of 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 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 affected 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’ disinhibition or aggression (Kreutzer et al. 1994). Thus, familial post-discharge struggles was an important theme captured in Scene 12, as Elliot plays Scrabble™ (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 frustration with the
ways some family members 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 with individual support following
weekend passes. The following example provided in an interview with a Registered Nurse is

noteworthy:

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 struggles to reestablish social relationships,
as well as to critically expose institutional constraints and perceptions of practitioners as
disapproving of physical intimacy. 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 [coyly 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 clients’ 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 with a client revealed that while the practitioner addressed ongoing physical and cognitive concerns, he only nominally enquired about the client’s relationship with his girlfriend:
[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]

At post-intervention, staff were also observed prioritizing clients’ non-sexual friendships and sociability with peers in hospital:

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, an SLP replied,

An example is to ask [clients], “What can you not do now that you could do before that you want to do?” Um, and then I usually get back responses, like yesterday, “Uh, I wanna go to Java Joe’s™ [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™.” So, we have found him a new apartment close to Java Joe’s™. Um, 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™ 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 among nursing and allied health practitioners in this study may be suggestive that there exists a unique climate (Coeling & Simms 1996) 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 care providers fail to display the appropriate emotion or display 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 among 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 might be 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. 2012; Kontos et al. Forthcoming) 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 behaviour 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 fate 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 an 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 addressed 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 might be a better data collection strategy than focus group discussions for exploring troubling perceptions of brain injury and their consequences in rehabilitation.

The suppression of empathy for clients was in striking contrast to the increased empathy that staff experienced post-intervention for 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 activities of care-partners, and better handling of family and spousal dynamics. The difference in staff response to 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 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 for care-partners, 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 within strict 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). 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 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’ physical 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, therapeutic emotion work around intimate relations must also include proactive concerns around coercive acts including
those that may occur in the context of pre-existing intimate partner 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. Though After the Crash had little impact in increasing empathy in staff for their clients, it was particularly effective at improving interprofessional TBI staff responses to relationality issues. The demonstration, at 12 months post-intervention, that staff continued to reflect on the portrayal of the struggles around familiar relations and client sexuality and friendship provides important evidence of the long-term efficacy of theatre as an education strategy for practitioners in the realm of relationality and 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 between the performance paradigm, emotion work, and health services research.
References


33


Smith, Pam, & Gray, Benjamin. (2000). *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.* South Bank University, Faculty of Health.


