THE EXPERIENCES OF COMPLICATED-MILD TO SEVERE TRAUMATIC BRAIN INJURY SURVIVORS IN COUNSELLING

by

Angela Ivy Leong

B.A., The University of British Columbia, 2018

A THESIS SUBMITTED IN PARTIAL FULFILMENT OF THE REQUIREMENTS FOR THE DEGREE OF

MASTER OF ARTS

in

THE FACULTY OF GRADUATE AND POSTDOCTORAL STUDIES

(Counselling Psychology)

THE UNIVERSITY OF BRITISH COLUMBIA

(Vancouver)

December 2018

© Angela Ivy Leong, 2018
The following individuals certify that they have read, and recommend to the Faculty of Graduate and Postdoctoral Studies for acceptance, a thesis/dissertation entitled:

The Experiences of Complicated-mild to Severe Traumatic Brain Injury Survivors in Counselling

submitted by  Angela Leong  in partial fulfillment of the requirements for
the degree of  Master of Arts
in  Counselling Psychology

Examining Committee:

Dr. Izabela Schultz  
Supervisor

Dr. Richard Young  
Supervisory Committee Member

Dr. Jennifer Baumbusch  
Supervisory Committee Member

Dr. Ronald Ruff  
Additional Examiner
Abstract

After traumatic brain injury (TBI), survivors often struggle with emotional issues such as low mood, anxiety, anger, a “shattered sense of self” and grief (Ruff & Chester, 2014; Levack, Kayes & Fadyl, 2010; Aboulafia-Brakha, Greber-Buschbeck, Rochat & Annoni, 2013). The complicity of these issues, which do not respond well to medication, has led to the rise of psychological counselling in rehabilitation. Due to massive neurobehavioural differences between TBI survivors and the general population, research-validated counselling practices are needed. The American Psychological Association (2006) states that research-validated practice is to be comprised of clinical expertise, controlled studies and client feedback. However, the literature describing best practices for TBI survivors in counselling is dominated by theoretical guidelines based on clinical expertise. This study aims to fulfill the gap in the lack of feedback from survivors regarding treatment received. A qualitative method was used. Ten participants were recruited through posters posted in various establishments in Metro Vancouver. Using the Interpretive Description method, participants were asked to provide an in-depth description of helpful and unhelpful experiences in counselling, including their experiences of the interventions used, their relationship with their therapist, and any environmental factors experienced. The inquiry was guided by semi-structured interview questions, which were developed and re-developed with the cumulative data from each successive participant. Participant descriptions were interpreted, coded and analyzed, from which three major sub-themes of data emerged: participant descriptions of barriers and facilitators in the therapeutic environment, in the therapeutic relationship and in the components of psychotherapeutic treatment.
Lay Summary

Experiences in counselling are a well-studied topic, however, not much is known about the experiences that traumatic brain injury survivors (TBI) have in counselling. Due to differences in physical, cognitive, sensory abilities and overall neurobehavioural changes post-injury, it is plausible that survivors have experiences that differ from those without TBI. This study seeks to understand survivor unique experiences in counselling therapy in the hopes of developing a guide for mental health practitioners in clinical practice. The study will use a qualitative methodology to guide the data collection and analysis process. Three major sub-themes of data emerged: participant descriptions of barriers and facilitators in the therapeutic environment, in the therapeutic relationship and in the components of psychotherapeutic treatment.
Preface

I, Angela I. Leong, made the identification of the research intentions and subject of study. Parameters for the study were set in part by Dr. Izabela Schultz. Design of the research program was developed with assistance from my supervisor, Dr. Izabela Schultz, and committee members Dr. Richard Young and Dr. Jennifer Baumbusch, with supporting feedback from Dr. Ronald Ruff. The literature review, recruitment of participants, selection of participants, interviewing of participants, and the coding and analyzing of research data was conducted by myself, Angela I Leong. The identification of traumatic brain injury (TBI) severity for the study participant inclusion criteria was determined with the assistance and supervision of Dr. Izabela Schultz, a clinical neuropsychologist with a special interest in TBI.
# Table of Contents

Abstract ........................................................................................................................................ iii

Lay Summary ................................................................................................................................ iv

Preface ........................................................................................................................................ v

Table of Contents .......................................................................................................................... vi

List of Tables ................................................................................................................................. ix

List of Figures ............................................................................................................................... x

Acknowledgements ........................................................................................................................ xi

Chapter One: Introduction ............................................................................................................ 1

  Background and Significance of the Research Problem .............................................................. 1

  Important Definitions .................................................................................................................. 3

  Rationale for the Study .............................................................................................................. 4

  Aims of the Study ...................................................................................................................... 7

  Research Questions .................................................................................................................. 7

Chapter Two: Literature Review .................................................................................................... 9

  TBI Survivors’ Experiences in Counselling .............................................................................. 9

  Client Experiences of Counselling in the General Population .................................................. 12

  Therapeutic Alliance Formation with TBI Survivors ............................................................... 14

  Theoretical Models for the Treatment of Survivors in Counselling ........................................ 17

  Therapist Adaptions and Accommodations for TBI Survivors in Counselling .................... 20

  Applicable Modalities of Treatment for TBI Survivors .......................................................... 24

  Literature Review Summary ...................................................................................................... 28

Chapter Three: Methods ............................................................................................................... 29
<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Interpretive Description (ID) Methodology</td>
<td>29</td>
</tr>
<tr>
<td>Theoretical Fore-structure</td>
<td>31</td>
</tr>
<tr>
<td>Recruitment</td>
<td>33</td>
</tr>
<tr>
<td>Theoretical Sampling Process</td>
<td>35</td>
</tr>
<tr>
<td>The Selected Sample</td>
<td>37</td>
</tr>
<tr>
<td>Data Sources</td>
<td>39</td>
</tr>
<tr>
<td>Data Analysis</td>
<td>42</td>
</tr>
<tr>
<td>Rigour and Credibility</td>
<td>45</td>
</tr>
<tr>
<td>Ethical Considerations</td>
<td>48</td>
</tr>
<tr>
<td>Chapter Four: Findings</td>
<td>51</td>
</tr>
<tr>
<td>A Note about the Findings</td>
<td>53</td>
</tr>
<tr>
<td>Sub-theme 1: Environmental Barriers</td>
<td>54</td>
</tr>
<tr>
<td>Sub-theme 2: Developing the Therapeutic Alliance</td>
<td>68</td>
</tr>
<tr>
<td>Sub-theme 3: Components of Counselling with TBI Survivors</td>
<td>82</td>
</tr>
<tr>
<td>Chapter 5: Discussion</td>
<td>97</td>
</tr>
<tr>
<td>Positioning the Results in the Literature</td>
<td>97</td>
</tr>
<tr>
<td>Limitations of the study</td>
<td>118</td>
</tr>
<tr>
<td>Future Research Directions</td>
<td>120</td>
</tr>
<tr>
<td>References</td>
<td>124</td>
</tr>
<tr>
<td>Appendices</td>
<td>148</td>
</tr>
<tr>
<td>Appendix A: Pre Pre-screening Phone Interview</td>
<td>148</td>
</tr>
<tr>
<td>Appendix B: Pre-Screening Form</td>
<td>149</td>
</tr>
<tr>
<td>Appendix C: Injury Severity Assessment Interview Guide</td>
<td>152</td>
</tr>
</tbody>
</table>
Appendix D: Semi-Structured Interview Guide ................................................................. 153
Appendix E: Consent Form ............................................................................................ 154
Appendix F: Transcriber Confidentiality Agreement ....................................................... 158
Appendix G: Script for Group Announcements .............................................................. 159
Appendix H: Recruitment Poster .................................................................................. 160
Appendix I: Recruitment Handout ................................................................................ 161
List of Tables

Table 1 ........................................................................................................................................ 39

Table 2 ........................................................................................................................................ 53
List of Figures

Figure 1 – Amygdala drawing used to explore emotions in therapy ............................................ 90
Acknowledgements

I would first like to thank Erin Guntly, writing consultant from the UBC Centre for Writing and Scholarly Communication, whom I consulted with for the majority of my writing process. It was with her compassionate guidance that I found the strength to carry on in my darkest days. I would also like to thank my editor, Sasha Wiley, who was also an incredibly supportive person in this endeavor. In the same regard, I would like to thank Ria Nishikawara, who generously offered her advice and feedback on my writing. These three women shaped my writing to become the state that it is now. I would also like to thank my dear friend Jennifer Diep for offering and taking the time to edit my work. And last but not least, I would like to thank my partner, Aydin Kilic for the gestures of love and support he provided me in this academic endeavor.
Chapter One: Introduction

This foundational chapter forms the introduction to the research study. Firstly, some important definitions are provided, background to the research problem is discussed, followed by a description of the context in which the problem is situated. Subsequently, the rationale for the study is introduced, followed by the aims of the study, and finally, the research questions are presented.

Background and Significance of the Research Problem

A traumatic brain injury (TBI) is damage to brain tissue caused by an external force and/or acceleration or deceleration of the brain that results in altered functioning or pathology (Lezak, Howieson, Bigler & Tranel, 2012). TBIs belong to a larger category of head injuries labeled acquired brain injuries, which are defined as any sustained damage to brain structure that is not related to congenital disorders, developmental disabilities, or processes that progressively damage the brain (Toronto Acquired Brain Injury Network, 2005). With the new advance in medical and assistive technology, more individuals are surviving TBIs than ever before. The WHO (2006) predicts that TBIs will be a leading cause of death and disability by the year 2020, surpassing many other diseases and disorders. Worldwide, it is estimated that 10 million people are affected by TBI annually (Hyder, Wunderlich, Puvanachandra, Gururaj, Kobusingye, 2007).

Although the majority of TBIs are mild, between eight and ten percent fall in the moderate category. The remaining ten percent comprise the severely injured category (Lezak et al., 2012). TBIs are most commonly cause by falls, motor vehicle accidents, blows/missiles to the head and sporting impacts (Vicini & Goswami, 2016). Uncommon causes of TBIs include lightning, electrical accident, and blast wave injuries (Lezak et al., 2012). It is generally agreed upon by practitioners that more severe injuries produce more severe deficits (Klonoff, 2014).
In addition, clinical experts state that in TBI, the sum of the deficits is often greater than its individual impairments (Coetzer, 2014). The range of impairments spans the physical, cognitive, behavioural, sensory and psychological (Carroll & Coetzer, 2011) and are often life-long. Physical impediments can include loss of the use of a limb. Cognitive issues can involve deficits in memory, mental speed, attentional deficits, cognitive efficiency and when severe, issues with high-level concept formation, complex reasoning abilities, and executive functions can occur (Lazak et al., 2012). Sensory alterations (visual, auditory, olfactory, vestibular), seizures and communication disturbances (aphasia) can also occur (Sadaka & Quinn, 2015). Survivors often report confusion, irritability, and fatigue (Lezak et al., 2012). Meanwhile, disinhibitions (speaking without thinking), inability to read abstract social cues, and changes in personality can lead to impediments in casual and intimate social relationships (Ponsford, Draper & Schonberger, 2008). Due to the complexities of the above deficits, the individual is often left unable to resume employment and is in requirement of a caregiver to live independently. It is estimated that 70% of survivors with moderate injuries do not return to work (Vuadens, Arnold & Bellmann, 2006).

After brain injury, emotional difficulties stem from neurological damage to areas of the brain which yield emotions, such as the amygdala, temporal lobe and orbito-frontal cortices (Klonoff, 2010). Emotional difficulties also emerge as a reaction to the cataclysmic life changes that are the result the injury; survivors grapple with tremendous loss: the loss of relationships, the loss of potential opportunities, and the loss of their pre-injury identity (Ownsworth & McKenna, 2004). In addition, psychological issues including depression, anxiety and substances abuse become commonly diagnosed (Whelan-Goodinson, Ponsford, Johnston & Grant, 2009).
Qualitative meta-analyses on recovery and outcome have found that survivors experiencing a tremendous amount of difficulty with adjusting to the changes in body, mind, and self-concept (Levack, Kayes & Fadyl, 2010). Stigmatization and discrimination by society is another compounding emotional frustration (Levack et al., 2010)). Evidently, the TBI population is in significant need of assistance in accessing, defining, expressing and integrating their emotions, which may lead survivors to seek psychological counsellors and other mental health therapists. Insufficient coping with such emotional turmoil can undermine rehabilitation participation and intimate relationships.

TBI is a societal-wide issue. One European study found that the combined cost of acute health care services, long-term reliance on government social services, and the lost fiscal output of working-aged individuals can significantly affect the economic output of a country (Gustavsson et al., 2011). Thus, it is imperative that healthcare treatment for TBI survivors, including counselling treatment, be optimized so to support success in return-to-work endeavors and to decrease strain on care providers of the survivor, which can both then drive the economic robustness of a country.

**Important Definitions**

This study will limit the discussion to moderate to severe TBIs. Moderate and severe brain injuries are marked by a positive result on a computed tomography, although a subset of individuals with mild TBIs have shown detectable oedemas and hematomas in the brain (Prichep et al., 2012; van der Naalt & Spikman, 2015). These individuals with mild TBIs with positive results in neuroimaging are forming a new category of TBI termed “complicated-mild”; they perform similarly to individuals in the moderate severity group in neuropsychological tests (Lezak et al, 2012). Thus, in the medical system, they are provided with similar treatment and
services as individuals with moderate brain injury (T. Blake, personal communication, September 29, 2017). For these reasons, individuals with complicated-mild injuries will be included in this study.

Counselling refers to the psychotherapeutic interventions that are used by mental health therapists (such as counsellors and psychologists) to promote emotional well-being, reduce psychological symptoms, develop behavioural skills and coping skills, and teach psycho-education. Counselling in this text will sometimes be referred to as psychotherapy, therapy, psychological counselling or counselling therapy—these terms are considered synonymous in this text. Similarly, mental health therapists can be referred to as counsellors, psychological counsellors, counselling therapists or simply therapists. Specific to TBI survivors, clinical experts have discussed supporting TBI survivors with gaining awareness of the injury, developing compensatory tools for cognitive impairments, modifying socially inappropriate behaviour, and re-defining identity and meaning in life in counselling. They also provide support with return-to-work endeavors and other goals that encourage societal re-integration. Some mental health clinicians provide support with spiritual exploration that arises from major life changes.

**Rationale for the Study**

The treatment of any health concerns requires guidance from of a substantial body of called evidence-based practice (EBP). In 2005, the American Psychological Association (APA) appointed a Presidential Task Force to define a policy statement to guide the use of EBP in psychological treatment. The new policy statement now accounts for diversity in clients (e.g.: presence of a disability, culture, gender identity, social class, sexual orientation, race, ethnicity) and how it may shape personality, values, worldview, relationships, psychopathology, and
attitudes towards treatment and treatment outcome. To account for diversity, the policy statement emphasized a third component to EBP, the component of ‘client perspectives’. Thus, EBP in psychological treatment is now upheld up by three principles: (1) external scientific evidence; (2) clinical expertise; and (3) client perspectives.

*External scientific evidence* refers to the empirical results of intervention strategies, assessment and clinical problems that are found in a laboratory or in field settings—these include controlled experimental studies, such as double-blind randomized controlled trials (RCTs) or clinical trials.

*Clinical experts* are the psychological counsellors and other mental health therapists who have the training, education, and experience to manifest effective practice. Clinical experts are individuals who are responsible for integrating the best research evidence with clinical data (e.g.: information concerning the client obtained over the course of treatment) to make recommendations for clinical treatment and to make conclusions about research effectiveness. However, the issue with clinical expertise is that it is not infallible. Whenever clinicians move from clinical observations to making inferences, there are often risks such as misinterpretations, over-generalizations, biases and other errors in judgment. Even well-intending clinicians can make such errors; thus, to mitigate such human error, clinical experts can elicit client perspectives (APA, 2006).

*Client perspectives* are the client’s feedback regarding the psychological counselling therapy they received. Feedback can be systemically elicited in research studies in the form of questionnaires or qualitative interview studies, or informally collected through client surveys through the agency where the service is provided.
Although empirical evidence such as RCTs can create a strong basis for widespread agreement of the parameter of the problem, it would be incorrect to assume that the knowledge produced by RCTs would inherently have value across all context or conditions. Health care policymakers increasingly understand that controlled studies are based on particular measures, instruments and problems and that they can answer some questions but not others. For instance, clinical trials may be able to produce uncontradictable evidence that embryonic stem cells can be cultivated to produce specialized cells of benefit to the treatment of an infinite range of diseases, but that evidence does not lead to the conclusion that it is the right thing to do. Human subjective experience, ethics, economics, equity, and values need to be considered in the larger context in which research results are utilized (Thorne, 2016).

In summary, the APA’s has proposed a new “gold standard” in what is considered EBP in psychological treatment. This new “gold standard” calls for “the integration of the best available research with clinical expertise in the context of client characteristics, culture, and preferences” (APA, 2006, p. 273). Research has found that clients who received their preferred treatment have a 58% chance of showing greater improvement, with lower chances of dropping out of treatment (Swift & Callahan, 2009). In addition, Olkin and Taliaferro (2006), disability researchers with disabilities, state that there is a lack of evidence that counselling techniques that are found to be effective with able-bodied and neuro-typical individuals are generalizable to a TBI population. Survivors may experience certain interventions are highly problematic due to their cognitive, physical or sensory barriers.

Currently, the research literature is bursting with quantitative studies that support the utility of various psychological approaches and counselling interventions with survivors of TBI which lack the corresponding in-depth qualitative commentary. Conceptual and practical
treatment models were developed top-down, from clinical judgement, rather than being informed by client experiences. Thus, the research literature is in dire need of client feedback of experiences in counselling to support APA’s definition of EBP.

Aims of the Study

The aims of this research study are to explore complicated-mild to severe TBI survivors’ experiences in counselling and to describe themes of facilitators and barriers to treatment. This study will also focus on hindering experiences of psychological counselling treatment, as prior qualitative studies have only garnered positive experiences. It is known from the general research on client experiences that a portion of clients has negative feedback to share (Henkleman & Paulson, 2006) that can help improve practice.

The study aims to fill a gap in the research literature, namely the lack of qualitative research evidence which describes individual counselling therapy from the perspective of the survivor of TBI. It also aims to challenge the assumption that counselling interventions that have been developed and framed around the psychological challenges of the general population can be applied to a TBI survivor.

In accordance to the methodology of choice, Interpretive Description (ID), this study attempts to augment what researchers and clinicians currently understand rather than to confirm what is already known. In addition, ID was designed to produce data that is applicable to clinical practice. The findings of this study aim to provide practitioners in the discipline of counselling psychology, vocational counselling, and rehabilitation counselling and other related mental health disciplines with a clinical guide to treating TBI survivors in counselling.

Research Questions
With the aims of the study in mind, the following research questions have been developed to guide the exploration of survivor experiences in counselling:

(a) What environmental factors of the therapeutic environment are described by TBI survivors and what are their experiences of them?

(b) How do survivors of TBI describe the therapeutic alliance?

(c) What are the survivors’ experiences with various counselling interventions and the way such treatments are delivered?

In the ID methodology, it is possible that research questions change as a result of emerging data. Hence, these three stated research questions serve as a guide in which to start the process rather than to serve as immutable structures.
Chapter Two: Literature Review

In Interpretive Description (ID), the objective of the literature review is to present a critical review of the “state of science” in relation to the clinical problem under study (Thorne, 2016). This literature review will offer a critical reflection on what does and does not exist, and offers interpretive commentary on the strengths and weaknesses of the overall body of knowledge (Thorne, 2016). Furthermore, because the aims of ID as a methodology are to explore additional truths to a topic of inquiry, it is necessary to have a thorough explication of the existing knowledge. In fact, Thorne (2016) writes that in order to have authoritative confidence, the literature search needs to be “as extensive as humanly possible” (pg. 63), and thus the literature review in the next several pages will be as such. The literature review serves as one element of the two-part process in “scaffolding a study” (Thorne, 2016, pg. 59). The second element of scaffolding has to do with describing the biases that are brought to this study as a researcher and will be discussed in chapter three: methods.

The literature review chapter is split into two major sections. The first section reviews client experiences of counselling. Under this section, I will review the experiences of TBI survivors in therapy, the therapists’ experiences with alliance formation with survivors, and the general population’s experiences in counselling. Second, is a discussion of the theoretical models that have been applied in the treatment of TBI survivors. The third section concerns the various approaches to counselling that have been applied to survivors. This area of knowledge has been mainly informed by external scientific evidence and clinician expertise. Fourth, there is a discussion of known adaptations that have been made to counselling to compensate for TBI-related impairments. Finally, chapter two concludes with a summary of the literature review.

TBI Survivors’ Experiences in Counselling
Although client experience of counselling has been studied for nearly half a decade (Gladstein, 1969), it has not been well studied in the brain injury population. This may be due to long-standing beliefs that cognitive deficits would pose as an insurmountable barrier to the production of meaningful data in in-depth qualitative interviews (Paterson & Scott-Finlay, 2002). This view is gradually shifting. One study found that persons with cognitive disabilities value being able to talk about their problems in therapy and highlighted the therapeutic relationship as a key component to their therapeutic work (Pert et al., 2013). With the rise of more TBI survivors receiving counselling treatment, there is a need for a qualitative inquiry on survivors’ experiences in counselling. The emerging literature on survivor experience of counseling is summarized in this section.

Kristofersson et al. (2016) described survivor perceptions of a mindfulness-based stress reduction (MBSR) program. In this program, 10 survivors of mild to severe TBI participated in group body scan exercise, mindful eating, mindful movement, mindful breathing, and yoga. In the focus group discussion, clients of the program reported being able to perceive the benefits of the program. Clients described the MBSR program as being relaxing, “gives you nice little tools to deal with anxiety” (p. 250). Participants suggested that more education on the relevance of mindfulness-based intervention in brain injury recovery would be helpful for staying engaged with the intervention. Background noise such as coughing, hard breathing, vacuuming, and the clanging of dishes were reported as being distracting for individuals in this group program.

Azulay and Mott (2016) briefly reported on the survivor feedback of a group “mindfulness attention program”. The program was modeled after Kabat-Zinn’s MBSR program but was conducted with modifications which placed more emphasis on attention training and meditative guidance on uncomfortable physical and emotional experiences. In terms of qualitative findings,
Azulay and Mott’s (2016) study found that despite some individuals being unable to recall the rationale behind the mindfulness attention program, gains were exhibited. Participants in Azulay and Mott’s (2016) study described the treatment as “life-changing”. One participant reported, “it works. I don’t go around feeling angry all the time” (Azulay & Mott, 2016, pg. 6). Another participant stated eloquently, “I am no longer brought to my knees by the fear of my own pain or that my emotions will shatter me into a thought sand pieces or lead me into a pit of depression. I now feel in control of being out of control” (Azulay & Mott, 2016, pg. 6).

In Ashworth, Clarke, Jones, Jennings and Longworth's (2014) study, survivors of mixed injury severities received individual and group sessions of Compassion-Focused Therapy (CFT). CFT targets depression and anxiety symptoms and increases feelings of self-worth by teaching clients self-compassion techniques. The first six weeks of the CFT program was focused on psychoeducation on the biopsychosocial consequences of acquired brain injury and tools to manage these consequences. The final week of the group focused the concept of CFT and techniques of “compassionate mind”, such as rhythm breathing and safe place imagery. Participants reported that CFT gave them a new way to relate to themselves, facilitated a re-evaluation of self-worth and gave them tools to manage their difficulties. Participants in Ashworth and colleague’s (2014) study state: “for the first time, I could actually look at it and really mean it when I say ‘I am not stupid’ (p.13)”. Another participant stated, “without being compassionate to myself, I would still not have had the tools to be able to stop myself going deep into the depression stages (p.14).”

The preliminary research on survivor experiences is beginning to establish that counselling produces feelings of positive affect, control over emotions and having “tools” for coping. Unfortunately, no existing studies took an in-depth approach at understanding the
experiences of TBI survivors in therapy, as their research goals included either quantitative measures of efficacy or the elicitation of a caretaker’s experience.

**Client Experiences of Counselling in the General Population**

In the general population, client experiences are a well-studied area of research. It has become established that counselling that is directed by client feedback has been found to be highly effective in creating positive counselling outcomes (Duncan & Miller, 2000. Duncan et al., 2003). It is helpful to gain an understanding of the existing client experiences literature in the general population to guide the inquiry in client experiences in TBI survivors. Based on a review of the recent literature, the general client experiences of counselling can be grouped into two sections: (1) the identification of variables important to the formation of the therapeutic relationship, and (2) research on hindering experiences in counselling.

**Client experience of the therapeutic alliance.** The client’s perspective of the therapeutic relationship is the single most consistent predictor of improvement, even more so than the therapists’ perspective of the alliance (Manthei, 2007) and potentially more so than any other common factor in therapy (Lambert & Barley, 2001). In Bedi (2006), forty participants identified eight categories of therapist behaviours which facilitate a “positive working relationship”. The eight categories are as follows, in the order of greatest to least importance: (1) Validation (the counsellor normalized my experience), (2) Education (the counsellor taught me skills), (3) Nonverbal Gestures (i.e.: nodding, leaning forward, eye contact), (4) Body Language and Presentation (i.e.: did not fidget, smiled, sat facing me) (5) Guidance and Challenging (the counsellor confronted or challenged me), (6) Referrals and Recommended Resources (the counsellor recommended reading materials or made calls to other agencies), (7) Honesty (the counsellor shared personal information), (8) Emotional Support and Care (the counsellor let me
cry, we laughed together, offered to hug me). In addition to the above established factors which facilitate the therapeutic alliance, Krause, Altimir and Hovarth’s (2011) research found that clients must also view their therapist as someone who possesses expertise.

In the follow-up study by Duff & Bedi (2010), using the factors identified by Bedi (2006), the researchers found empirical evidence that most of the factors that clients think are responsible for positive therapeutic alliance formation actually are responsible. It was concluded that clients indeed could be a reliable and insightful agent of knowledge.

**Research on hindering experience in therapy.** Researching unfavourable experiences in counselling may produce knowledge about the therapeutic alliance that inquiring about helpful experiences cannot (Henkleman & Paulson, 2006). Although the majority of clients who seek therapy have a positive experience with their therapist, 11% of clients report dissatisfaction with their therapist (Olivera, Brian, Penedo & Roussos, 2013). Paulson, Overall and Stuart (2001) interviewed eight clients concerning what they found hindering about their counselling experience.

One category of hindering experiences in Paulson and colleague’s (2001) study is ‘Negative Counsellor Behaviours’ and is characterized by statements such as: ‘feeling that the counsellor wanted to get me out of the office as soon as possible’, ‘the counsellor not really listening’, ‘the counsellor using words that felt judgemental’, ‘the counsellor deciding to end counselling’, and ‘the counsellor being too concerned about fees’. These examples are valuable to be aware of as a practicing clinician. There were three more categories related to counsellor behaviour: ‘Insufficient Counsellor Directive-ness’, characterized by ‘not being pushed enough by my counsellor’; ‘Lack of Counsellor Responsiveness’, characterized by the statement, ‘the counsellor dealing with the specific concern I came in for but not others’ and the category ‘Lack
of Connection with Counsellor’ characterized as ‘not feeling connected from session to session’. Other studies have found the following counsellor behaviours to be hindering: inappropriate, intrusive or confusing self-disclosures, lack of strategies offered, poor time management, unclear goals, counsellors talking too much (particularly if about themselves), and counsellors forgetting what was previously talked about (Manthei, 2007).

Another factor which mediates a hindering experience in counselling is the dislike towards personal attributes that the therapist has, such as having a counsellor who is of a different culture, different age group, undesired gender, different life experiences, or different religious affiliation. Extensive literature finds that clients fare better with a therapist who matches their ethnic or cultural background (Farsimadan, Khan & Draghi-Lorenz, 2011). Thus, survivors of TBI may have a preference for a clinician who has had a TBI or a related disability, however, this has not been confirmed in the literature.

Another thematic category in Paulson et al.’s (2001) research is ‘Structural and External Barriers’ to counselling. Issues of structural and external barriers to counselling include not having adequate sessions, the one-hour session not of sufficient duration, having to talk to more than one counsellor in an agency, and having to pay for therapy. Two categories in Bedi’s (2006) study factors mediating positive working alliances: setting (described as the ambiance of the room, the friendliness of the support staff, being given choice for blinds, room temperature and where to sit) and session administration (i.e.: being able to reach the therapist in between sessions) exemplify the weight in which clients place on structural and external factors in the experience of therapy. It is presumed that the nuances of a TBI disability could lead to more or different structural and external barriers.

**Therapeutic Alliance Formation with TBI Survivors**
Underlying all psychotherapeutic approaches is the common factor, ‘therapeutic alliance’, which is the therapeutic relationship that forms between the therapist and the client. The therapeutic alliance is sometimes known as the therapeutic relationship or the working alliance. The strength and depth of the therapeutic alliance can vary depending on the ability of the therapist to foster interpersonal closeness, however, it is also known that the nature of certain interventions can obstruct interpersonal closeness. Therapeutic alliance is an important factor in counselling because it has been considered to be the key variable in which change is attributed (Lambert & Barley, 2001). In addition, the alliance has been regarded as more impactful than the intervention or approach used by the therapist (Schonberger, Humle & Teasdale, 2006a; Zuroff & Blatt, 2006).

Currently, the existing literature on alliance formation with TBI survivors does not include client perspectives. A study in the United Kingdom examined the views and experiences of alliance formation with moderate to severe TBI survivors from the perspective of 21 clinical psychologists and neuropsychologists (Judd & Wilson, 2005). The psychologists in Judd and Wilson’s (2005) study described their psychotherapeutic treatment with survivors as consisting of psychoeducation about the effects of the brain injury, cognitive behavioural strategies to help with the development of coping strategies, followed by the development of compensatory tools, and finally a re-definition of the self. Survivors in this study were seen on a long-term basis. Therapists in this study reported that impaired memory was the most significant challenge to forming a therapeutic alliance with this population. Other challenges to the formation of alliance included lack of insight, inflexible thinking, poor attention, and behavioural issues such as disinhibition. Therapists in this study reported using psychoeducation, reality testing, memory aids, identifying short-term goals, shortening sessions and involving significant others to support
with alliance formation. Schonberger, Humle and Teasdale’s (2006b) study, therapists report that they have particular difficulties in alliance formation with survivors with low awareness. Sixteen of the 21 therapists interviewed reported that they experienced a negative emotional reaction towards the challenges of alliance formation.

A strong therapeutic alliance is the most consistent and robust predictor of positive counselling outcomes (Kottler & Balkin, 2017). In TBI counselling, therapists who report a positive working alliance had corresponding clients who reported better attention span, memory, general intelligence and executive functioning (Schonberger, Humle & Teasdale, 2007). However, preliminary research of alliance formation between therapists and survivors found that the clients’ ratings of the working alliance with their treating therapists differed from therapist’s ratings of the working alliance (Schonberger et al., 2007). It is not known why this is the case. In addition, Schonberger and colleagues (2007) found that client perception of working alliance is unrelated to performance on cognitive ability assessments — both good and poor performance on cognitive tests can result in a perception of a good working alliance. Thus, poor cognitive functioning does not appear to be a barrier for client ability to form alliances with their therapist, contrary to what therapists believe.

Coetzer (2007) point to other aspects of the survivors which might impede rapport building. In Coetzer’s (2007) case study, he concludes that biological and psychological factors commonly seen in survivors, such as apathy or aggression, may adversely affect the therapeutic relationship. The most positive experiences in therapy are ones where the therapist and client co-constitute and actively participate in the relational process of therapy and it is possible that apathy and aggression are major barriers to the client’s ability to actively participate relationship development.
Both Judd and Wilson’s (2005) and Schonberger and colleague’s (2007) study has noted that counsellors with neuropsychological training tend to fare better with alliance formation than counsellors that do not. It suggests that experience and training with neuropsychological consequences are an important mediator of alliance formation. Currently, the literature lacks qualitative research on the therapeutic alliance from the perspective of TBI survivors. An in-depth qualitative study would illuminate why and how experiences of the therapeutic alliance in TBI survivors can vary from therapist experiences and what can be done to strengthen therapeutic relationships with TBI survivors.

Theoretical Models for the Treatment of Survivors in Counselling

The major competing model of psychotherapy after TBI is most well-defined by Klonoff (2010) and involves a collaborative working relationship between therapist and TBI survivor, with the goals of increasing self-awareness, acceptance and realism “about his or her predicament” (p. 2). Additionally, the therapist educates and supports the client’s family and community connection while renewing a sense of identity, hope, and meaning. Klonoff (2010) also describes a major emphasis on psychoeducation, coping and adjustment in psychotherapy after brain injury.

To elaborate on some definitions, self-awareness is defined as “the understanding and acknowledgment of post-injury neurological strengths and difficulties, as well as their functional implications (Klonoff, 2010, p.46). Acceptance is the survivor’s “ability and willingness to cope with his or her new reality and identity” (Klonoff 2010, p.100), which is exemplified by the embracing of compensatory strategies. Realism is the “integration of accumulated internal perceptions and external life experiences to produce healthy judgement and attainable objectives for the future (Klonoff, 2010, p.198).
In order for acceptance to occur, clients must achieve first achieve awareness. Unfortunately, in TBI survivors, denial and/or anosognosia is often present and becomes a major barrier to awareness (Coetzer, 2007). Anosognosia is the biologically mediated lack of awareness and is associated with specific neuroanatomical correlates while denial, is the psychological equivalent of anosognosia, which exists as the unconscious mind’s way of protecting the ego from anxiety (Klonoff, 2010). Both anosognosia and denial can be present in the same individual, and therefore, it can be hard to assess whether the former or the latter is a barrier to client progress.

Lack of awareness can become a major barrier to therapeutic outcomes (Coetzer, 2007). Both Coetzer (2007) and Ruff and Chester (2014), he suggests that feedback that is frank and pragmatic bestows upon the client a sense of the reality of his or her functional deficits. Although, Klonoff (2010) forewarns therapists to be conscientious about how, how much, and in what context psychoeducational feedback is provided. Klonoff (2010) also suggests survivors group together an “advisory board”, individuals in the client’s life who can echo the psychotherapist’s realistic feedback regarding his or her predicament. Qualitative research evidence on how clients receive feedback about the “realities” of their deficits is needed to further elucidate this pernickety and controversial task—awareness of deficits “almost inevitably” (Klonoff, 2010, p. 54) leads to an emotional, catastrophic reaction. Schonberger and colleagues (2006a) found that increased awareness was related to the amplification of depressive symptoms. Others have regarded this “catastrophic reaction” as a natural and necessary grieving process (Ruff, 2013).

Theoretically, catastrophic emotional reactions in therapy have been categorized as an “in-session impact” in Orlinsky and Howard’s Generic Model of Counselling, a comparative
research model for studying psychotherapies (Coetzer, 2007). In-session impacts are the immediate responses to a session such as insight and emotional relief. Coetzer (2007) states that emotional reactions can lead to insight, which can then lead to acceptance, which can then allow the individual to be proactive in addressing his or her deficits, but this process can take longer to observe than other clinical populations.

Once the client has been given an opportunity to emotionally grieve this realization of deficits and “loss of self” in counselling, they can be guided towards acceptance (Coetzer, 2007). Full acceptance of circumstances may allow the client to start re-carving a new sense of self and start making meaning out of the traumatic event (Ruff, 2013). These are the “sequential events”, the temporal events that occur in the psychotherapeutic process that can be separated into blocks or phases of treatment (Orlinsky & Howard, 1995). The sequential events of therapy with survivors as described by Coetzer (2007) include: (1) clinical assessment, (2) provision of information about “what happened”, (3) discussing the effects of “what happened”, (4) emotionally processing the losses and (5) the creation of a sense of meaning of life as it is now. Klonoff (2010) adds life skills training, mediating family life, re-developing communication and social skills as additional events which are a necessary part of psychological adjustment for many TBI survivors.

Finally, in individual counselling for survivors of TBI, there appears to be a significant role in including family members in psychological and emotional recovery. There is no debate that brain injury affects the whole family (Klonoff, 2010) and the literature describes many interventions which treat survivor mental health and well-being from a systemic perspective. The involvement of family members in individual counselling for TBI survivors can be described in Klonoff (2010 and Klonoff (2014).
Although Klonoff (2010), Coetzer (2007), Ruff (2013) and Ruff and Chester’s (2014) clinical guides are tailored to the unique biological and psychological factors in survivors, these treatment models are based on clinical judgement and case studies. In accordance with APA’s call to action, before these theoretical treatment models can be considered evidence-based practice, they require the qualitative research evidence in the form of client feedback to support its use and application. Without client feedback, we simply do not know the implications of these supposedly helpful theoretical models and subsequent therapist interventions.

**Therapist Adoptions and Accommodations for TBI Survivors in Counselling**

The following section describes adaptations made to psychological counselling with TBI survivors as discussed in the literature. Exploration of therapists’ use of adaptations in counselling and its impact on client experiences has not been conducted in the literature. The qualitative exploration of this aspect of client experiences could illuminate preferences around adaptations which could allow.

**Clinical assessment.** In the initial consultations, counselling therapists may make a preliminary inquiry into the client’s awareness, acceptance and realism, gain an initial sense of pre and post-injury psychological status, and evaluate the family’s capacity to collaborate with the client and therapist (Klonoff, 2010). If an individual is a good candidate for psychological counselling, a pre-injury psychosocial history can be taken, followed by an exploration of the client’s perceptions of neurobehavioural concerns and finally an initial identification of therapy goal. Due to memory, auditory processing and comprehension issues, both Klonoff (2010) and Coetzer (2007) suggest the importance of a therapeutic contract delineating the purposes, risks and benefits of psychotherapy.
In general, the conceptualization of issues in psychological counselling is continuously developing as goals and histories emerge and change throughout the process. In psychotherapy after brain injury, Coetzer (2007) specifies that due to the dynamic nature of neural recovery which follows TBI, the initial clinical assessment may need to be re-assessed throughout treatment. The client’s self-reported issues may continually emerge as the survivor discovers more aspects of their disability. In addition, it is not uncommon for psychological and medical assessments to occur repeatedly, particularly if third parties require them. New information from self-observation, family observation, clinical observation, and emerging formal assessments may change the therapist and client conceptualization of the client’s issues in counselling therapy.

**Therapist qualities and personal approach.** Klonoff (2010) writes that therapists who work with TBI survivors need to utilize “a more directive and information dispensing approach in their intervention” (p.38). Generally, the therapist will need to supply useful exercises and facilitate dialogue in order to support the client with conceptualization, problem-solving, goal setting and execution. Therapists who want to work with TBI survivors will require special skills such as exceptional patience given the laboriousness of the recovery process, exceptional executive function skills to compensate for the lack thereof in client’s, an ability to collaborate with a team of neurorehabilitation professionals, and the enthusiasm to transmit a belief in a better future for TBI survivors (Klonoff, 2010).

**Frequency, duration, and length of sessions.** Frequency, duration, and length of a single session may differ from a general population due to issues biological and psychological difficulties that TBI survivors often experience. Shorter session lengths were recommended for clients with fatigue, poor attention spans or pain issues (Hsieh et al., 2012). In contrast, Kangas and McDonald (2011) suggested that a 90-minute session may be more apt for clients who tend
to become tangential (go off topic), over-explain or have other auditory processing or comprehension difficulties.

A longer duration of treatment (number of sessions) has been recommended by clinicians to accommodate the chronicity of issues that follow a TBI (Hsieh, Ponsford, Wong and McKay, 2012). Additionally, as treatment nears ending, clinical experts suggest increasing the spacing between appointments from weekly, to fortnightly, to once a month (Kangas & McDonald, 2011; Hsieh et al., 2012). Clinicians state that this gradual spacing not only encourages maintenance and generalization of skills but also allowing the space for clients to learn how to cope without a therapist (Hsieh et al., 2012; Ponsford et al., 2016). In Coetzer’s (2007) case study with an individual with severe TBI, sessions were gradually spaced further apart over a five-year period until it was mutually agreed upon that an annual booster session was sufficient. Life-long therapy with continuous infrequent sessions to maintain progress is not uncommon for TBI survivors (I. Z. Schultz, personal communication, March 6, 2017).

The survivor’s pace and ability to make changes in therapy will also have an impact on the frequency and duration of treatment. Pace and ability to make changes in therapy may vary depending on the individual’s personality style, localization, severity of brain damage, the degree of the individual’s psychological maturity, motivation and the presence of denial (Ruff & Chester 2014, Klonoff, 2010). These factors may be the result of post-injury neurological changes or from pre-injury individual psychological factors.

Compensatory techniques. “Compensatory techniques”, taught in neurorehabilitation are often can be adopted by therapists in session to facilitate the counselling process. Due to cognitive issues such as difficulties with memory, planning, initiation, self-monitoring, and organizing, compensatory techniques are extremely important adaptations to counselling. Three
compensations used by counselling therapists will be described: note-taking in session, the
distribution of handouts, and encouraging the use of a planner or an agenda.

Note-taking in sessions with TBI survivors is another compensatory strategy that can become a key part of success in psychological counselling. While some have argued that note-taking detracts from the therapeutic process, others have found that it is vital for success in the TBI population (Kortte, Hill-Briggs & Wegner, 2005; Whitehouse, 1994). According to therapists, note taking facilitates synthesis, summarization, and integration of the contents of therapy (Kristofersson et al., 2016; Klonoff, 2010). Deciding when and how to prompt a TBI survivor to take notes has been at the discretion of the therapist—clinical experts have recommended that the more severe the cognitive deficits, the more often note-taking should occur. Furthermore, it is necessary to spend time reviewing the notes from the previous session at the beginning of the next session, particularly for clients with memory recall issues or if there are significant gaps between sessions. Clinical experts claim that survivors often confabulate to avoid the embarrassment of not recalling information (Langenbahn et al., 1999; Whitehouse, 1994), therefore, note-taking can be a tool in which to limit confabulatory ‘rabbit holes’.

Handouts are sometimes used in counselling to compensate for memory and to support the generalization of skills. However, individuals with TBI may require simplified versions of didactic material due to issues with information processing and ability to manipulate abstract materials (Hsieh et al., 2012; Kristofersson et al., 2016). Hsieh and colleagues (2012) and Azulay and Mott (2016) emphasize the provision of handouts in booklet form in order that pages do not become disordered and thereby overwhelming for clients. Finally, use of a day-planner is an essential compensatory tool which supports the client with arriving to a scheduled session or with completing any homework assignments (Klonoff, 2010).
Applicable Modalities of Treatment for TBI Survivors

Although this is a study that does not aim to provide a comparison of one modality of treatment to another, it may be valuable to provide a brief overview of various counselling modalities discussed in the literature. There are many different modalities surrounding psychological counselling for TBI survivors have been discussed in the literature, each differing in its conceptualization of the client’s life difficulties and etiology, as well as management of emotional disturbances. Behavioural therapy, cognitive behavioural therapy, mindfulness-based interventions, compassion-focused therapy, acceptance and commitment therapy, dynamically-oriented therapy, narrative therapy, and existential-based interventions will be briefly described in the following paragraphs. Although the literature tends to emphasize group therapy, the focus of the discussion will remain on individual counselling.

Cognitive behavioural therapies. Initially, psychological counselling for survivors of TBI emerged as heavily as behavioural therapy oriented. Techniques such as video feedback and cueing place minimal reliance on higher-order cognitive processing and were believed to be an ideal treatment for those with TBI (Mcdonald et al., 2008; Meghi, 2002). The literature suggested that BT can be helpful with reducing inappropriate sexual remarks (Meghi, 2002; McDonald et al., 2008; Lu et al., 2012). Behavioural therapy is frequently combined with cognitive reformation strategies, the practice of which is called Cognitive Behavioural Therapy (CBT). There is substantial scientific evidence that CBT can assist with remediating depression and anxiety in individuals with TBI (D’Antonio, Tsaousides, Spielman & Gordon, 2013; Waldron, Casserley & O’Sullivan, 2010). In addition, CBT has also been found to be effective in the development of anger management and coping skills, and with addressing Posttraumatic Stress and Obsessive-Compulsive Disorder (Aboulafia-Brakha, Greber, Rochat & Annoi, 2013;
Mindfulness-based interventions. Mindfulness has been steadily gaining popularity as treatment intervention in psychological counselling. Recently, it has been established as a highly viable treatment option for individuals with TBI. According to a rigorous review, mindfulness-based interventions have been found to significantly reduce depression symptoms and has been found to improve quality of life in TBI survivors (Ozen et al., 2016). Mindfulness-based interventions adapted for TBI include skills such as breathing exercises, visualization, meditations which cultivate non-judgmental, moment-to-moment awareness and the belief that thoughts and feelings are a fleeting mental event rather than depictions of reality (Bédard et al., 2003; Bédard et al., 2014). Findings have suggested that mindfulness-based interventions may even be helpful for reducing impulsivity and over-selectivity (the neuropsychological phenomenon where one aspect of the environment becomes disproportionally salient, resulting in poor decision-making), and fatigue (Kristofersson et al., 2016; McHugh & Wood, 2013; Ulrichsen et al., 2016) in survivors of TBI. In addition, researchers have speculated that the non-judgmental quality of mindfulness-based interventions is a nutritive environment for facilitating acceptance of self and findings new ways of conceptualizing disability (Bédard et al., 2003).

Compassion focused therapy. Compassion focused therapy approach hypothesizes that the underlying processes experienced by individuals who have anxiety and depression are shame and self-criticism (Gilbert, 2014). The model draws upon attachment theory and neurophysiological approaches to affect regulation. Gilbert (2014) theorizes that compassion activates the human self-soothing system, which balances our affect regulating systems. A mixed
methods study by Ashworth and colleagues (2014) found success in applying compassion-focused therapy to individuals with acquired brain injuries in a combined group and individual format. Depression and anxiety symptoms had significantly reduced by the end of the 18-week program and maintained at a three-month follow-up. The self-criticism measure in this study exhibited a reduction in the ‘hated self’ and the ‘inadequate self’ and increased identification with the ‘reassured self’ (Ashworth et al., 2014).

Acceptance and commitment therapy. Acceptance and commitment therapy (ACT) is an empirically based therapy that has roots in Eastern meditative practices, Gestalt therapy and emotion-focused therapy (Kangas & McDonald, 2011). ACT is composed of six core processes: (1) cognitive defusion, (2) acceptance, (3) contact with the present moment, (4) self-as-context, (5) values and (6) committed action (Hayes at al., 2003). In their meta-analysis, Kangas and McDonald (2011) suspected that ACT allows individuals with brain injuries to move forward with their lives by facilitating acceptance, which allows for the psychological flexibility required for the next phase of ACT: the identification of goals for behavioural change. There is a growing body of evidence supporting the effectiveness of ACT in individuals who have acquired a brain injury. A case study did find ACT to be successful in helping a stroke victim in reducing anxiety symptoms and returning to work (Graham, Gillanders, Stuart, & Gouick, 2015). In a small-scale study of adults with brain tumours, participants exhibited a retraction of anxiety and depression symptoms following an ACT-based program (Kangas, Mcdonald, Williams & Smee, 2015). A large-scale RCT with a group of veterans with mild to moderate TBI suggests ACT can improve psychological symptoms, functional impairment and mental health-related functioning (Bomyea, Lang & Schnurr, 2017).
**Existential psychotherapy.** Frankl (1963) developed the existential approach to therapy after he had lost all of his possession and family members when emerging from imprisonment in a Nazi concentration camp. The theory of this approach was founded on the belief that human nature is motivated by the search for a life purpose and that meaning in life can still be found even when a catastrophic loss (such as a brain injury) occurs. Ruff (2013) applied existential principles to a brain injury survivor. Steps to treatment involved: (1) exploration of lost future goals such as having children or a particular career, (2) supporting the client with acceptance of deficits, including a discussion of preserved strengths, (3) supporting the client with grieving what was lost, and (4) identification of a hero and the core values that hero would hold, followed by a discussion of how the survivor can still hold those values, despite their disabilities. When the client realizes that much of their pre-morbid values can still be held, a sense of control is regained, and distress is reduced.

**Narrative therapy.** In narrative therapy, a new self-concept is developed as the stories being told by the client become heard and validated (Weatherhead & Todd, 2016). The opportunity to feel heard facilitates an opportunity to reconcile and come to terms with what has been endured (Harrington, 2005; O’Brien & Clark, 2006). In a qualitative study, Medved (2007) found that persons with anterograde amnesia were able to produce personal narratives even in the absence of autobiographical memory. Use of the narrative technique on survivors of TBI has begun to be explored in Weatherhead and Todd’s 2016 book.

**Dynamically-oriented therapy.** Ruff (2013) suggests that there is limited value in using dynamically-oriented therapies, such as therapies that involve the use of interpretive statements and exploring the unresolved past for this clinical population. The life-altering changes that follow a TBI and the adjustment to such change will trump any pre-morbid issues (such as one’s
relationship with their primary caregivers) and can be avoided altogether (Ruff, 2013). However, Klonoff (2010) offers limited aspects of dynamically oriented therapy that are applicable to TBI survivors: ego development and separation-individuation, feelings of inferiority associated with loss of roles in the family, and issues of transference.

**Literature Review Summary**

In the literature review, it is observed that clinicians (e.g.: Klonoff, 2010; Ruff and Chester, 2014; Kangas & McDonald, 2011; Hsieh et al., 2012) have made recommendations as to what works in counselling TBI survivors based on expertise, clinical experience, and opinion. Suggestions were made for frequency and duration, and the use of compensatory techniques. There are a growing number of publications in the external scientific evidence category of EBP. Preliminary research has found that the therapeutic relationship is a greater mediator of outcome than the modality of counselling used (Schonberger et al., 2006a; Zuroff & Blatt, 2006). A small number of studies have reported qualitative evidence that CFT and group-based mindfulness-based interventions have been received positively by clients (Kristofersson et al., 2016; Ashworth et al, 2016; Azulay & Mott, 2016). This dearth of in-depth qualitative research describing survivor experiences in psychological counselling supports the need for the current study.
Chapter Three: Methods

A qualitative research method was used to examine the research questions. This chapter introduces the methodology, Interpretive Description (ID), followed by a description of the theoretical fore-structuring of this study. A description of the recruitment procedures, the participant inclusion method and a description of the setting in which the data was collected follows. The next section describes the data analysis, followed by an explanation of the rigour and quality upheld in this study and a discussion on ethical considerations.

**Interpretive Description (ID) Methodology**

ID methodology was used to answer the following research questions: (a) ‘What environmental factors of the therapeutic environment are described by TBI survivors and what are their experiences of them?’ (b) ‘How do survivors of TBI describe the therapeutic alliance?’ and (c) ‘What are the survivors’ experiences with various counselling interventions or approaches and the way such treatments are delivered?’

ID is a qualitative method that departs from more traditional methods of qualitative study in that it seeks to create clinical relevance and applicability from the data (Thorne, 2016). ID was originally developed to create explanations for questions pertaining to human health and illness to serve the practice of nursing in the 1990s. ID is now used across healthcare disciplines (Thorne, 2016). Ideally, a clinician would be able to use the products of research using ID to provide a backdrop for assessment, intervention planning and strategies, and clinical decision making and reasoning (Thorne, Reimer-Kirkham, & O’Flynn-Magee, 2004), but at the very least, to inspire critical thinking on a subject.

ID borrows strongly from three traditional qualitative methods — ethnography from anthropology, grounded theory from sociology, and phenomenology from philosophy (Thorne,
2016). As a result of researchers in the 1980s adapting and “mish-mashing” traditional methodologies to conduct “legitimate qualitative research for which, as yet, there is no name” (Thorne, Kirkham, and Macdonald-Emes, 1997, p.171), Thorne et al. (1997) refined the combination of methods that were already in use and coined the term *interpretive description*.

As in the case with many other traditional qualitative methods, ID originates from a constructivist epistemology, a theory of knowledge which states that meaning is not an absolute waiting to be discovered but rather it is socially constructed through the person who experiences it (Crotty, 1998). Thus, reality is complex, socially constructed, and ultimately subjective. Thorne (2016) states that description in qualitative research refers to the “itemization or documentation of something” (p. 54). *Description* in qualitative research is an open and exploratory way to define a phenomenon. The term *interpretive* implies that the realities do not exist as objective entities but as a socially constructed understanding that is crafted by the subjective person who experiences them (Thorne, 2016). This study acquires a subjective documentation of the clinical phenomenon of counselling.

ID requires that research projects be grounded in an “integrity of purpose”. It is through this integrity of purpose that a researcher seeks to describe a whole phenomenon by accessing a variety of data sources, using sampling techniques that are purposive in order to locate data that supports emerging themes or their variants (Thorne, 2004; Thorne 2016). Purposive sampling follows an inductive line of reasoning. An inductive line of reasoning builds findings by moving from specific observations of a phenomenon towards broader generalizations about patterns or theoretical constructions. This is in contrast to deductive reasoning, which starts with an existing theory and gathers data to prove or disprove theory, such as the case in many quantitative studies. Inductive reasoning involves testing and challenging preliminary interpretations rather
than merely accepting what is already known as the whole truth. Thus, the products of ID can be considered a tentative new truth about a clinical phenomenon (Thorne et al., 2004).

**Theoretical Fore-structure**

There is a two-part process to scaffolding a study. The first is to develop a literature review, which was observed in Chapter 2, and second, is to clarify “a theoretical fore-structure” (Thorne, 2016, p. 70). The theoretical fore-structure, which is the careful account of (a) where you locate yourself in your discipline, (b) theoretical allegiances prior to entering the study, and (c) your personal relationship to the ideas you hold. In the following paragraphs, each of these three points is elaborated upon.

**Disciplinary orientation.** Thorne (2016) writes, “our disciplinary orientation is our epistemological positioning, and as such, it deserves to be accounted for in the way we articulate what it is, that is scaffolding our study” (Thorne, 2016, p. 75). The discipline in which this study is oriented around is counselling psychology, which is an applied discipline that aims to develop emotional well-being, enhance quality of life, reduce stress and alleviate career stagnation in their clients.

**Theoretical allegiances.** Although ID takes a disciplinary orientation, no human being is truly immune from any theoretical influence. Explicit recognition and understanding of how our “theoretical baggage” may influence the research process is an important prerequisite to the inductive reasoning process. In contrast to quantitative studies, which usually seeks to neutralize any influence the researcher might bring into the process, ID, like other qualitative approaches, capitalizes on the researcher’s theoretical allegiances. Thorne (2016) suggests explicitly dissecting the ideas, thoughts, perspectives, or personal experiences that may influence the angle of vision one possesses. Thinking about the personal positions that we hold and how it may be to
our advantage or disadvantage will minimize any oversights or invalid assumptions about the data (Thorne et al., 1997). I briefly detail my theoretical allegiances and personal positions in the following paragraphs:

My personal experiences with working with marginalized members of society and the injustice I witnessed led me to develop my beliefs on disability rights. Chiefly, the belief that one cannot write policies from the outside looking inwards; one cannot assume one knows about the needs of an individual with a TBI disability, having never experienced a TBI for oneself. A survivors’ thoughts, opinions, wishes, and preferences need to be considered when developing policies. Furthermore, knowledge of treatment utility should include and prioritize the receivers of treatment, rather solely focused on the perspectives of caregivers, staff, or professionals. Survivors of brain injury were long thought to be cognitively incompetent in providing useful feedback about what they have experienced (Paterson & Scott-Finlay, 2002). A radical change the belief in TBI survivors’ ability to produce meaningful data is expected to be facilitated by this study.

I have worked with individuals TBI in part-time and full-time capacities as a support worker in a non-profit organization. This non-profit organization provided housing and life skills remediation support to adolescents and adults with acquired brain injuries. As a support worker, I assisted my clients with re-acquiring life skills such as housework, meal prep, personal care, managing and attending medical appointments, and navigating applications for social housing and government social service programs. This experience provided me with the advantage of knowing the nature and extent of support survivors need in the home in order to live a productive and meaningful life. However, this experience also created a bias because many of the survivors
I supported had very severe TBIs, which left me unable to predict the capabilities of one with less severe brain injuries.

Working as a support staff to survivors of brain injury inspired me to conduct a study about their experience in counselling. As a committed future counselling practitioner, I wish to be able to provide the best services possible to this clinical population. As an emerging therapist, I am aware that the lens which grounded my investigation of experiences in counselling will not be as sophisticated as someone who commands extensive clinical practice and experiences. However, as an emerging therapist, I do not have any deeply rooted biases towards any particular modality of work, where more senior clinicians might. I believe that my naiveté allows the subjective perspective of the survivor’s narrative to emerge from the data.

I am aware that such life experiences, theoretical allegiances and disciplinary orientations of mine may lead to bias in the way that my ideas and thoughts are formed. I will be working alongside my research supervisor during the thematic organization process to ensure that my interpretations have as much validity as possible. More details regarding the upholding of epistemological integrity will be discussed in the rigour and credibility section.

**Recruitment**

Forty-eight individuals were screened. Recruitment posters (see Appendix H) were posted by me, an undergraduate student volunteer, and several brain injury survivor volunteers. Areas posted include the posting boards of local coffee shops, universities, libraries, community centres, counselling offices, physiotherapy offices, brain injury drop-in centres, brain injury rehabilitation centres, non-profit organizations, retail stores and medical clinics across the lower mainland. Online classifieds postings were uploaded onto Craigslist, The Vancouver Sun and The Province. Social media advertisement was posted on the researcher’s personal Instagram,
Twitter, Facebook, LinkedIn and the accounts of various local brain injury awareness groups such as Brainstreams, and Brain Resources Advocacy and Information Network. The majority of participants were recruited from various brain injury support groups and social groups, and events by announcing the study, handing out recruitment handouts (Appendix I) and connecting with the attendees (see Appendix G for a script for group announcements). Three participants were recruited by word-of-mouth (i.e.: a friend had seen the poster and referred them to the study). One participant was referred by another participant.

**Pre-screening**

Initial pre-screening involved a short phone interview (see Appendix A) to verify that the interested volunteer had acquired a traumatic brain injury and not a concussion or non-traumatic brain injury such as stroke, aneurysm or brain tumour; and had received counselling in the past year. If they fit the two criteria, I arranged to meet with the prospective participant in person where they will sign a consent form before moving forward. (Refer to Appendix E for the consent form.) Thereafter, a more thorough pre-screening was conducted using the Pre-screening Form (Appendix B). During this time, participants were asked to answer the questions in Appendix C, Injury Severity Assessment Guide to the best of their memory. Determination of injury severity was confirmed by Dr. Izabela Schultz, R Psych. Participants were also asked to report for the month and year in which they had received their counselling and the names of counsellors. Participants who referenced more than one counsellor were asked to focus their discussion on their most recent post-injury counsellor.

In-person pre-screening allowed for rapport to be developed early on and for preliminary data to be collected that was used to select participants. I was also able to assess the participant’s sensitivity to noise and light, and energy management during this time (Paterson & Bramadat,
1992), information that was later used to collaboratively decide on the best possible location to conduct the interview.

In the end, forty-eight individuals were screened, and ten were selected through a theoretical sampling method. Sixteen individuals were screened out because the TBI was too mild (the individual reported having a concussion or that their MRI results indicated no change to neuroanatomy), four individuals did not qualify because their injury was too severe (by my judgement), two were screened out for incorrect type of brain injury (e.g.: tumour, stroke), two did not have a brain injury, nine people were screened out because their counselling treatment had occurred more than a year ago, three people were screened out because they had never had counselling. Participants with injuries that were considered too severe included individuals with speech that was unclear or incoherent, or that they had difficulty recalling their experience, or was excessively tangential in their narrative and/or did not respond well to re-direction.

**Theoretical Sampling Process**

This study utilized a theoretical sampling process. The goal in theoretical sampling is to achieve ‘maximum variation’ of relevant concepts (Thorne, 2016). Each interviewee was selected based on the provisional analysis of previous interviews (Robinson, 2013). I applied my judgement as to what type of interviewee would fulfil the developing theory. Through the pre-screening process, participants often volunteer ‘snippets’ of their experience, which I would compare against that I already knew from previous participants. If the participant appeared to have something novel to contribute, they were selected.

During the participant selection process, the criterion having had ‘counselling within a year’ was shortened to ‘counselling within the last seven months’, because it became apparent that individuals who had counselling more recently were available. I believed that not selecting
for participants who had counselling more than seven months ago gave my study more credibility, as confabulation in this population is common.

One individual, although his injury was moderate, and he appeared extremely articulate, was not selected to participate because of his tendency to take up air-time in asking the researcher for help with filing a lawsuit relating to his brain injury. His perseveration on the topic was persistent and he responded with aggression to re-direction. He was dropped as a study participant as he was not a good fit for the study’s aims.

By my fourth participant, I encountered an individual who experienced childhood trauma before his accident and the processing of this trauma was a significant part of his post-injury counselling treatment. As this was novel data, I selected participants who had narratives of childhood trauma in their experience of counselling. My fourth participant produced useful data, despite having a TBI which was categorized as severe. Hence, thereafter, my sample criteria expanded to also include individuals with severe TBI but were highly articulate.

Near the second half of participant selection, I encountered two individuals who fit the study criteria and were significantly more detailed in their discussion of barriers and what did not work for them in counselling compared to previous participants (who only spoke of positive experiences in counselling), thus they were interviewed in-depth several times instead of selecting for other participants who also fit the criteria but did not have anything novel to contribute to the existing data.

By the completion of the third interview of the two aforementioned participants, I decided that the data has become complex enough to be considered ‘saturated’ (Ryan & Bernard, 2004). I feared that any further addition to the data would become unmanageable for a researcher at my novice level of experience. The concept of data saturation is defined as the point in which
no new information or themes as observed in the data. Based on an analysis conducted by Guest, Bunce and Johnson (2006) in an attempt to operationalize the concept of data saturation, they found that 92% of codes will be developed by the twelfth interview and I had conducted fifteen.

The Selected Sample

The sample was made up of ten participants with injuries that ranged from complicated-mild to severe. Two individuals were complicated-mild, four had moderate injuries and four had severe injuries. Individuals with multiple TBIs were qualified based on their most severe injury, which for one case, was not the most recent. Individuals with a single mild traumatic brain injury or concussion were excluded. Participant date since injury ranged from seven months to eight years.

Participants ranged from 28 to 63 years old. All participants in this study had acquired their TBIs from a moving motor vehicle accident either as a pedestrian, passenger, a bicyclist or a motorcyclist. Two participants acquired secondary TBIs through a fall. Moving motor vehicle accidents are the most common cause of TBI in adults (Lezak et al., 2012), thus the participant profile is equivalent to statistical reports of causes of TBI.

By chance, this study achieved an equal gender ratio of five self-identified females to five self-identified males. Statistically, males acquired TBIs twice as often as females (Lezak et al., 2012), making this study sample a statistical anomaly.

The treatment duration at the time of the interview ranged from less than one year to six years. Most participants saw their therapist on a weekly or bi-weekly basis. The minimum number of sessions which qualified a participant for this study was three sessions. Nine of out the 10 participants had a relationship with a therapist for at least thirteen months. The time since treatment ranged from seven months to currently in treatment. Seven of the 10 participants had
already ceased to attend counselling at the time of interview. Participants referenced one to three counsellors from various time points in pre and post injury treatment in their narrative.

All participants recruited were fluent English speakers. Three spoke an additional language. Four participants reported having premorbid mental health diagnoses compared to seven reports of post-morbid diagnoses. One participant reported having a pre-morbid diagnosis of Asperger’s. Other demographic information such as alternate language, ethnic background, level of education, employment status, method of payment for counselling, marital status, members in household was collected from the participant and is summarized in the following table.
Table 1 Participant demographics summary table

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>N</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Age, y</strong></td>
<td></td>
</tr>
<tr>
<td>28-35</td>
<td>3</td>
</tr>
<tr>
<td>35-45</td>
<td>2</td>
</tr>
<tr>
<td>45-55</td>
<td>1</td>
</tr>
<tr>
<td>55-63</td>
<td>4</td>
</tr>
<tr>
<td><strong>Gender</strong></td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>5</td>
</tr>
<tr>
<td>Female</td>
<td>5</td>
</tr>
<tr>
<td><strong>Ethnicity</strong></td>
<td></td>
</tr>
<tr>
<td>European/Canadian</td>
<td>6</td>
</tr>
<tr>
<td>Ethnic Minority</td>
<td>4</td>
</tr>
<tr>
<td><strong>Marital Status</strong></td>
<td></td>
</tr>
<tr>
<td>Single</td>
<td>3</td>
</tr>
<tr>
<td>Married</td>
<td>4</td>
</tr>
<tr>
<td>Divorced/separated</td>
<td>3</td>
</tr>
<tr>
<td><strong>Severity of Injury</strong></td>
<td></td>
</tr>
<tr>
<td>Severe</td>
<td>4</td>
</tr>
<tr>
<td>Moderate</td>
<td>4</td>
</tr>
<tr>
<td>Complicated-Mild</td>
<td>2</td>
</tr>
<tr>
<td><strong>Years post-accident</strong></td>
<td></td>
</tr>
<tr>
<td>&lt; 1</td>
<td>1</td>
</tr>
<tr>
<td>1-3</td>
<td>2</td>
</tr>
<tr>
<td>5+</td>
<td>6</td>
</tr>
<tr>
<td><strong>Current Employment Status</strong></td>
<td></td>
</tr>
<tr>
<td>Employed full time</td>
<td>2</td>
</tr>
<tr>
<td>Employed part time</td>
<td>1</td>
</tr>
<tr>
<td>Student</td>
<td>1</td>
</tr>
<tr>
<td>Unemployed</td>
<td>6</td>
</tr>
<tr>
<td><strong>Treatment Status</strong></td>
<td></td>
</tr>
<tr>
<td>Terminated</td>
<td>7</td>
</tr>
<tr>
<td>In counselling</td>
<td>3</td>
</tr>
<tr>
<td><strong>Method of Payment</strong></td>
<td></td>
</tr>
<tr>
<td>Insurance</td>
<td>9</td>
</tr>
<tr>
<td>Pro-bono</td>
<td>1</td>
</tr>
<tr>
<td><strong>Education Level</strong></td>
<td></td>
</tr>
<tr>
<td>Some post-secondary</td>
<td>3</td>
</tr>
<tr>
<td>University/College Completed</td>
<td>7</td>
</tr>
<tr>
<td><strong>Place of Abode</strong></td>
<td></td>
</tr>
<tr>
<td>Family home</td>
<td>8</td>
</tr>
<tr>
<td>Independent home</td>
<td>2</td>
</tr>
<tr>
<td><strong>Data Sources</strong></td>
<td></td>
</tr>
</tbody>
</table>
**Interviews.** If the participant fit the screening criteria and was selected to participate in the study, they were asked to provide verbal consent (in addition to written consent provided before pre-screening) to continue to proceed with the study. Interviews were audio-recorded using QuickTime Player Version 10.4 on a macOS Sierra version 10.13.3 and back-up recorded using Apple Voice Memos App on an iPhone iOS 11.0.3. The interview was scheduled to take between 60 and 90 minutes, however, for two of the participants near the end, they were interviewed three times for about an hour each time to compensate for slowed speech, fatigue and breadth of content. In total, fifteen interviews were conducted, totaling 21 hours and 57 minutes from 10 participants. The average participant produced 2 hours and 16 minutes of data.

Semi-structured interview questioning is an inherent part of ID methodology and is a common feature of qualitative research. A semi-structured interview is organized around a set of predetermined questions but allows for questions to emerge from the interview dialogue (Whiting, 2008). The interview guide was originally developed from a review of the literature. The questions were structured around elucidating helpful and unhelpful experiences of a particular parameter of counselling.

Following techniques inherent to ID, I used probing (i.e. “can you tell me more about that”), paraphrasing, and summarizing are typically used to elicit further elaboration on a subject. In the process, I employed the participants’ key words and ways of speaking to prompt further explanation (Paterson & Scott-Finlay, 2002) (e.g. “so not enough ‘social’, you're not getting enough social contact?”). As a self-reflexive contemplation, I found that paraphrasing and summarizing too often may have contributed to participants losing their train of thought. Contradicting messages were challenged: the survivor was asked as to how they would reconcile two competing messages. For instance, “I noticed that at one point earlier you said that you had
wished for more space to emotionally process and accept what had happened to you but at the
time you say that the ... talk therapy about how sad this was, wasn't helpful. How do you
reconcile?” was one such question that produced a rich response. In addition, I found that
participants in this study also stopped to correct me if I misunderstood something, rather than
simply going along with the incorrect interpretation.

I questioned with an attitude of the participant as expert. If a participant had a lot to say
regarding a certain topic, I would follow the participant in his or her narrative. I did not interrupt
when participants had tangential comments or stories and I believe that this approach helped
build the rapport that allowed for rich, intimate, revelatory and elusive experiences to be
collected.

Paterson and Scott-Finlay’s (2002) article suggested several prompts that could be used
to assist participants to describe their personal experiences in more detail. One prompt I often
used was “some people have said X was important/was an issue/was helpful: what are your
thoughts on that?” X was informed by prior participant responses. I asked questions in this way
because I found that participants often had trouble with questions that were too broad. On
occasion, participants would have trouble offering a word to finish a sentence or make a
statement. Although there were times in which I could not resist helping the participant with
finding a word, I did try to refrain from inserting too many of my own words and allowing the
participant to use their own language.

**Supplementary data.** One participant submitted a drawing that was part of the
therapeutic discussion with his therapist. This drawing has been included as supplementary data.
The drawing can be found in Figure 1.
Researcher’s journal. Although the interviews are the chief source of data, the researcher’s journal was important for maintaining data integrity. Notes were made either on site or as soon as possible following an interview. Sixteen pages of hand-written notes were made on the interview site. Another 3195 words were recorded electronically immediately following the interview or during the analytic process. The researcher’s journal can be made available upon request. The following three types of notes were made:

(a) Additional data – Additional data included non-verbal body language, environmental influences, and utterances not caught on tape, which conforms to the participant observation aspect inherent in ID methodology.

(b) Preliminary analyses were noted – Prior to formal coding, preliminary analyses arose as a result of being immersed in the data collection process.

(c) Self-reflexive thoughts or memos were noted, as they arose during data collection. Self-reflexive memos around my personal position as a researcher were written down to support the intellectual integrity of my study.

Data Analysis

This study aimed to generate a descriptive product in which patterns and meaning in the data are identified through an analytic and interpretive process (Thorne, 2016). Since ID does not prescribe explicit analytic instruction, analytic strategies were drawn from various qualitative research traditions to fulfill the purpose of the investigation (Thorne, 2004). The analysis of data is inductive and iterative in ID and therefore occurred concurrently with data collection. An iterative process means that a gradual understanding of the data is slowly gained as the process of data collection and analysis is repeated. The structure and direction of the inquiry evolve as new possibilities arise and are considered (Thorne et al., 2004).
The process of data analysis began with the completion of the first interview. The audio recording was listened to and transcribed verbatim. Ten interviews were transcribed using Trint auto-transcription software and were edited for errors. Of the 12 that were uploaded onto Trint, five were edited by authorized transcriptionists and reviewed by myself. The remaining five Trint uploads were edited by myself only. Five interviews were fully transcribed through Rev, a transcription agency with human transcribers. Paraverbals (um, ah and uh), coughs, laughs, sighs, pauses, outside noise, telephone rings, and interruptions were included in the transcription, however, the majority have been removed in the final writing due to limited space. Review of the audio recording with the transcribed text was conducted as soon as possible to facilitate recall of significant non-verbal, environmental information or to integrate any insights developed.

After transcription, the transcripts were uploaded onto NVivo for Mac. NVivo data analysis software assisted in the organization and analysis of data. The software allowed me to move easily from coding to writing, minimizing disruption to the analytic flow. Every passage of the transcript was read and re-read, highlighting parts of the text (sentence, paragraph or section) that addressed the interview question in some clinically meaningful way. These passages of interest were highlighted through the NVivo software to potentially become “codes” later on.

“Coding” is the process of generation of “codes” or labels or from the raw data. These codes describe, name, and classify the concepts that arise from the data. Initially, the goal of coding is the creation of temporary constructs. Thorne and colleagues (2004) state that formal coding ought to be avoided early on, as it can derail the identification of patterns, differences, and connectedness among pieces of data. In other words, any preliminary constructs should be kept broad and generic until the analysis is further developed. In addition to codes, any memos
that were made in the researcher’s journal were copied onto the Annotations Tab in NVivo and were considered as part of the framework of analysis.

All subsequent interviews were conducted using refined interview questions and observation strategies that were shaped by the analysis of the immediately preceding interview (Thorne, 2016). In the end, the interview guide was changed a total of six times to support the emerging concepts in the data. The original interview guide had nine questions (see Appendix D). The interview questions changed gradually, until I met my seventh participant, from which I was able to expand from a 17-question to a 31-question interview guide. By the 10th participant, the guide had 38-questions, broken into five categories: Context Questions, Questions about How Counselling was Delivered, Questions about the Counselling Relationship, Questions about the Counselling Process and Interventions, and Other Feedback.

With subsequent interviews, the constant comparative method was used to compare the emerging codes (Boeije, 2002). The constant comparative method dictates that all data previously gathered and coded is to be compared to that which is currently being coded. Under this method, two codes may merge into one or one code may replace another code. Codes may become deleted or re-named to better suit the underlying content. A passage may have more than one code. Two codes may merge into one. Eventually, the descriptive labeling of codes was re-developed into interpretive meaning. This iterative coding process was facilitated by NVivo data analysis software in which all codes are linked to corresponding data, and are therefore, easily viewed, re-labelled, and moved.

As codes became heavy with data, they were grouped into categories. When the credibility of categories strengthened, they were arranged into a pattern. There were some codes that fit this pattern and others which did not. The end goal was to find the inter-relationships
among the data clusters across and within individuals that relate to the research questions and could be relevant to clinical practice. However, before committing to patterns, I explored every possible formulation of the way in which data can be clustered and linked along with considering the implications of such formulation. Reflective questioning such as “what will this structure illuminate that others will not?” and “what does it mean that certain elements are more prominent in this scheme than in the other?” assisted in the formulations of the data. The literature was re-visited to search of frameworks or explanatory factors to aid data analysis. Eventually, the categories were conceptualized into themes and re-assembled into a coherent analytic scheme. These themes provide an interpretive description of the experiences of counselling for individuals with a TBI.

Some qualitative researchers advocate returning to the participants for follow-up to collect feedback about the interpretation (Paterson & Scott-Finlay, 2002); while others claim that a researcher ought to be entrusted to make an interpretation that is representative of the experience (Melia, 2010).

Rigour and Credibility

Qualitative research attempts to provide descriptions rather than to measure and to generate rather than tests hypotheses. If qualitative research is to have practical application, it must have a set of criteria developed that allow for evaluation. Having these measures to support the credibility of a qualitative study are as vital to qualitative research as maintaining validity and reliability is to quantitative research (Thorne, 2016). Four criteria were used to judge the credibility of this study: (a) epistemological integrity, (b) analytic logic, (c) interpretive authority and (d) representative credibility. Although each qualitative methodology may differ slightly in their guidelines for judging the theoretical, epistemological and technical soundness of a study,
quantitative scholars have more or less accepted these four criteria as the main guiding principles. These four criteria will be defined in the following paragraphs along with an explanation of how such criteria intend to be fulfilled.

Epistemology is the understanding a researcher brings to their work about what constitutes knowledge and the process of knowing. In order for findings to be considered to have epistemological integrity, the research process must reveal a research question that is consistent with the stated epistemological standpoint and an interpretation of data sources and interpretive strategies that follow logically from that question. ID follows a constructivist epistemology, which is a theory of knowledge that states that meaning is constructed and is subjective. Thus, it is the participant’s constructed experiences which become knowledge. A constructivist epistemology was used to develop the research questions: (a) ‘What environmental factors of the therapeutic environment are described by TBI survivors and what are their experiences of them?’ (b) ‘How do survivors of TBI describe the therapeutic alliance?’ and (c) ‘What are the survivors’ experiences with various counselling interventions or approaches and the way such treatments are delivered?’ The questions ask about a survivor’s experience rather than the survivor’s family member or a clinician. The survivor’s responses to the interview questions are sufficient as ‘knowledge’ in and of itself. Interviews with the survivor was this study’s chief source of data, rather than observational data or the researcher’s reactions to the interview. Allowing the participant to guide the interview process also respects the constructivist nature of this study. In the analysis, identified constructs of importance emphasize subjective needs, barriers and nuances.

Second, qualitative studies are expected to demonstrate an analytic logic that render the reasoning of the study explicit. This is typically performed in two ways, by having “thick
descriptions” of findings and by generating an audit trail. “Thick description” is a term borrowed from ethnographic research, which entails that there is an in-depth illustration of the context. An audit trail is a clear record of how data was collected, analyzed and interpreted. The audit trail in this study included items such as interview transcripts, codes and coding categories, and the researcher’s journal, which included “thick descriptions” relating to the process, context, methodology, theory, analysis, and personal responses. All notes were organized in an electronic or physical notebook. The audit trail items of my research are available upon request. The “thick” display of data in Chapter Four allows the reader to assess whether the researcher’s interpretation is supported. I made sure to not discount data that contradicts the interpretation of data.

A third guiding principle of rigour and credibility in qualitative studies is the demonstration of interpretive authority. To ensure my research claims represent an individual subjective reality, the thematic organization was crossed-checked by my research supervisor, Dr. Izabela Schultz (Creswell, 2014). Any counter cases in the analysis were challenge. Considering competing explanations and questions around my interpretation will not only created interpretive authority but also provided an additional layering to the epistemological integrity of the study (Creswell, 2014).

A fourth way that qualitative studies can demonstrate rigour and credibility is through representative credibility. Representative credibility means that the theoretical claim this study purports to make is consistent with the manner in which my study was sampled (Thorne, 2016). This study sampled ten participants with complicated-mild to severe TBI. Considering the small sample size of this study, theoretical claims made were tentative and considered to be preliminary results. This study only makes claims which are relevant to the sample that was
achieved. This is the inductive nature of ID. For instance, it does not seek to compare participants who are living independently versus those in care facilities, as no participants reported living in a care facility at the time of the study.

**Ethical Considerations**

Approval from the Behavioural Research Ethics Board (BREB) at the University of British Columbia (UBC) was obtained prior to the commencement of the study. Participants were informed that this study was regulated by the BREB and should there be any reason to suspect the unethical conduct of the study or harm to participants, an investigation would ensue. The contact information of the ethics board and the principal investigator was made available on the consent forms that participants were given at the start of the study. The following section discusses the manner in which ethical concerns relate to informed consent, confidentiality, traumatic re-experiencing, and issues of power.

**Informed consent.** The concept of informed consent means to ensure that research participants fully understand the design and expected outcomes of the study and will accept, without coercion, the potential risks to which they may be exposed (Haverkamp, 2005). As individuals with TBI are considered a vulnerable population, it is essential that informed consent be delivered using language that can be easily understood and which is confirmed at multiple points in the study as evidence that their consent to participate in the study remains valid. Recorded interviews were not be conducted until at least 24 hours after written consent was provided (written consent is signed before conducting in-person pre-screening) to give participants time to raise any concerns they may have had about the study. Participants were given a copy of the interview questions in advance so that they were aware of the nature of the questions being asked.
Confidentiality and data storage. Confidentiality was protected by using acronyms in place of real names and by changing identifying markers (e.g. place of work, area of residence). All documents containing identifying information were stored on a separate USB drive that was password-protected. No files were stored on any cloud servers. Non-identifying files in use were temporarily stored on a password-protected computer intended for researcher use only. No files were viewed in a public place. All individuals who assisted with transcription were required to sign a confidentiality agreement (Appendix F) and were given strict instruction to not keep any files on cloud servers and to delete any files that were no longer in use. It was ensured that online services used to hire transcriptionists or any individuals who came into contact with the transcribed document or audio followed strict confidentiality policies. To the extent possible, interviews were conducted in private spaces. At the conclusion of the study, any identifying information on transcripts and field notes and tapes were destroyed. Unidentifiable data will be kept for a five-year period in a locked cabinet in my supervisor’s locked office to facilitate any potential publication of the findings.

Traumatic re-experiencing. The other potential ethical concern was the risk of producing an adverse emotional experience from recalling painful memories surrounding the counselling experience. When this occurred, I remained sensitive to the difficult experiences that had arisen. The participant’s feelings were validated, and I acknowledged that they were discussing a difficult time in their life. They were given an option to stop the study altogether or to resume at another time. Participants were informed that it was not the study’s intention to cause any adverse emotional experiences.

Issues of power. Finally, it is important to acknowledge the power issues that may exist between the researcher and the participant, especially considering that the population studied
herein is a vulnerable one. Issues of power were considered in the consent process, selection of interview location and time, and in the delivery of questions. In addition, all language that was used in this research study aimed to be non-oppressive and respectful. For instance, TBI survivors are considered to be individuals with disabilities and not disabled individuals. To create a sense of respect for their time and resources, monetary compensation ($10) was provided for participants who completed the study. However, many participants expressed feeling that the experience of sharing their thoughts on counselling to be a gift in and of itself and declined the offer.
Chapter Four: Findings

Analysis and organization of coded transcripts confirmed one major theme: Barriers and Facilitators in Counselling, and three sub-themes: Environmental Barriers, Developing the Therapeutic Relationship and the Structure and Components for Counselling with TBI Survivors. These themes and sub-themes were pre-determined, a priori themes derived from the aims of the study, which was to elucidate facilitators and barriers in counselling and from the research questions: (a) ‘What environmental factors of the therapeutic environment are described by TBI survivors and what are their experiences of them?’ (b) ‘How do survivors of TBI describe the therapeutic alliance?’ and (c) ‘What are the survivors’ experiences with various counselling interventions or approaches and the way such treatments are delivered?’

The first sub-theme of this chapter, Environmental Barriers, includes three categories of environmental barriers experienced and described by survivors in therapy: physical barriers, barriers due to cognitive demands of therapy, and systemic barriers. A barrier is something which limits an individual from fully benefitting from a service or that which makes a service less therapeutic than another population. Physical barriers are the architectural, design and layout barriers encountered by the client in the physical environment of the clinician’s practice such as bright lighting, patterns and prints, distractions, noise, and non-supportive seating. The cognitive demands of therapy become a barrier due to the cognitive deficits a survivor has. Under this category, inconsistency with time and date, lack of notes, lack of breaks, and therapist interjections can become barriers to therapy. Finally, systemic barriers are the wider societal issues that become reinforced in the counselling environment, including unconscious reinforcement of power, cost, and limited services.
The second sub-theme of data emerged as Developing the Therapeutic Alliance. This sub-theme includes categories of Client as Expert, Additional Support, and the Person-Centered Approach to counselling TBI survivors. The Client as Expert category involves allowing client autonomy around interventions, frequency and duration of sessions, and goals. Aspects of the theme Additional Support include having between session contact and coordinating care with other providers. The Person-Centered Approach category includes allowing for hope, having positive regard, revealing the person behind the therapist and having experience with brain injury.

The third sub-theme of data identified in this study is the Components of Treating Survivors in Therapy. In this sub-theme, the first category is Early Post-Injury Needs. Participants describe the involvement of a therapist in the neurorehabilitation team early in the post injury stages as extremely necessary for oneself and significant others. The second category under this topic is Overlooked Emotional Processing Needs – which introduces the participant described concept that past trauma is not irrelevant post-injury, the need for accurate reflection of the magnitude of loss, the participant need of a concept of acceptance that includes hope, and the utility of art therapy to facilitate grieving. The third category under this topic is Acquiring Compensatory Tools. To use compensatory tools, participants described their need to accept the use of the tool, to be taught personalized compensatory strategies and to be provided with assistance with problem solving potential issues with using compensatory tools. The fourth and final category is Reintegrating into Society. Participants described their therapists assisting them with developing scripts to inform peers of their ‘invisible illness’, and/or providing written letters requesting workplace or school accommodations.

The following table is a summary of sub-themes and categories in this study.
### Theme 1: Environmental Barriers

**Physical barriers.**
- Bright lighting.
- Patterns and prints.
- Distractions.
- Noise.
- Non-supportive seating.

**Cognitive demands of therapy.**
- Inconsistency of time and dates.
- Lack of memory aids.
- Lack of breaks.
- Management of communication deficits.

**Systemic barriers.**
- Power dynamics.
- Cost.
- Limited accessible services.

### Theme 2: Developing the Therapeutic Alliance

**Client as expert.**
- Autonomy around intervention selection.
- Consideration of the client’s goals.
- Autonomy around frequency and length of sessions.

**Additional support.**
- Between session contact.
- Coordinating care with other providers.

**Person-centred approach.**
- Allowing hope.
- Positive regard: “it was the way he treated me”.
- Revealing the person behind the therapist.
- Having experience with brain injury.

### Theme 3: Components of Treating Survivors in Therapy

**Early post-injury needs.**
- Early involvement of a therapist in the rehabilitation team.
- Involvement of loved one in therapy.

**Emotional processing needs.**
- Childhood trauma is still relevant post-injury.
- Grieving: “it’s like the magnitude of the loss was not validated”.
- Using the arts to facilitate emotional processing.

**Acquiring compensatory tools.**
- Accepting the use of tools.
- Personalized compensatory tools.
- Problem solving the use of compensatory tools.

**Reintegrating into society.**
- Raising awareness of the invisible disability in those around the survivor.
- Work/school accommodations.

---

**A Note about the Findings**
All quoted text is from my original fieldwork. The notation, which follows each block of quoted text, indicates the participant’s gender, age and severity of injury. Any interjections made by the interviewer that do not add context have been removed. Words have only been added or removed if quotes are unclear. Although mindful of length and clarity, quotes have been kept as much as possible in their original transcription to allow the style of expression of the survivor to show. Therapist names and location of services have been removed to protect participant confidentiality.

Sub-theme 1: Environmental Barriers

The narratives of the sample population exhibited three types of barriers experienced by survivors in counselling therapy: environmental, cognitive and systemic.

Physical Barriers. Survivors of brain injury discuss bright lighting, patterns, distractions, noise, and non-supportive seating in the counselling environment.

Bright lighting. Five out of the 10 participants mentioned photosensitivity. Three of those participants required the use of darkly tinted glasses even in indoor settings to cope with the discomfort.

Her blinds didn’t close properly. So, my eyes were always watering, my eyes were always hurting in her office. … I started to bring my sunglasses. … By the time I left her office because of all the light coming in, … I would have trouble leaving, getting my stuff on and [pause] because I would be disoriented. (F-58-M)

The following participant describes how photosensitivity made it difficult for him to find words to say:

It’s more like pressure in the head. Like as soon as I take [the sunglasses] off, I started feeling [the tension] already there. … Once it starts, it just starts kinda spreading. …
When the headaches come, it's hard to focus, right? … It matters a lot, that the lighting condition is comfortable, because I wouldn't have to, you know, try to block out the light or endure the brightness. … (M-36-CO)

I observed during the interview process how survivors could have difficulties with harsh white lighting, such as fluorescents and the screensavers of laptops and cellphones. “I would make them … turn off the lights and shut down anything that was on” (F-58-M). During one interview, one participant arrived early and had turned off all the overhead lights and sat with her back to the window. Some participants report that soft, warm lighting is tolerable. “So, the room, … it was not too bright. … It was an energy that I was able to open up. … The lighting was not bright. It was more of an ambient type. … It wasn't white lighting.” (M-36-CO)

Many individuals have expressed their appreciation for counsellors who have been sensitive to their photosensitivity such as the participant below:

Oh! He was so respectful. … he asked, like "is there a better light for you." Like, does this light bother you or, right? It's like, "do you want me to turn it off." (F-61-M)

For some survivors, blinds are not adequate and the use of a heavy curtain is additionally needed to further “diffuse the light” (M-36-CO).

**Patterns and prints.** Patterns and prints in the therapy environment can become difficult for TBI survivors to cope with. One participant stressed her difficulty with therapist attire: “yeah, if you wear checks, ugh, certain checks or stripes or things like that can be so difficult, visually, if something has a visual, you know, [issue]” (F-61-M).

Blinds are not only insufficient in blocking out light, it appears that the slats cause an additional issue described by F-61-M:
And he put my back to the window … because they were, what do you call those, slats?

On the window, the blinds? Venetian kind of blinds? That's a killer, those lines for people with brain injury … All those stripes, it can make you dizzy actually. (F-61-M)
The participant further elaborates: “I don't think it would matter [whether it’s horizontal or vertical]. It's distorting the vision for you and you're having enough trouble trying to put everything together”. The data points to the fact that there are certain things in the visual field that can cause survivors discomfort, nausea and dizziness, which may become a barrier to counselling if not addressed.

**Distractions.** Participants in this study talked about several objects and behaviours in the therapy environment that were distracting for them. One individual described how shaking and tapping of limbs and pens can be difficult for survivors: Views outside a window are also a source of distraction because there can be trees swaying and people passing by. One participant said, “You would be sitting there and like, there's like, the beautiful [city] view behind her, so I was very distracted by her background.” (F-29-S). Another participant (F-61-M) describes one strategy her therapist used:

Most of us get distracted pretty easy. So, he had my back to the window, which was great, and then it was just a blank wall in front of me and there wasn't a lot of like pictures or patterns, you know. Patterns, pictures, polka dots, all those things are distracting.

Another participant, when asked about what the therapy environment was like, was able to describe in detail the kinds of cat posters that were on his therapist’s wall. Thus, patterns and prints are not only disorienting, they can also simply be distracting as well. Distracting attire extends to accessories worn by therapists. One participant remarked, “like if somebody's wearing
big earring that are ‘nin-ni-nin-ni-nin,’ — instead of listening to what somebody's saying, I'm watching the earrings, right?” (F-61-M). Screensavers of electronics can also be a source of distraction. During the interview, participant F-61-M put a piece of paper over the interviewer’s recording device because it was producing audio waves on the screen. Another participant, when asked about distractions in the environment, pointed out how the screensaver of the researcher’s laptop was competing for his attention.

**Noise.** Four individuals interviewed reported sensitivities to noise. In this study, there were two types of sound sensitivity issues observed: the inability to filter out background noise and the magnification of sounds that are normally benign. One participant (M-36-CO) arrived at his session wearing earplugs, which exemplifies how everyday sounds such as footsteps, faucets and sirens can become magnified for TBI survivors. The participant below describes her difficulties with soft background noise in a room and some of the ways her therapist helped her cope:

P: Sound can be, uh, way louder for me. …You hear that, do you? The motor cutter of the air thing, can you hear it?

I: Yes, now that you mention it.

P: Well, that's coming into my brain as important as you talking to me. And so, I'm constantly having to go, "no, that's not important, what did she say", you know? … So, any noises, … it's like my brain doesn't know, "filter that, it's not important". It's all, it's all coming in, so. …

I: So, what did [therapist name] do for you to help you with that?
P: Well, he had a clock that ticked, right? And … especially when it was like, I had to think, … it would be like, "TICK! TICK!" So he e-, he ended up, he would take the batteries out. (F-61-M)

To cope with more disruptive noise that come and go such as sirens, one participant reported using a humming strategy with his therapist.

If we're in a session and a police car or a fire truck goes by … he'll plug up his ears and he'll start humming and … he'll do it in a way that's very [pause], you know, he'll look at me [plugging his ears, head nodding]. And then I'll be like "OK, OK I get it, OK, I'll do it."(M-36-CO)

The participant suggested that having his therapist use the tool with him helped him find acceptance of his noise sensitivities. The participant also spoke of the helpfulness of a white-noise generator in ameliorating noisy conditions.

What I like about [therapist name]'s waiting room is uh, he has … a white noise generator. So, … it's just this hum, so it takes the edge off the footsteps in the hallway. … I didn't notice it until he pointed it out and then I kinda started putting things together, like why does it sound so … different, like the waiting room compared to the hallway. Or just in comparison to other waiting rooms. … There was once when … I was seeing [other therapist name], … she turned it off once … and she asked … how did I feel. And I preferred [the white noise generation] on. (M-36-M)

Non-supportive seating. There were several participants who mentioned chronic pain being a prominent feature in their lives. One individual described how the counselling environment can accommodate for chronic pain. One participant (F-61-M) suggested that therapist should monitor for signs of discomfort and ask the client about their needs.
You'd have to check it out. … Because when you're working with brain injury, some of these people have had really bad car accidents and everything else, and they're in pain and they can't sit that long. And they're starting to fidget, right? … But like, it would be great if they could pick up that you can tell that somebody's getting tired or that needs a break or needs to stand. (F-61-M)

One survivor mentioned her appreciation of the choices in seating and support props: “I would grab a pillow and hug it and we would talk. … So, it helps that like, that like, wherever the setting is, that there's options, like, the couch, the table, or the ground, you know, or like, sandbags” (F-29-S). As the manifestation of injury can vary, having options can be helpful. However, there is only so much one can do to assist with a patient’s chronic pain. Participants reported that sometimes, despite following all medical recommendation, they may still have “a pain day” (M-63-M):

    Every so often, I get a pain day. A lot of people … get a pain day no matter what drugs they take. … I get that. I get that once, once or twice a month.

In the following quote, a participant expresses his regret with attending a session when he was having ‘a pain day’:

    I was already overwhelmed and tired. And my symptoms were really on the high end, [but] I still pushed. Instead of calling in to cancel, I st—, I still showed up. And my leg, because of the neuropathy, the nerve pain, that was, that was, the whole session I wasn't able to have real dialogue with him. I was constantly shifting around, I was like, "ow, I'm in pain", you know. And, so I kind of wasted his time and my own time. And then after that when I got home, I, I snapped and I was breaking things. Yeah, I, I was over, over stimulated. (M-36-CO)
Some survivors may need support with identifying when it might be a better idea to take ‘a pain
day’ and stay home from therapy in order to prevent further distress.

**Cognitive Demands of Therapy.** The cognitive demands of therapy can pose as a major
barrier to counselling therapy. Categories of cognitive deficits and their corresponding lack of
adaptations include: inconsistency of time and date, lack of memory aids, lack of breaks, and
therapist interjections.

**Inconsistency of time and dates.** Five participants talked about their need for consistency
in counselling session date and time. The following are two examples from participants who
struggle with arriving to an appointment at the agreed time or date.

When they changed … was when I tended to miss them. … I would usually call or e-
mail. Or sometimes I wouldn't until after the fact though because I wouldn't realize that I
missed it till after. … Sometimes I would miss multiple in a row. (F-34-CO)

Brain doesn't like changes during its healing stage. … There's been times where I forgot
the appointments ‘cause I got so used to coming in for one o'clock … that when it was
booked for ... four-thirty, I would end up showing up early. (M-36-CO)

Consistency of appointments not only helps with absenteeism, it assists the client with being
mentally prepared for therapy:

Constantly changing threw me off. And then sometimes I'd sat there and that would be
the reason it took so long to start. I need the consistency. So, I'm constantly ready and
able to dive in. Prior to that accident, I did yoga four times a week … on different days
and I would switch it up. But after the accident, no switch up. (F-58-M)

Another participant expressed her reliance for the advanced email and text message reminders to
assist her with orienting herself to the correct date.
Yeah, [consistency] was huge. … Thank God they sent reminder. ... Um, because sometimes I would think it was Tuesday and it was Wednesday already … I totally had the wrong day, right? (F-61-M)

In addition to a regular time and day of the week, participants also stressed the importance of being able to see their counsellor during a time of day when they feel the most alert and energized. Many survivors report having a hard time with mornings:

It takes forever for me to get going in the morning. … Mostly because I feel sick … I wake up … and I always felt like I had the worst hangover in the world … And I'd sit up, and the room would keep going. … And uh, so, for me the time of day made a big difference. (F-61-M)

Additionally, non-peak hours are preferred so that the survivor can avoid rush hour crowds.

I've had some five o'clocks before with [therapist name] and … I don't think it was too productive, ... because his office is in downtown … and that's same period people are getting off work. So, it's really chaotic … people are constantly invading my space, the elevator is packed … (M-36-CO)

Although the majority prefer early afternoon, there are some who remain morning people. F-58-M stated that her optimal time is “any time up until noon. Anything afternoon, I didn't want to be there, I didn't wanna talk anymore. … You have a brain injury, you're tired.”

*Lack of memory aids.* Although many participants in this study admitted to struggling with memory issues, it did not preclude meaningful data to be collected in the interview; furthermore, they expressed that memory difficulties did not render counselling useless. To counter for poor memory, many participants expressed finding it helpful that they were given a sheet of notes.
I wouldn't even be through that door and I would probably forget 98 percent of the conversation. ... So, she'd write things down. ... It would help that I could ... look at it. ... She wouldn't write down like pages and pages and pages. She'd write maybe a couple things for me to work on. (F-56-M)

One participant expressed how much she appreciated that her therapist understood this need:

I couldn't have written down the notes and listen to what he said. That was one of the things [I appreciated], he didn't make me feel bad about writing them down or anything. And actually, he said "I'm gonna write that down for you." Like he knew that I couldn't do both, right? (F-61-M)

Notes, however, do not serve a purpose if they are lost or if the client does not remember to review them. One participant noticed how helpful it was that her therapist used coloured paper. “It's funny. The yellow piece of paper would stand out to me, so I'd see it during the week” (F-61).

In addition to notes, F-61-M also described a creative approach that her therapist took to facilitate recall, which utilized a tangible, take-home object.

So, he explained to me that with my depression, ... he would say that I'm holding it like this [clenches up Kleenex in hand] ... And he would have me like, hold it, hold it, hold it, hold it, and then just let go and, and see the differences in how I feel. ... So, a lot of the goals, I think, were to try ... to become friends with ‘my little depression’ and then ... eventually it would open up. ... I told him, I'm taking [my Kleenex] home! And ... I took it out during the week and looked at it, ... it triggers your memory, right? ... I have my little Kleenex ... on my desk and then I go, "ohh, yeah," and then ... I'd think about what he told me.
It appears essential for TBI survivors to have something to take home as a memory aid. Brief notes appear to be a foundational need for most clients. Additional tangibles representing important concepts appear to be tremendously effective.

**Lack of breaks.** Fatigue as a barrier to therapy is articulated by the following participant’s desperation for clinicians to be mindful of shifts in energy levels.

I know I've been at appointments where I'm like *(makes a dazed look)* ... like, and they're still talking and telling me everything and I'm out. I'm gone. I'm so far gone … But like, it would be great if they could pick up that … somebody's getting tired or … needs a break or needs to stand… *(F-61-M)*

As I experienced during the data collection process, the onset of fatigue can be quite sudden. I had arranged to meet with a participant to go through the pre-screening questions. We were actively engaged in the process when suddenly, at 40-minutes, her rate of speech had suddenly slowed, and her affect flattened. She requested to stop the screening process. One individual had stated, “the fluctuation in energy… it's so unpredictable” *(M-36-CO)*. *(F-61-M)* reported that taking a break would help “recharge [her] batteries” and “helped [her] retain more and be able to process more”.

Although not recorded on tape, several participants *(M-63-M, F-58-M, M-36-CO, F-61-M)* reported that after having attempted to participate in an activity or task that was beyond their energy limits, they have required bed rest for several days.

**Management of communication deficits.** There are two types of communication deficits that were observed and described by participants: tangential speech and slow processing speed. How a therapist manages these deficits can allow it to become a barrier or a facilitator.
Tangential speech. A common phenomenon after brain injury is tangential speech. At times, a tangential story can enhance the original point, but at other times it can be a hindrance. Participants have talked about unintentionally going on a tangent and forgetting the point they were trying to make. Both M-36-CO and F-61-M talked about how her therapist makes a respectful interjection.

Tangents are one of my brain injury things. You know what [therapist name] did? He would say “okay!”, [waves arm around in a large circle] like we decided that. … [laughs] I was only allowed to tell a story or two and then he'd say, "okay, let's come back now"

And I'd say okay, you're right. And we came up with that together actually.

Effective management of tangents, whether through hand gestures or otherwise, appear to be highly personalized.

Slow processing. Due to “too much noise, or too much stimulation” (F-61-M) or other issues, survivors can be slower to respond to questions or statements. Slow processing can be particularly impeding if it is early after the injury. F-61-M, who was five years post-injury, recalled that “probably even six months ago that, uh, … your normal talking would be way too fast for me to take in. I wouldn't, I just wouldn't be processing it.”

One participant reported that she eventually learned to say, “‘oh that was too quick for me’, or ‘can you say that again’.” However, she warns that not all survivors may be able to.

“Early on ... , for me anyways, I didn't want to have a brain injury, so I wasn't gonna tell you … I had no clue what you were talking about, right?” (F-61-M)

Thus, because of resistance to admitting deficits, one participant suggested that clinicians check whether the individual has grasped the content.
If I was a therapist counseling somebody, I would try to get them to tell me back what I just explained to them. … You can't assume somebody got something, … unless you really check it out with them. (F-61-M)

In addition to checking for understanding, F-61-M urged clinicians to wait for a response after asking a question once rather than re-phrasing a question. “There is one thing that makes a big difference … is that, uh, when somebody asks me a question that they wait for a little bit. Because it's coming in and I'm thinking and I'm slow, right?” (F-61-M)

Finally, auditory processing barriers appear to be even more apparent in telephone conversations. In therapy, there may be certain instances where telephone communication may occur, such as when scheduling arrangements need to be made.

I have a really hard time … on the phone. … So many times somebody calls and say, "uh, hi, it's so and so, can you call me back, [fast forward tape noise]," right? And it's just like, “what?!?” … I have to listen to it like a zillion times …. (F-61-M)

Slowing down appears to also apply to phone conversations as well. Participants have expressed a desire for clinicians to confirm with them to determine if they have understood content, slow down the speed of conversation and wait before re-phrasing questions.

**Systemic Barriers.**

Systemic barriers are barriers erected by the attitudes, beliefs, culture, structure, organization or policies of the practice, wider governing body, other authorities or society. Categories in this sub-theme include power dynamics, stigmatization of drug use, cost, and limited services. Although these are not issues specific to TBI survivors, they are commonly experienced by TBI survivors due the accumulation of financial, psychological, and physical hardships that are often endured post-injury.
**Attitudes towards drug use.** Although it may be reasonable for therapists to decline seeing someone if they are using a recreational drug that impedes analytical thinking, substance use becomes a more multifaceted issue when it is used for pain management. Misjudgment in this issue can be a major barrier to accessing therapy. One participant (M-28-S) reported that his psychologist would not provide him with treatment as long as he was using marijuana.

P: Cause I'm smoking too much pot and he says … he's not understanding. And whatever he was trying to teach me, … it wasn't registering with my brain. And … that's one of the reasons why he kinda, doesn't want to see me right now …

I: Well, why do you smoke pot? …

P: It helps my body pain a lot. I have a lot of broken bones. … without it, it's kinda hard. …

This presents as a major barrier: he requires marijuana to cope with chronic pain, however his therapist has stipulated that using this drug makes him unfit for counselling. Whether marijuana in its medicinal or recreational form is a suitable method of pain management for survivors is beyond the scope of this thesis. However, it is worthwhile to present this survivor’s experience for future research exploration.

**Power dynamics.** Although issues of power dynamics can be applied to any population, they are particularly poignant in survivors of brain injury. For an individual who previously viewed himself or herself as one who held authority, expertise and competence but can now no longer operate at their previous level of functioning, the experience of unequal power with a therapist can result in a negative view of the self and feelings of shame.

I've been places where, uh, the doctor or the therapist sits in a nice, fancy chair and then they put out, like lower "cucky" chair for the person that comes in. … Or, … if they have
a place where they have, uh, coffee or tea, and that theirs is in a cup or a mug and the one
that they serve [clients] is in Styrofoam. … I think when your brain injured, … you're
feeling like a second-class citizen, and … you see all those little, subtle things. (F-61-M)
The following excerpts indicate that the issues of power dynamics extend to the waiting room as
well. Participants in these interviews articulated both positive and negative experiences with
waiting rooms:

Well, I loved [therapist name]'s waiting room because um it was uh, it was, they rent an
office in a business office …, so people … are seeing lawyers and … accountants, and all
different people. So, you're not there to see the psychiatrist, you know what I mean? Like
nobody knows why you're there, right? ... [And] the wom[e]n that … answers the phone
there for all the people, ... both of them are very friendly, which was really nice ... 'Cause
sometimes you can go to a place where ... they're sitting higher ..., looking down at you ...
Or it's ‘One Flew Over the Cuckoo's Nest’ kind of uh, place, where you go up and they
have this glass thing because they're so afraid of you. (F-61-M)
The experience of being treated with respect and as a valued member of society appears to be of
utmost important for survivors because “brain injuries … affects the person's personal
relationship with himself and their self-worth and the self-esteem” (M-36-CO).

Cost. The cost of therapy was identified by some participants in this study as a major
barrier to counselling. F-61-M admitted to struggling alone with suicidal feelings, partly due to
not being able to find pro-bono services when she sustained a fall. She states, “I can afford some
stuff, but I couldn't afford like a—, a 185 an hour. Uh, I can afford it, but I wouldn't be able to go
very often, right?” Another participant (M-28-S) exclaimed that even though counselling was
very helpful, he “[doesn’t] think $180 is worth one hour of [his] time to pay a doctor to listen to
[his] stories”. Both M-28-S and F-61-M had waited between three and four years before starting their relationship with their therapists, which suggests that some individuals struggle for a long time on their own because the cost of treatment is a barrier.

**Limited accessible services.** For two participants’ (F-61-M, F-58-M), although they accessed different hospitals in different provinces, they both expressed feeling that because they were “walking and talking,” their need for services had been “ignored”. They also expressed that they had to “overdo it” or “play the system” in order to continue to receive necessary care and treatment. In addition, both of these participants were terminated by their main counselling therapist sooner than they had wished.

I: Um, did, was there anything you didn't like about [your counsellor]?

P: Truthfully no, the only thing was that I couldn't continue to see him. … If I could continue to see him [continuously], every few months like I said, I think that would help, help me, b- get, function better. (F-61-M)

P: Mm-hm. So. It got terminated [after about a year] — let's be fair — because the money ran out. I didn't like it. … I felt I needed more. No matter what you say, I felt I needed more. (F-58-M)

Since both participants accessed their counselling relationship through publically funded or pro-bono services, it is likely that they were discharged from services due to limited resources. However, this was experienced by the client as “falling in between the cracks” or being “ignored.”

**Sub-theme 2: Developing the Therapeutic Alliance**
Three categories were identified as being facilitative to building a strong therapeutic relationship with survivors: client as expert, additional support, and person-centered approach. Lack of these factors can result in barriers to building a therapeutic relationship.

**Client as expert.** Putting the client in a position of expertise on their condition involves providing autonomy around the discontinuation of unhelpful interventions and consideration of the client’s goals for therapy and collaborative deciding on frequency and length of sessions.

**Autonomy around intervention selection.** Research has found that clients who received their preferred interventions had better outcomes (McLeod, 2012). In this study, participants reported using a range of interventions and modalities. Interventions mentioned in this study include Gestalt’s ‘empty chair’\(^1\), trigger-awareness-grounding, role-playing, visualization, meditation, deep breathing, letter writing, cognitive behavioural therapy, prolonged exposure therapy, systematic desensitization, and eye-movement desensitization and reprocessing. Those who were given the autonomy to decline the interventions that were unhelpful appeared to have more positive feelings towards their therapist.

Although almost all the interventions and modalities mentioned in the study were described as being helpful, there are a few that were not. Some participants expressed having autonomy in not going forward with unhelpful interventions while others did not have the choice. Henkleman and Paulson (2006) have suggested that qualitative descriptions of unhelpful experiences are more revelatory in understanding gaps in clinical practice than helpful

---

\(^1\) The Empty-Chair intervention is where the client engages in an imaginary dialogue with a person of interest. It is designed to access restricted feelings and under the guidance of the therapist, these maladaptive feelings become restructured (Paivio & Greenburg, 1995)
experiences. Thus, the following paragraphs will describe participant experiences with unhelpful or incompetent interventions.

Two participants, both involved in motor vehicle accidents, reported that their therapists used Prolonged Exposure Therapy (PET) to treat the Posttraumatic Stress Disorder (PTSD) symptoms that arose from their accidents. Refer to Byant (2001) for a discussion of PTSD post TBI. Both participants reported that it was a frustrating experience, as they could not recall any details of the accident. M-36-CO describes feeling appreciative of the freedom to decline this unhelpful intervention:

He offered [Prolonged Exposure Therapy]. ... I was open to that. I said yeah! ... Um, so he wanted me to go home and write about it. That's when I was like, I can't do it, I-I-I just can't, it's too many bits and pieces.

Another participant (F-29-S) also spoke of her inability to usefully engage with PET.

P: I did that with [my first counsellor] ... but, it was very much like, broken.

I: You don't remember?

P: Yeah, exactly. So, it was like, "Uh," and then I just woke up and saw my mum in the hospital.

The data suggests that although PET may be an effective form of treatment for a general PTSD sufferer, those with amnesia due to medical reasons do not benefit.

Another unhelpful intervention that was not recorded on tape was M-36-CO’s experience with EMDR. The theoretical concept behind EMDR is that the repeated side to side saccades of the eyes allows one to calmly and coherently process traumatic memories (Chen, Zhang, Hu & Liang, 2015). One way to deliver EMDR is to instruct the client to watch the therapist’s finger or
pen as it is waved back and forth. M-36-CO reported that he experienced nausea when he attempted this intervention in therapy.

Overall, this study’s findings suggest that in the treatment of TBI survivors, not all counselling interventions are equal. In addition, prior research suggests that it is the client’s response to the intervention that is more strongly linked to outcome rather than the intervention in isolation (Henkleman & Paulson, 2006).

**Consideration of the client’s goals.** Participants in this study have reported experiencing a misalignment between their own goals in therapy and the goals of other stakeholders. F-58-M reported that she was told she “had to” go forward with systematic desensitization therapy, to desensitize her from the traumatic accident that occurred in her house, as this was a directive from the insurance agency. “I kept telling her I don't want to be here. And she kept telling me, ‘well you have to’ ... it was part of the rehabilitation that I had to experience this.” She reported that even at termination of therapy, she could not stay in the house alone for longer than 10 minutes. She states, “to this day that house just represents ugliness to me” and “I would see devils on top of [that house].” It is clear that these misalignments have caused harm in the participant, or at least led to counselling which was likely not as helpful as it could have been.

Other participants have expressed having difficulty with insurance agency directives to use a specific intervention.

‘Cause [the insurance agency] kept asking him ... "what are you doing with [M-36-CO]”, right? “If-if-if [he] wants us to pay, then we want him to be doing something that's accident related”. And what [my therapist] was saying is that everything [I’m] going through is brain injury and [I] got a brain injury from the car accident but [the insurance agency] says that they would only pay [my therapist] if I do counselling specifically
about the car accident. And it's like, how can I do [prolonged exposure therapy] if I don't even remember [the accident]? [sighs]. (M-36-CO)

However, this participant expressed appreciation that when he told his therapist that he could not recall details about the accident, that the intervention was dropped. “So, there was no pressure, ... it was like, yeah, you know what, don't worry about it. So, that helped build the bond too, right?” (M-36-CO). Thus, consideration of client’s goals in therapy builds trust and rapport and facilitates the formation of “a real relationship” (Keenan & Rubin, 2016).

**Autonomy around frequency and length of sessions.** This study found a range of preferences for frequency and length of each session. Some survivors (F-61-M; M-36-CO) reported feeling that a one-hour session was long enough for them to get into the therapeutic process and not so long that they would become fatigued. “I would cry ... and then, I would be pretty much brain dead. Like I wouldn't really be processing anymore. ... So ... one-hour is ... good. 40-minuets is a bit too short.” (M-36-CO)

Two participants, however, felt very strongly that a one-hour session was insufficient for them to get into the therapeutic process. F-58-M reported the need for 90-minutes: “It takes me a while to start talking. So, it, it, for me, [one-hour sessions are] frustrating because by the time the hour’s up. It's time for me to go. Right?” (F-58-M).

F-34-CO describes her desire for a “flex hour” due to her need to present an entire story in order to identify her concerns.

I would love an hour that has like I know the practitioner has 15 minutes of space at the end of the appointment that if we've gotten somewhere really essential or I'm too messy and I need their help getting back together before we go that not someone sitting right outside the door, waiting. (F-34-CO)
Other participants discussed how their preferred length of a session depended on whether there were issues that needed to be discussed:

I think maybe an hour, hour and a half [is ideal]. Yeah. 'Cause then we can get into deeper things. But, sometimes, ... like the last couple times, it's been very much like, updates and we never really got to the deep things. So, sometimes it'd be 45-minutes and I'm like, "okay, when is this hour gonna end?"

In terms of frequency of sessions, most survivors reported feeling as though weekly sessions were sufficient. One participant strongly felt that he benefitted the most from twice weekly sessions.

When I did the twice-a-week sessions, I noticed that I was doing a lot better in terms of managing the world. ... Because a lot of times, the weekends tend to be difficult. Um, and I would see him on like a Thursday ... so that I can pull through the weekend and also reflect on how I felt and how things are and how I'm reacting or responding to things. ... So then, we'll catch up the Tuesday and then we'll kinda keep building onto it. But once that system gets prolonged and I see him maybe once a week or once every two weeks... it's a lot of chaos ... It's hard to even know where to start.

Another participant pointed out that in the early stages post-injury, she would have benefitted from counselling that occurred more frequently: “Maybe twice a week, even. ... But for shorter times, ... like half an hour or 45 minutes” due to poor content retention. “You don't remember one week to the next a lot of times. It's very hard.”

Meanwhile, others such as M-28-S felt the need for a session every other week. He states, “When it was weekly, it was kind of hard for me to figure out what to talk to him about. ... The
only thing that was going on in my life at the time was rehab.” Another participant reported
terminating with his therapist because he felt too busy with other rehabilitation demands:

I just was tired of having to go to a ton of different appointments and doctors. ... I'm
always at the hospital doing some sort of test it seems. ... Getting to a counsellor is just
one more thing I had to schedule in and I was just tired of it. (M-40-S).

All participants in this study reported that their therapist gradually reduced the frequency
of sessions (tapering) instead of abrupt termination. One participant reported preferring tapering
because she wanted to test out her ability for self-sufficiency (F-56-M). One participant
suggested that, if need be, reduced frequency can increase again if the client requires it:

Like instead of seeing her every two weeks, two weeks, two weeks, we'd say well, let's ... 
see how [a] three week’s [gap] goes, if it doesn't [go well], we go back to two weeks. (M-
63-M)

Due to the complexities of cognitive, behavioural and emotional issues that survivors experience,
it is evident that respecting the client’s pace with tapering or even life-long therapy is extremely
important:

Yeah, and I, it's the kind of thing that I think I would benefit for the rest of my life to
have [my therapist] there. ... I probably would benefit from one month or every two
months, just checking in. ... helping me function and trying to figure that all out. And I
don't have anybody to talk to about it. And talking for me helps me figure out how to fix
it. If I have nobody to talk to about it, then I can't really fix it, right? (F-61-M)

In summary, it is evident that survivors have different needs for frequency of sessions and the
length of each session. However, long-term therapy with gradually tapering sessions appears to
be the commonly required structure of providing counselling to TBI survivors.
Additional support. This study found that survivors were appreciative of the ways therapists provided support beyond talk therapy. Participants described two ways in which their therapist provided additional support: between-session contact and care coordination.

Between session contact. Many participants expressed deep appreciation of being able to have contact with their therapist through phone or email between sessions. One participant reported using email to express his thoughts to his therapist between sessions when he was undergoing a particularly emotionally overwhelming phase.

Sometimes I would uh, write, I would journal sometimes to him. [sigh] And I will do just some wacky, really wacky, emails, dark, [inaudible] stuff. And you know, and he'll respond, ... he'll acknowledge it, and [pause] that's really helpful. (M-36-CO)

Another participant (F-58-M) expressed her appreciation of her therapist offering her to call if she wasn’t feeling well after her session.

P: If the session was rough, she’d call me at home to make sure I was OK. And I appreciated that! Or she said, "call me." Right? I think I only called her once. But just the fact, she gave me that—

I: Option.

P: Yeah. Didn't make me feel like a number.

Another participant, reported using text messages to inform his psychologist when he was successful with using socially appropriate language and behavior.

When I came out of hospital, I wasn't really good with the communication. … I'd just said things that were rude or ... just cursing. … He actually had me text him for any time I had good communication. (M-28-S)
Another participant relied on the ability to reach her therapist between sessions to prevent relapsing into a state of alcohol abuse.

I was using alcohol to dull the pain and to try and I guess, self-medicate. … If I drink, I have no desire to stop drinking … so the best thing to do is to not to drink. … And then sometimes I think that I want to drink. … I email her when I'm thinking in my head “oh, it seems like a perfectly good idea to drink” and I'll say to her "why don't I drink?". And then ... she'd give me a kind reminder. So, she'd respond to your email and remind you why it wasn't a good idea. (F-56-M).

Another participant (M-36-CO) claimed that having a therapist reach out is particularly important when clients suddenly drop out of therapy or miss appointments.

P: Just because that person is not calling you for appointments, it doesn't mean that they're doing well. You know, in my experience, if I don't end up calling [my therapist] for appointments … it's likely because I'm dead. … It's not that I'm doing awesome, it's quite the opposite. …

I: Right. So, … if you … or another TBI client didn't come in for their next scheduled session, a check-in would be really important.

P: Yeah. Yeah, just to make sure that they're ... not falling into a pit. 'Cause sometimes that phone call, ... it's just someone from the outside, you know, to, to peek in a little bit and let some light back into the room, right?

Between session contact, whether initiated by the client or the clinician, can be extremely valuable for TBI survivors, whose impulsivity and emotional liability may be higher than average. Additionally, contact between client and therapist through text messages and emails
celebrating successes can be helpful in reinforcing desirable behaviours or reducing maladaptive behaviours.

**Coordinating care with other providers.** Several participants reported receiving help from their therapist to coordinate care with other care providers. After brain injury, managing five or ten different practitioners becomes exponentially more difficult when an individual is coping with severe mental fog, difficulties with problem solving, fatigue, and executive functioning issues. One participant (F-34-CO) described her appreciation:

She would provide really practical suggestions like who to talk to about things. You need to talk to your OT about that, you need to talk to physio about [pause]. Umm, and she was actually ... better than anyone else I worked with at being a team member on my health care team. So, she would be in contact with the other people that I was working with post-accident. (F-34-CO)

Another participant (M-53-S) also expressed appreciation that his psychologist agreed to make a referral:

P: [My psychologist] helped me in researching the right people to get me deemed capable [of handling my own finances]. And at that point, [I] went for an [neuropsychological assessment] interview. … He would much rather see me handle my own affairs. ... And he feels and has said that he thinks I can do it. But, he's not the right person to say that I can do it.

I: So, he was very supportive of you … and he understood.

P: Huge.

The fact that this participant’s psychologist supported him in moving towards financial independence was monumental to this participant because he did not perceive his family as being
supportive. This quote indicates the necessity of mental health professionals playing the role of advocate at times, particularly when it comes to making sure that client’s needs are heard and the correct referrals are made.

**Person-centred approach.** During this study, it became clear that the therapist’s personal qualities and manner of relating are central to survivors’ personal growth in therapy. This link between therapist relational qualities and personal growth is a central tenet of Carl Rogers’s person-centered approach (Keenan & Rubin, 2016). This section describes four personal manners of relating: the provision of hope, having positive regard, revealing the person behind the therapist and remaining open-minded.

**Allowing hope.** Several participants described how important it was that while they were coached towards acceptance of their injury deficits and symptoms, that their therapist still allowed them a sense of hope of continued recovery. Acceptance was a concept that was highly discussed in therapy for participants in this study:

He was saying like, well, healing comes after [acceptance], ... If you don't accept, ...

there's a lot of energy being put in to fighting it, right? ... You know, accepting that I have to wear ... shaded, ... special glasses ... even at social events.

However, this participant expressed feeling very conflicted about being forced to accept the permanence of their symptoms.

I, I, I, I got mad at my, my, my OT. ... I tell her, "Well, I had trouble doing this, I had trouble doing that." ... And then she would say, "Well, you know, it, it's been over two years. You know, you need to accept that you can't do these things." And when I hear that, it's like, it hurts. It, it, it hurts. Um, so ... I bring it back to [my therapist], and [he]’s
like, "Well, maybe that's not what she means, that you know, ... it's not for the rest of your life," right? ... You accept it, but it doesn't mean that it's gonna stay like that.

M-36-CO describes how it is less distressing for him when he can hold onto hope that his symptoms can continue to improve. He described appreciating his therapist disclosing his own experiences with recovery:

He told me that ... his sense of smell didn't come back until like ten years later. ... So, like here I am like working with this guy for so long, and that I find out that, that he's made it through the storm! It was huge. ... It's inspiring.

The desire for acceptance that doesn’t betray hope was echoed by F-61-M:

The biggest thing was accepting ... that I'm not gonna get better from this, right? Like I might improve but ... to not take away my hope, but to give me hope.

The data indicates that acceptance of one’s current status of deficits and symptoms is easier when one is allowed to have hope for future improvement.

*Positive regard: “it was the way he treated me”*. From the analysis of the data, it is clear that participants who felt most helped by their therapist experienced their therapist as regarding them in a positive way. For instance, one participant reported that when he told his therapist that he had accidentally called his rehabilitation assistant “a dyke”, he said that he and his psychologist laughed together before moving onto solution making. Participants who experienced effective therapy described not feeling inadequate because of their behavioural quirks. In the following example, a participant describes how she found acceptance of her deficits through the way her therapist treated her.

I: Was there something about [therapist]’s personality or presence ... that helped you...?
P: Well, yeah. It was the way he treated me. ... Like, ... I found him fun ... to meet with kind of thing. ... He accepted me, ... he didn't make me feel stupid because of the things that I couldn't do or because of my inability to stay focused or, uh, you know, ... go off on those stupid tangents all the time and you feel like I don't even know what I'm talking about anymore. ... He wasn't one of those guys that'd be checking his watch. Like you're explaining something, and they say, "So what do you think about whatever?" And then they go [looks at wrist]. (F-61-M)

Another woman reported that she had thought that people with brain injuries were “stupid” and was relieved to know that her therapist still found her “intelligent.” “That's probably one of the biggest things that she gave to me. ... I mean, she still to this day will say that I'm highly intelligent” (F-56-M).

**Revealing the person behind the therapist.** Another factor which helps build trust and the development of an authentic and effective therapeutic connection is self-disclosure and revealing the person behind the therapist role. Self-disclosure may include sincere reactions to the client’s behaviour. M-36-CO talked about feeling shocked about his counsellor’s reaction.

P: [My counsellor], [clears throat] ... straight up told me, ... that I, what I'm doing is, is selfish, that ... I'm shutting ... out [my fiancé]. And ... I was saying like, I'm not the same person ... after the accident. ... I'm broken! Like I can't walk as fast as everybody else ... And [I don’t want her to be] a babysitter. ... And uh, [my therapist] said uh, how do you know that she doesn't want to be a babysitter? Maybe that's what she wants to do. You ... should ... allow her to care for you, ... So, I-I think of that from time to time. Like, I was quite shocked, I always thought [my therapist] was like on my side. [laugh] ... But I don't think she was telling me that [I] was wrong, she said ... that ... I'm trying to mind read ...
I: You're deciding for someone else.

P: Yeah, yeah! That's what she said. She said that you can't do that, right?

In this example, the participant was able to use the authentic responses of the therapist to embrace and work toward what he really desired from his severed relationship. The person behind the therapist was very present in this therapist response and was helpful in allowing the client to gain awareness and see another perspective. On the contrary, some participants described their therapist as “very, like impersonal. Like, I know very little about her” (F-34-CO). F-29-S described her desires for deeper contact with her therapists, which she describes as wanting to hear her therapist’s thoughts on certain matters.

This is what I compare it to. ... [My speech pathologist] would tell me what she thinks ... [but my counsellor] would not tell me what she thinks. [My counsellor] would only be like, "well, what do you think? What was your opinion?" I'm like, "Well, I wanna know what your opinion is too," right? ... Like for me, I guess, I like the counsellor to also share their part, so I can feel connected. ... Of course, they need to be professional. ... But um, yeah, I felt like ... she was a wall and like, that's it. I'm just talking to a wall.

As indicated in the above quoted text, an impersonal therapist is perceived as shallow and frustrating for survivors of brain injury.

*Experience with brain injury.* Participants in this study reported that it was easier to develop trust with therapists who were perceived to have specialized knowledge or experience with brain injury. Many participants reported that “it would be very hard to go to somebody that doesn't have experience with people with brain injuries” (F-56-M). She explains:

If I had a counselor that didn't understand about brain injuries that just thought, ‘oh well there's nothing wrong with you, it's all in your head’, [it would be so hard]. It's not in my
head. *I have a brain injury* [emphasis added]. Just the empathy of, the understanding, believing you. (F-56-M).

Individuals in this study also appreciated therapists who were able to provide anecdotal stories of how other individuals with TBIs have made their recovery:

Um, she said she has several TBI clients and high functioning adults. … She was like, “oh, yeah. Trust me. I have this client who does this. Blah, blah, blah”. And like, hearing those examples was a little bit inspiring too. Or like, makes me feel a little bit better, like I’m not that bad. (F-29-S)

However, it appears that having professional experience in working with brain injury survivors may not be sufficient if one does not approach each new client with an open, caring and curious attitude. Another participant describes why she felt her therapist was effective in working with her although she felt that he did not have past experience working with survivors.

I didn't think he had a lot of experience in brain injury. ... I think he just, just cares about doing the best job he can do. And in doing that, is checking in with people, ... watching us and seeing when we fade or our eyes go or, right? And ... stuff about how you set up your office, I think comes from educating yourself ... and also asking people ... ‘Cause not everybody has the same problem. (F-61-M)

F-61-M explains that although therapists can educate themselves on the neuropsychological consequences of TBI, or gain experience in working with survivors, due to the wide range of neuropsychological presentation in survivors, an open-minded approach is needed. Thus, experience with brain injury can be understood as the clinical understanding that every brain injury can vary in its presentation and can therefore have unique needs.

**Sub-theme 3: Components of Counselling with TBI Survivors**
The third sub-theme clusters together (in temporal order) the components of counselling survivors of TBI. The first section describes early post-injury needs, followed by emotional processing needs, followed by descriptions of the delivery and maintenance of compensatory tools and finally, descriptions of community integration support from therapists. The latter is not a gap identified by participants but rather a gap in scientific literature.

**Early post-injury needs.** Under the category of early post-injury needs is the participant description of the desire to involve a significant other or family member in therapy sooner, rather than later; and the involvement of a counselling therapist to support the individual with understanding what had happened to them and to assess their readiness for counselling.

**Early involvement of a therapist in the rehabilitation team.** There is data supporting the early provision of psychological help for survivors. Many participants pointed to their therapist as being the one professional who assisted them in finding the motivation to continue in rehabilitation. F-61-M explains that she needed the encouragement of her therapist to see neurorehabilitation professionals, such as an ophthalmologist and physiotherapist and to realize that the depression and isolation from her peers would hinder her recovery.

I: You needed all these [professionals] to be in place [to start feeling better] and, like, [your therapist] was a big part it, but he wasn't the only part.

P: But sometimes I think he got me to get a lot of those, like he encouraged me. ... [He] made me realize that I'm not going to get better unless I start shifting some of these things, like socially. (F-61-M)

In the following excerpt, M-36-CO describes how he needed counselling to find a will to live. Needless to say, without the will to live, any form of rehabilitation can be difficult to commit to.
Brain injury without supports such as counseling, um, can be a, a real death sentence. … Like for me to been to that point where I decided to take my life, um, and come out of it, and looking back, [my therapist] [voice breaks, starts to tear] came to mind and I, the connection that we had built over the past few years. ... And I thought like, like wow, ... we wouldn't be able to share those ... giggles, or you know, ... it felt like that if I had succeeded [pause]. That ... [my therapist] would miss me [voice breaks]. … And that's when I realized, um, that I do have a place [voice breaks] in, in, in the world. And sometimes it starts with, um, it has to start with a professional. (M-36-CO)

Such descriptions can be interpreted as the need for counsellors to be involved early in the post-injury stages to aid the client in understanding what has happened to them neuropsychologically, coping emotionally with the awareness of the injury and to encourage their continued seeking of other neurorehabilitation professionals’ support. M-36-CO stated that if he had known about possible post-injury phenomena early on, he “wouldn't feel so bad or stupid for not being able to tie my shoes.”

In conclusion, it appears that survivors believe they would benefit from having access to counselling earlier in post-injury stages to acquire psychoeducation knowledge on their anticipated neurological sequelae, to find the will to live and to find the motivation to participate in other aspects of neurorehabilitation.

**Involvement of loved one in therapy.** Participants in this study expressed the need for “someone to help the family and those that are close to the survivor understand their needs and their symptoms” (M-36-CO). Another participant stated that psychoeducation for significant others is needed for improved outcomes:
I was having rages and I was swearing … and uh, I still have impulse controls things, so I can say pretty awful things, which is very different than I was. … if they can explain it to [my spouse] about what I go through, and how my memory doesn't work, … these things would really help me. … I just don't get is why spouses aren't involved … [and] they're having to deal with, "that's not the person I married" (F-61-M)

One individual stressed how inviting a spouse into session could help partners understand and process the feelings that arise in both parties as a result of the behaviours emerging from the injury:

   And trying to see if, you know, “how would you feel, [spouse’s name], if, if you to-, said this to her” and, you know, how would I feel if she did. And I would think, "Oh, yeah. I really wanted to do that.” That would help me so much, right? (F-61-M)

Another individual reported that his therapist invited his mother in for one session to help her understand his symptoms and what he needed when he was experiencing these symptoms.

   So … he actually invited my mom in, we did one session, 'cause things were getting really, really bad. [sigh] Um, 'cause ... I would be in distress and my mom would approach me, ask me if I'm doing OK. And I would freak out. Like the PTSD or the brain injury, it just wanted that space. So, we did a … group session ... and we developed a strategy, a visual one, because when I'm under stress, I can't speak. So, ... I would put my head down, and cover my head like this, to say that I'm having a headache I'm not feeling well. … And … it was agreed that this would be the signal that I need to be left alone

In addition to teaching psycho-education and management of symptoms, bringing in family members to an individual session could also help tackle some of the cultural barriers to recovery.
M-36-CO stated, “there may be a, you know, cultural stigma. You know, you're being lazy. You know, why are you sleeping so much?”

**Emotional processing needs.** In this category, two main types of emotional processing needs can be described: the need to process past traumas and the need for sufficient validation of the enormity of losses for grieving. In addition, within this section is a description of the use of the arts to facilitate emotional processing in survivors.

**Childhood trauma is still relevant post-injury.** Several participants’ narratives contained concepts of pre-morbid trauma. In some cases, pre-morbid trauma appeared to completely supersede the emotional difficulties of adjusting to life after brain injury. In other cases, coping with the recovery from the TBI elicited unresolved past trauma.

A 28-year-old man who acquired a severe TBI, stated that his psychologist “was the most helpful um with, my father's passing.” Here, he describes how he received guidance to address the emotional ordeal of processing the death of his father:

My dad died in 2014 … This is all after my car accident and it was kind of hard to focus. ... Like, I was in school and I should have been focused on school. But at the same time coming back from my dad's funeral all I could ever think about was my dad and what kind of upbringing he gave us ... right? … My dad wasn't really a good guy … My dad was a big drug user growing up and uh, a lot of beatings, a lot of unnecessary hurt that he caused me and my family. … And … all the things that my dad ever did, I thought I get back at him for. But it didn't happen because he died. So, ... there are a lot of pent up feelings that I have about my father and his family. … So, what [my psychologist] taught me [was] that it was not just getting over my dad's funeral and whatever my
father's family did to us, but it was more of seeing … that they're the ones who messed up … and that I'm not at fault.

One of the key components of healing from the trauma of childhood abuse and neglect is arriving at the realization that the victim did not deserve or cause the abuse. In addition to the emotional processing that occurred in session, M-28-S reported that he continued his process at home through letter writing:

I wrote many, many, many, many letters to my dad, to my friends, to family. … That really, really, really helped me. .... By … just getting the thoughts onto paper and to get it out of my heart. … That was that was the biggest thing that he taught me. … So, next time I get frustrated, I'm not going to swear at anybody, I'm not going to yell at anybody. I'm gonna go home and write a letter to them.

This excerpt suggests that letter writing was an especially useful intervention to process feelings one has towards friendships, significant others or with someone who has deceased. It served as an effective outlet for this individual to express anger and frustration. Ultimately, M-28-S’s emotional work with his psychologist allowed him to gain new perspectives on himself, his social relationships, unresolved feelings from the past and the death of his father. Thus, even in the case of severe traumatic brain injury, past relational trauma does not become irrelevant in the survivor’s identity.

For another participant (F-58-M), the process of recovering from the TBI triggered past trauma that was not dealt with fully. She, as in the case of M-28-S, also had a significant amount of relational trauma that was not related to the accident, such as the abusive relationships she was involved in during her recovery, childhood sexual abuse, and her difficult relationship with her
parents. In addition, she emphasized how the hurdles in recovering from TBI “accents” unresolved issues from childhood.

My past shortcomings um, or things that I didn't deal with throughout childhood, it brought those all up and blaring, right there. The accident brought out … ‘no support, nobody there to help me, on my own’, ‘having to do it and pushed through’. And ‘everybody thinking I don't need help’.

The excerpt from F-58-M reveals how the TBI recovery process can trigger past traumas. During the interview, it became clear that F-58-M struggled with a lifelong habit of being self-reliant even when she desperately needed help; this can be seen as a maladaptive habit which stems from her childhood sexual abuse. In her final feedback, she provided a poignant description of her needs in counselling:

I: What would you change or make better with the counselling you received?

P: To encompass all of me, not just the accident. Because the accident is a moment in time. It's not the whole clock.

In conclusion, the research participants stipulate that emotional adjustment to TBI does not supersede relational trauma from the past, in fact, acquiring a TBI can “accent” past relational trauma. In addition, the participants in this study desired a more holistic approach to counselling therapy, rather than one that only emphasizes accepting deficits and developing a new identity thereafter.

**Grieving: “it's like the magnitude of the loss was not validated”**. Some participants describe feeling unable to mourn their losses because they had felt incorrectly acknowledged in some way. F-34-CO described how her therapists’ inaccurate reflections limited her ability to grieve.
I really liked who I was before. ... I was really proud of things I was. ... And I knew looking at myself, that I would not be able to operate ... in the same way I had before and that was a tragedy in my life. ... And I feel like ... that wasn't acknowledged in that way. ... Acknowledging that you're sad and then looking for some solutions to deal with your sadness is not the same as walking someone through grief.

Other participants echo F-34-CO in that they felt that their experiences were diminished when their therapist did not acknowledge the situation with the correct severity classification: “if she said things like, ... “when you had your concussion”. And ... to me that was ... minimizing it ... Because I had a traumatic brain injury, I didn't have a concussion!” In addition to feeling that the intensity of the situation was invalidated, F-34-CO felt that the origins of her depression were not correctly understood, which seems to have also led to a barrier in grieving.

Almost right off the top ... we were working on getting me out of the major depressive episode. But that wasn't how I felt. It felt like my depression was completely circumstantial. Completely based on life events and that it wasn't that I had a mood disorder that we needed to fix. It was that I had gone through a massive life transition and I needed ... someone to see [that] so badly.

Thus, inaccurate understanding of the root of emotions and insufficient validation of the enormity of losses can become a barrier to grief expression.

**Grieving through the expressive arts.** The expressive arts are commonly used with children to help them become aware of, explore or reflect on repressed feelings (Jantz, Comerchero, Canto & Pierson, 2015; McFerran, Roberts, & O’Grady, 2010). However, it appears that art can play an important role in adult survivors who often struggle with articulating the depth of their emotions due to cognitive or communication barriers. The expressive arts can
include metaphors, music and art; M-36-CO reported making use of drawings to express himself therapeutically.

When I draw, a lot of stuff comes out … and it helps me kinda of decode myself. …

Because if I see myself as the person that in the picture, then I can say, "well, if he looks like that, then he must be kind of feeling this and what would he need?" … it's quite profound, in terms of healing. It kind of makes the … guilt and, and the troubled feelings um, more acceptable.

This individual noticed how concepts which could no longer be verbally accessed due to memory loss could be expressed through the drawings he created. The drawing that he refers to in the excerpt above can be found in the figure below.

*Figure 1 – Drawing used to explore emotions in therapy.*
Another participant (F-61-M) also talked about a drawing she had made of “someone holding their head ... and the weaves of their hair are the water. And, and, but really, to me, they were probably tears and everything.” She reported talking about the emotions in that drawing with her therapist and she said, “I feel like that picture now”, in reference to how she feels about her brain injury. The data suggests that drawings can be a powerful way to express and move through emotions. F-61-M also talked about the use of music in her recovery: “music gave me an outlet. ... I could play those really uh, uh, you know, heart-wrenching Irish traditional tunes to get ... the depression out of me.”

**Acquiring compensatory tools.** Participants in this study discussed the need for assistance with accepting the use of the tools, the desire for tools to be more personalized and the need for continual maintenance of such tools through follow-up and assistance with problem solving barriers as they arise.

**Accepting the use of tools.** F-61-M talked about how her therapist helped her accept the use of techniques. She reported learning many useful strategies from her therapist such using a reminder app and the “parking lot technique,” where you find a sheet of papers to park intrusive, distracting thoughts and ideas so that they do not detract from the task at hand. Being unable to accept the use of compensatory techniques can become a barrier. Thus, one of the things F-61-M learned from her therapist that helped her move forwards was the acknowledgement that she is not “an idiot” for talking to herself when she does certain tasks:

He told me … it's not uncommon for people to walk into a different room and forget stuff. But if … they say what they're gonna get in the other room as they're walking in, they remember it. … So instead of making me feel like a fool, he made me feel like I'm using a really good technique.
Through working with her therapist, F-61-M also learned that she deserved to take a break. I'm supposed to rest my brain, … about 10 minutes every hour. Uh, and I wouldn't do it, because I didn't think I deserved it. I did nothing by the time it was time to take a break — I had just what, sat up and got dressed, you know? I don't wanna lay down again, right? … So … he talked to me a lot about stuff so now I'm more apt to take a break … and save myself [from] hitting that wall. … If I don't take a break and hit the wall I'll be out of commission for a half a day or a day, right?

**Personalized compensatory tools.** Another participant, F-34-CO, talked about her frustration with how her compensatory strategies had her feeling like they were “a bit from a list” and were not personalized, and she had a lot of trouble with applying them as a result. She states that she was told that, “people who suffer this kind of brain injury, we see success with them using this kind of scheduling to help them remember to XYZ or … the process of list-making is extremely important … and some of the suggestions just felt [wrong].”

**Problem solving the use of compensatory tools.** Participants in this study expressed the need for week-to-week follow up of tool acquisition and problem solving. One of the major pieces of feedback F-34-CO discussed was the need for follow-up when compensatory strategies were assigned.

Follow up. … That … was a huge missing link, is that all these suggestions would be made, but the next week would not be like, "how did that go for you?" "Did you try that?" Like if I had been asked, I would have been like "no, I was I felt completely overwhelmed by this suggestion and I couldn't even figure out how to start implementing it." And then they could've ... started at an earlier point or with simpler things you know?
F-61-M also talked about feeling overwhelmed by the instruction for a tool and describes how she needed to be able to talk through the barriers with her therapist.

I had an OT come in, she would give me all this stuff to do. First of all, I'd be so overwhelmed. Uh, second, I wouldn't know where to start. And three is, I'd run into barriers. … So, nothing would get done. Not that I didn't want it. Not that I was lazy. …

Because I know a lot of that stuff that I needed … I just can't do it unless I sort of verbalize it and talk about how I'm gonna do it. … So, when he would say to me, …

"Well what's gonna get in the way?" It would help me problem solve … When I was seeing him, he might say to me, "Well what could you do about that?" And, and I could say "I get to go straight home and do it now, … right? And then he might remind [me and] … say, "So … what are you gonna do when you get home?" … And then, and then I might remember to do it, right?

In addition to addressing barriers to the use of compensatory techniques, she discussed how she can have difficulty with prioritization, and needed the help of a clinician to determine what problems to address first. “With the brain injury … [I could] pick this thing that’s “who cares,” … like, “really? You're focusing on that?” … And so sometimes, uh, I think we need help with … what to do.”

F-61-M suggested that for survivors who struggle with implementing strategies, a home visit from a therapist might be extremely helpful.

Uh, because people can't take what you say in an office always and be able to do it outside that office. … Like … people with really severe OCD are not gonna get better unless somebody's beside them and helping them through in the environment where they
have the issue, right? … I guess my question [is], … why can't somebody help with some of that stuff?

In addition, one individual expressed how much she needs continual maintenance of these compensatory strategies through long-term, potentially life-long counselling.

**Reintegrating into society.** Societal re-adjustments through return to work, school, volunteering, hobbies and socialization are a key phase in the psychotherapeutic treatment of TBI survivors as described by Klonoff (2010). The following is the clients’ perspective on how they were assisted with tacking discrimination and returning to their community.

**Raising awareness of the invisible disability in those around the survivor.** M-36-CO talked about several different assertiveness scripts that he had developed through role play with his therapist. One script was developed after an unpleasant experience where a community member forcefully tried to pull him out of his disability seating on public transit:

So, if someone came up to approach me or touch me again, … I would back up, create distance, put my hand up to gesture "stop". So, I would say, "Stop. I don't appreciate what you're doing. I have a brain injury. I have the right to be here". And that was short enough, … it raises attention. It, it, it allows me to, um, have that dignity, that I deserve to be here. … I mean, if I had crutches, I don't think anybody would pull me out of that seat. … In the beginning, like my head was down. It, it just felt awkward and, and I felt ashamed to be speaking up to say like, like my brain is messed up … We, we, we crafted it in, in a way that was pretty much bulletproof. It was really strong ... And then when I did finally get a chance to practice that ... That the person was like, "Oh my gosh! I'm so sorry. I'm so sorry." And they gave me space. And then the people around started to shuffle a bit. And it was like, that's when I was like, ha! [made a proud face]
The data indicates that an essential part of psychotherapy after brain injury is to help clients see their right to belong in society despite discrimination and prejudice.

**Work/school accommodations.** Some participants mentioned appreciating their therapist for being “active in ... negotiating the workplace with a TBI” (F-34-CO); support with making accommodations can apply to work or school. A thirty-four-year-old woman who was currently navigating the university system with a TBI reflected on how validating it was that her therapist advocated for her needs.

So, like at one point she wrote a letter to my management about accommodations. ... That experience, is the reason that I know how to ask for accommodation now, in a university setting. Like, she taught me that, that as someone who had acquired a TBI, that I was entitled to that and that my ... [deficits] didn't diminish ... my ultimate capability, but I needed to approach things differently ... And I wouldn't have realized that ... was a possibility or that that was OK to ask for.

For some survivors, there is a lot of shame in having been away from work and there is difficulty in having to explain to colleagues why they have not been able to contribute. M-36-CO talked about how he gained the confidence to ask for accommodations from his colleagues:

Because we had a success with the bus script, it made me more comfortable to tell people, "Hey, I'm sorry I've been absent. ... I had an accident. Uh, it left me with a brain injury. .... I'm trying to get myself back. Uh, and ... I don't need to beat myself up ... for being absent. ... Um, ... not to assume that they would look at me differently, but just to be like, "Hey, ... I'm trying to come back. Uh, this is what's happening, and that I can't take on too much."
It is evident that TBI survivors experience a sense of validation when therapists assist them with making requests for accommodation, whether through a formal letter or by instilling the confidence in their client to speak for themselves.
Chapter 5: Discussion

In this final chapter, I discuss the key integrative findings distilled from the previous chapter. The findings were guided by the research questions: (a) ‘What environmental factors of the therapeutic environment are described by TBI survivors and what are their experiences of them?’ (b) ‘How do survivors of TBI describe the therapeutic alliance?’ and (c) ‘What are the survivors’ experiences with various counselling interventions or approaches and the way such treatments are delivered?’

As Interpretive Description (ID) is a methodology that emphasizes the extraction of practical clinical knowledge, the research study was conducted with a lens which asks for feedback on the counselling services that survivors experienced. In this chapter, the findings are compared and contrasted with the available interdisciplinary research literature to develop the clinical recommendations section. The following section is a discussion of recommended policy considerations. Next, I will discuss the limitations of this study, followed by a discussion of areas for further research. This chapter will end with a study conclusion section.

Positioning the Results in the Literature

Clinical practice related findings are discussed in light of the existing literature. There are three sub-themes of clinical findings: environmental barriers (physical barriers, barriers due to cognitive demands of therapy and systemic barriers), therapeutic alliance formation and the components of counselling with TBI survivors.

Environmental barriers. This section corresponds to the first research question, ‘what environmental factors of the therapeutic environment are described by TBI survivors and what are their experiences of them?’ This study found that individuals with traumatic brain injury (TBI) require removal of environmental barriers in counselling in order for them to experience
maximum therapeutic benefit. This finding is supported by Whiteneck, Gerhart and Cusick’s (2004) quantitative study which found that environmental barriers impede societal participation (e.g.: employment, community socialization) and life satisfaction. Specific environmental barriers are expanded on in the paragraphs that follow.

**Photosensitivity in counselling environment.** This study found that TBI survivors often experienced great difficulty with light sensitivity and had specific preferences with the arrangements of blinds, curtains and lighting fixtures, particularly fluorescent lighting. Three participants reported using tinted sunglasses to cope with settings that were too bright or uncomfortable. One participant noted that some survivors “might not be able to” inform their clinician of these specific photosensitivity needs. Photosensitivity needs were highly discussed in this study and when therapists were insensitive to lighting needs, it became extremely disruptive to the counselling process. Chamberlin’s (2006) study also found that TBI survivors experience their health care professional as being insensitive to their invisible symptoms.

Light sensitivity is broadly defined as a symptom of mild-to-severe discomfort experienced, without ocular inflammation, by a person in the presence of normal light levels (Digre & Brennan, 2012; Greenwald, Kapoor & Singh, 2012). There is no standardized procedure by which to diagnose light sensitivity; the presence of symptoms is based on self-report. Even at one-year post injury, symptom reporting of light sensitivity is 2.8 times more likely in a TBI population compared to a general trauma population (Dikmen, Machamer, Fann & Temkin, 2010). Lighting was identified as one of the most impactful barriers in a study of environmental barriers in TBI survivors (Whiteneck et al., 2004). Light sensitivity can profoundly affect communication, productivity, socialization, cognition, sleep and mental health (Callahan & Lim, 2018). The exact underlying neurology for photosensitivity remains unclear.
Some have suspected that it may be related to defective light and dark adaptation in the eye structures (Greenwald et al., 2012). Sensitivity to fluorescent lighting may be due to an abnormal threshold in which a flicker frequency becomes perceived as a steady presentation of light (Schrupp, Ciuffreda & Kapoor, 2009).

*Other visual disturbances in the counselling environment.* In addition to photosensitivity, there were other aspects of the visual environment which were described as being difficult to cope with. Several participants described window blinds causing a “dizzy”-ing effect. One participant described patterns and prints (e.g.: checkered, striped, polka dots, etc.) in the room or on a therapist’s shirt to cause visual difficulties. In parallel, an existing qualitative study by Lefebvre and Levert (2014) found that survivors reported experiencing mirrors, reflective surfaces and certain colours in retail stores to be “a bother”. Otherwise, there is a lack of literature which described survivor difficulties with the visual field and how it affects access to services and participation in meaningful events.

After TBI, visual disturbance commonly involves issues of versional deficits (issues with smooth pursuit of moving objects, saccades and ability to maintain eyes on a target), vergence dysfunction (simultaneous movement of both eyes to maintain binocular vision), gaze stabilization while head is in movement, and visual field defects (left or right side neglect) (Greenwald et al., 2012). Due to these visual disturbances, survivors have reported accounts of blurriness, difficulties with reading, eyestrain, motion sensitivity, dizziness/disequilibrium in visually-crowded environments, and forgetting or bumping into things on one side of body (Greenwald et al., 2012). These visual abnormalities are the result of traumatic lesions in the visual pathway and/or visual cortices. The dizziness that was emphasized by participants in this study may be the result of visual-vestibular deficits. Survivors who complain of dizziness,
vertigo, nausea, sensitivity to fluorescent light and increase sensitivity to visually stimulating environments (i.e.: crowds) often have abnormalities in the reflexes of the vestibular system (Greenwald et al., 2012). It seems reasonable that “visually stimulating environments” that might also extend to include busy prints on walls, carpets and attire. However, this is speculative and required further investigation.

**Distractions in the counselling environment.** Participants have expressed preferences to face away from windows because outside scenery can compete for attention with the therapy session. In addition, moving screensavers, jewelry with a lot of movement and certain clinician behaviours (wiggling/tapping of writing utensil and limbs) were mentioned to be a barrier to maintaining focus in session. Attention deficit issues is a common neurophysiological sequela after TBI (Arciniegas et al., 1999). A study by Gabriela and colleagues (2015) found that Canadian adults with TBI are twice as likely to be diagnosed with attention deficit and hyperactivity disorder. Attention abilities are required for higher cognitive processes such as executive functioning, problem-solving and acquiring new information (i.e.: appointment times, session insights, education materials) (Rizzo et al., 2000). There are three types of attention deficits that are relevant in the counselling environment: sustained attention (being able to concentrate on a continuous activity, such as a conversation), selective attention (maintaining attention in the face of competing stimuli), and divided attention (monitoring two or more kinds of stimuli or multi-tasking, such as taking notes while listening) (Rizzo et al., 2000). Student survivors of TBI in Hux and colleague’s (2010) qualitative study reported that difficulties with attention was a barrier to listening to lectures and learning course material. One strategy for attention deficits that was discussed in Hux and colleague’s (2010) study was sitting near at the
front lecture halls to reduce the number of visual distractions. This strategy is akin to a therapist closing the blinds in an office to reduce visual distraction.

**Noise in the counselling environment.** Participants in this study stated that reducing noise in the environment can be helpful. Participants in the study have reported seemingly benign noise such as the sound of footsteps to be painfully intrusive. In addition, ambient noise such as clocks ticking, and circulation fans can also become a barrier as it becomes a stimulus which constantly competes for attention. In my observation during interviewing, verbal communication became disrupted when emergency vehicles, large groups of children or coffee shop patron activity were in the vicinity.

Noise was identified as one of the most impactful barriers in a study of environmental barriers in TBI survivors (Whiteneck et al, 2004). Noise sensitivity refers to the internal state in individuals that becomes more reactive to noise. In TBI survivors, the pathology emerges from trauma to the auditory structures in the ear or the cerebral cortex. Noise sensitivity has been called phonosensitivity, hyperacusis and phonophobia in the clinical literature and the terms have been used interchangeably. Electrophysiological measures have identified significant differences in heart rate and heart rate variability in noise sensitive individuals (Sheperd, Hautus, Lee & Mulgrew, 2016). In addition, electroencephalographs and magnetoencephalographs exhibit abnormal neural encoding of sound in the auditory cortex of sound sensitive individuals (Kliucho, Heinonen-Guzejev, Vuust, Teraniemi & Brattico, 2016). In addition, survivors of TBI (all severity levels) are 1.38 times more likely to experience symptoms of noise sensitivity compared to a general trauma population even at 1-year post injury (Dikmen et al., 2010)

When treating a TBI survivor in counselling, therapists may need to select spaces with maximum insulations in walls and doors to reduce noise. Survivors who are not able to tune out
background humming from white-noise machines should be offered the option to turn them off. The research literature finds that a significant portion of TBI participants experience the “design and layout of a building” or a public place in the community to be an environmental barrier which impeded on comfort, safety, autonomy and efficiency within the space, and societal participant and life satisfaction (Whiteneck et al., 2004; Lefebvre & Levert, 2014). This thesis and the supporting qualitative and quantitative literature are suggesting that architectural and structural barriers for TBI survivors are a pervasive concern.

One participant in this study who was diagnosed with hyperacusis and tinnitus as a result of his TBI reported benefitting from using a “white noise generating” machine in reducing his sound sensitivity issues. Tinnitus is defined as the perception of sound in the absence of corresponding external acoustic stimulation (Langguth, Kreuzer, Kleinjung & Ridde, 2013). Initially, research suggested that broadband noise generators, which produce a constant stream of monotonous, “static-like” buzzing (white noise), were effective in attenuating tinnitus-provoked experiences of noise (Jastreboff & Hazell, 1993). Currently, the clinical literature suggests that individually-adapted tones or music of a particular frequency range appears to be more effective in reducing tinnitus volume and auditory-evoked cortical activity than broadband noise generators. However, research is still in the early stages and large-scale randomized trials are needed (Langguth et al., 2013; Shore, Roberts, & Langguth, 2016).

**Seating which accommodates for post-injury pain.** Participants highlighted the need for client seating to be of a certain dimension in order to reduce pain and find comfort. Inability to sit for the entire duration of the counselling hour is a concerning barrier to therapy. In a recent metasynthesis, it was found that 51.5% of survivors experience chronic pain (Nampiaparampil, 2008). In TBI, chronic pain in the body can arise from neuromuscular spasticity (abnormal
muscle tone), neuropathic abnormalities, and heterotopic ossification (abnormal bone tissue redevelopment after fracture), and complex regional pain syndrome (limbs that have become susceptible to swelling and loss of range of motion) (Gellmam, Keenan & Stone, 1992; Garland, Blum & Waters, 1980; Cosgrove, Vargo, & Reidy, 1989; Zafonte, Elovic & Lombard, 2004). Given the range and complexities of each of the possible disorder after TBI which may cause chronic pain, there is a lack of a single generalized protocol for environmental modifications which supports all etiologies of chronic pain in TBI survivors. In addition, comfort in seating has been notoriously difficult to assess (De Looze, Kuijt-evers & Van Dieen, 2003). However, therapists can be aware of non-verbal indicators of pain in commonly observed in cognitively impaired individuals such as grimacing, bracing, restlessness, and rubbing (Nygarrd & Jarland, 2006) and offer tools to reduce pain such the adjustment of a pillow or stool.

**Accommodating cognitive deficits in therapy.** Sixty-five percent of individuals with moderate to severe TBI and a subgroup of survivors with mild injuries report long-term problems with cognitive functioning issues such as executive functioning, planning, memory, attention, auditory processing, word retrieval, judgement, and decision-making (Jantz et al., 2015; Rabinowitz & Levin, 2014). Participants described the use of four different strategies that therapists can employ to accommodate for cognitive impairments so that the cognitive demands of therapy do not become a barrier.

TBI survivors reported having difficulties when appointment time and dates are changed, mainly due to issues with recalling the change. Participants reported that they were more likely to attend an appointment if the time and day of the week in which it occurred was consistent. Lefebvre and Levert’s (2004) study also found that memory loss and planning abilities were a major barrier to accessing community services. Struggling with automatic recordings, anxiety
with using the phone, difficulties with clear expression and word finding were identified as a barrier for survivors in Lefebvre and Levert’s study (2014). Thus, changing appointments over the phone can be a particularly burdensome barrier. Other studies have also reported a greater chance of treatment dropout and poorer treatment response when individuals had issues with memory (Aharonovich et al., 2006; Hsieh et al., 2012). Hence, to ensure program continuation, it is valuable for therapists to make accommodations for survivors that struggle with memory.

In addition to maintaining a consistent time and day for appointments, participants in this study reported a preferred time of the day for appointment because of dizziness and fatigue. One participant in this study reported dizziness when getting up from the sleeping position, which meant that an appointment in the morning became a barrier to attendance. Many participants in this study experienced fatigue, which meant that they were only alert and effective for a limited number of hours during the day and that appointments scheduled during rush hours times became too difficult to cope with to make counselling worthwhile. In the existing TBI literature, researchers have found that fatigue can affect many aspects of accessing a community service: from planning, to using public transportation services, and the physical use of a space. In addition, Lefebvre and Levert’s (2004) study found that the transportation abilities of survivors were affected by mobility, aches, tremors, balance problems, stamina, over-stimulation, and crowds.

Due to difficulties with memory, writing notes for clients during session appears to be an essential part of counselling TBI survivors. Participants in this study described receiving sticky-notes or single sheets to take home. However, there are instances when note-taking becomes a barrier.
I don't know why she was doing it — she was taking notes. In her computer. While we were talking. Um, and I understand why you want to take notes. ... And she was, you know, able still to keep eye contact on me and, and type, but ... it was, that was a bit weird. Like, you're not taking notes right now, or typing and it's a better feeling than her typing, to be honest. (M-40-S)

The participant explained that minimal note-taking by hand was acceptable but typing into a computer was “weird,” “impersonal” and “invasive” (M-40-S). Thus, although note-taking is necessary for clients with memory deficits, therapists need to be aware of whether excessive note-taking is becoming a barrier to forming a relationship. In the literature, assistance with note-taking was described as a widely needed accommodation for college students with TBI (Hux et al., 2010). Hsieh and colleagues (2012) suggested that post-treatment notes be provided in a work-book format for survivors rather than as loose sheets.

**Accommodating fatigue in therapy.** Another issue that participants in this study reported struggling with in a therapy session is fatigue. As I had observed during the interview process, onset of fatigue can occur unexpectedly and can be characterized by slowed speech and an averted gaze. It was recommended by one participant (F-61-M) that when fatigue occurs, therapists disengage and offer a five or ten-minute break with the lights and other stimulating devices off. Many participants reported that when they had kept pushing when they were fatigued, they would end up having to rest for weeks afterwards. After TBI, the prevalence of fatigue has been reported to be as high as 73% (Berginstrom, et al., 2018). Fatigue in TBI survivors is defined as the failure to maintain performance on a task requiring vigilance, which is not due to cognitive or motor deficits (Aaronson, Teel, Cassmeyer, 1999; Chaudhuri & Behan, 2000). Primary fatigue, due to injury, is exacerbated by secondary issues such as stress and pain.
(DeLuca, 2005). Depression and anxiety can in turn contribute to fatigue (Schonberger et al., 2014). Fatigue is not to be confused with flat affect, which is a pragmatic communication issue caused by frontal lobe damage (Stuss, Gow & Hetherington, 1992). When mental fatigue occurs, issues can occur with sustained attention, information processing, memory formation, verbal fluency and reading speed (Schultz, Sepehry & Greer, 2018). These consequences were reported by participants in this study. The existing literature also suggests that clinicians should be aware of signs and markers of fatigue and offer interventions. To date, there is no consensus achieved on optimal empirical measures of mental fatigue. In session, clinicians can look for behavioural indications such as increased distractibility, drowsiness, or changes in eye-movement (Schultz, Sepehry & Greer, 2018).

**Accommodating communication deficits in session.** Participants in this study reported that when therapists make interjections while they are in mid-thought-formation, that this can cause them to lose their train of thought. Participants recommended that therapists give them the time to process information or to reduce the pace of conversation. Delayed responses can be due to difficulties with thought formulation and reduced speed of information processing (Friedland & Miller, 1998). Working memory deficits may also present challenges with keeping up with the pace and flow of discussion (Channon & Watts, 2003). Samson’s study (2008) also found that individuals with learning disorders desired more time to articulate their ideas in counselling therapy. A case study also suggested that tolerance of silence of a positive strategy in facilitating successful communication with TBI survivors (Friedland & Miller, 1998). Conversation partners in the case study who had sufficient shared knowledge and were comfortable with silences had fewer conversation impairments with the survivor.
Participants in this study have also reported being aware of their issues with tangentiality (difficulty with staying on topic). Tangential client dialogue can be perceived as empty, vague, and rambling by the listener (Galski, Tompkins & Johnston, 1998). Other studies have qualified this survivor experience of tangentiality: “I have a problem, after my accident, with rambling. I will go off topic and then I’ll start in my own mind a new conversation,” said one participant in Gould and colleague’s (2017) study. Similarly, participants with working memory and processing deficits in Samson’s (2008) thesis expressed that they used tangents to create a cohesive whole and wished for therapists to be creative enough to tie in the tangential stories in relation to the overarching narrative. In this study, one participants described how clinicians and clients can co-develop respectful hand gestures to re-direct the session when the client has gone off topic. Klonoff (2010) recommended the self-monitoring of pragmatic communication difficulties to be an essential task of psychotherapy; she suggests using video recordings to provide feedback to the client on how their communication style is impacting others. Family members are encouraged to log inappropriate communication behaviours at home or at social events.

**Barriers due to systemic issues.** This study found that one survivor was dismissed from counselling due to marijuana use, but it appeared that the therapist failed to acknowledge this participant’s need for cannabis to manage chronic pain. In my experience as a support worker for adults with brain injury, I have also witnessed survivors being pushed out of social services due to policy. Policies or unyielding attitudes acted upon individuals who struggle cognitively with decision-making, problem-solving, communication and reasoning can be considered an oppressive act. Policies and rules of businesses, government programs, and education/employment programs were highlighted as major environmental barriers in Whiteneck
and colleague’s (2004) quantitative survey of TBI survivor perspectives. A qualitative study by Lefebvre and Levert (2014) also considered laws and regulation as potential barriers that could be experienced by survivors of TBI in accessing public spaces. Further qualitative research which describes the need for cannabis in TBI survivors for symptom management and the potential barriers they experience due to the use of cannabis is necessary.

**Office design with hierarchal undertones.** In addition to seating issues, participants have noted the way that therapist and client chairs suggest hierarchical undertones, i.e. one chair being taller, bigger or more elaborate than the other chair. Furthermore, excessively raised receptionist counters or counters protected by glass barriers can portray messages of ‘you are dangerous and beneath me’. These oppressive experiences are not only experienced by TBI survivors but by other marginalized populations (Sue et al., 2007; Hankivsky & Christoffersen, 2008) and by general service-users in healthcare environments (Izumi & Pitner, 2005). Structures that convey hierarchical undertones have been identified as “environmental microaggressions” by Sue and colleagues (2007). Awareness and acknowledgment of microaggressions in the therapeutic environment facilitates the modification of structural barriers, which may, in turn facilitate a stronger therapeutic alliance and improved mental well-being (Sue et al., 2007).

**Developing the therapeutic relationship.** This section corresponds to the second research question, ‘How do survivors of TBI describe the therapeutic alliance?’ Participants in this study made several recommendations for clinicians when attempting to build a strong therapeutic relationship with TBI survivors: asking for client input, providing additional support, allowing for hope when discussing acceptance, having unconditional positive regard, and using self-disclosure. The therapeutic relationship has been established as a key component to effective therapeutic work in qualitative interviews with individuals with learning disorders (Pert et al.,
2013; Samson, 2008). Quantitative studies have found that TBI survivors’ report of good therapeutic alliance correlated with reduced symptoms of depression and more accurate self-awareness (Schonberger et al., 2006b).

**Asking for client input.** The data suggests that clients who were engaged as co-collaborators in therapy experienced a positive therapeutic relationship. Participants who reported having a positive therapeutic relationship described the freedom to decline interventions or therapeutic modalities that were either contraindicative due to the nature of their brain injury or were not aligned with their personal values or goals. One definition of the therapeutic alliance described an alliance as (1) client and therapist agreement on the tasks of therapy, and (2) the client and therapist agreement on the goals of therapy in addition to the interpersonal bond between therapist and client (Bordin, 1979). The strengthening of the therapeutic relationship that emerged from the co-development of occupational therapy goals was also discussed in Doig, Fleming, Petrea, Cornwell and Kuipers (2009)’s qualitative study on TBI survivors.

Bajo and Fleminger (2002) first posed the research question of “what treatment, for which TBI group, would produce the best outcome, at what point in time, and under what conditions?” for TBI survivors. This section (and the sub-theme Components of Treating Survivors in Therapy) was guided by the research question, ‘What were the survivors’ experiences with various counselling interventions and the way such treatments were delivered?’ This study pointed to some encouraging directions to continue exploring with this population. Participants described Prolonged Exposure Therapy, Systematic Desensitization, Acceptance and Commitment Therapy, Eye-Movement Desensitization and Reprocessing as being unfit interventions for various reason including, post-accident amnesia, saccades causing nausea, disagreement with values of intervention, and disagreement of intervention. On the contrary, two
participants in this study expressed a desire for more Cognitive-Behavioural Therapy (CBT) intervention in their work with their therapists. The study results suggest that it may be beneficial to the therapeutic relationship if therapists engaged with in some co-collaboration with clients in terms of selecting interventions.

Participants in this study have described desiring a therapist with experience in working with brain injury survivors. However, other participants stated that experience and education on psychotherapeutic strategies with survivors is secondary to remaining inquisitive. As one participant stated, “not everybody has the same [symptoms]” and that it was important to ask the client about their needs. This point leads back to the theme of asking for client input.

**Availability outside of session.** Many participants in this study reported appreciating that they were able to reach their therapist in between their sessions through phone, text message or email when an urgent issue arose (i.e.: contemplating drug or alcohol use) or for non-emergency check-ins (i.e.: telling therapist about achievements). In the literature, there is qualitative evidence which suggests that that clients who are given the option to contact their therapist between sessions develop a strong therapeutic alliance with their therapist (Bedi, 2006). In Dialectical Behavioural Therapy, coaching over the phone is an established technique in outpatient programs which supports the generalization of skills initiated in the clinical setting to real-life settings (Swales & Heard, 2017). During phone contact, therapists offer skills coaching, leaving in-depth analysis of behaviours and emotions for scheduled sessions.

**Coordinating care with other providers.** Several participants reported feeling appreciative of the care coordination with other providers that was provided to them by the counsellor as they could not have managed on their own. Although contacting another care provider on behalf of the client can occur in psychological counselling for a client, it may occur
more frequently with TBI survivors as they commonly have multiple practitioners because of the range of sequelae. In Klonoff’s guide to psychotherapy after brain injury, the psychotherapist is often designated as a “team leader” in the coordinator of the multiple professionals (rehabilitation physician, neurologist, psychiatrist, speech-language pathologist, occupational therapist, etc.) that the survivor needs for care and recovery. Ideally, regular staff meetings should occur with all treating clinicians.

**Acceptance and hope.** Upon careful analysis of the interview data, it became clear that participants discussed what appeared to be a hope-oriented approach to the re-construction of self-identity after TBI, in that, although acceptance of symptoms and deficits may be encouraged, hope for continued change was not discarded. This finding echoes the results of a qualitative research metasynthesis, where survivors reported that a tension existed between acceptance for the current situation versus striving for a better one (Levack et al., 2010). Study participants reported that acceptance was something they did not feel ready or able to do (Muenchberger, Kendall & Neal, 2008; Jumisko, Lexell, & Soderber, 2005; O’Callaghan, Powell, Oyebode, 2006). Moreover, survivors felt that complete acceptance was like “giving up” (Jumisko et al., 2005) and the “desire for ongoing improvement,” or hope was needed to maintain motivation for rehabilitation and to maintain a positive outlook on life (Shotton, Simpson, & Smith, 2007; Chamberlain, 2006). To support these qualitative findings from Shotton et al. (2007) and Chamberlain (2006), Peleg, Barak, Harel, Rochberg & Hoofien (2009) found that survivors with higher levels of depression had lower levels of hope and optimism. Although a more deliberate research study on the topic of the hope-oriented approach with TBI survivors is warranted, the preliminary data suggests that this is a highly effective approach to take.
**Have a positive regard.** Participants in this study reported that positive regard from their therapist had helped them find emotional healing. Positive regard in this study included reports of laughing together with the therapist or receiving encouraging sentiments from the therapist. Feeling as though a therapist regards one positively, a concept otherwise known as ‘unconditional positive regard’, was first described by Carl Rogers in 1975 (Keenan & Rubin, 2016). In Bedi (2006), participants identified validation statements, affirming body language, being able to laugh with the therapist, and being offered a hug as features which define a positive therapeutic relationship. It appears clear that positive regard experienced from the therapist in counselling therapy is just as important for TBI survivors as it is in the general population.

**Use self-disclosure.** Participants in this study expressed wanting to know more about their therapist. The clinical usefulness of therapist self-disclosure is a somewhat debated issue in the scientific literature, but qualitative research suggests that therapist self-disclosures are helpful so long as it is not for self-serving reasons (Hill & Knox, 2002; Manthei, 2007). In Bedi (2006), participants reported having a positive working relationship with therapists who shared personal information about themselves. The results of this study also suggest that self-disclosure supports the development of a therapeutic alliance with survivors.

**Components of Treating Survivors in Therapy.** This study produced recommendations for key structures and components when developing a treatment plan with a survivor of TBI. The themes in this section was guided by the research question, ‘What were the survivors’ experiences with various counselling interventions and the way such treatments were delivered?’ The following clinical recommendations are discussed in light of the literature. The first clinical recommendation for treatment planning is discussing frequency and duration of sessions, involving a family member in therapy, assisting in grief expression through preferred artistic
means such as drawings, music and metaphors, processing pre-morbid traumas in addition to TBI-related traumas, providing personalized compensatory tools with long-term follow-up, and therapist interventions to assist with discriminatory attitudes.

**Discussing frequency and duration of sessions.** The preferred frequency and duration of each session with the survivor appears to vary on a case by case basis. Some survivors reported desiring 30-minute sessions twice weekly to help with retention or to cope with extreme stress whereas others may be so overwhelmed with other neurorehabilitation appointments that they prefer an appointment once every two weeks. Shorter session presented more frequently were described to be useful for clients with poor attention span and pain issues in Hsieh et al. (2012). Subjective experiences of being too busy to recall details of the week was also described in Samson’s study (2008). The length of a session will also depend on the client’s tolerance to fatigue. However, those who are processing trauma may want to have a 90-minute session, if their energy levels allow it.

Almost all participants reported tapering their sessions with their therapist, to give themselves time to learn to cope on their own. Two participants reported that their duration of treatment was not long enough. For one of these participants, a longer duration of treatment was desired to process the traumas from her past and how her brain injury reinforced the cycle of trauma. For the other participant, she reported the need for life-long counselling as she needed support with tackling new issues related to her cognitive deficits. This need for continued check-in session for maintaining skills matched the findings in Hsieh and colleague’s (2012) study. Participants in Hsieh et al. (2012) were given twelve sessions of CBT and in the qualitative feedback, the researchers recommended a longer duration of treatment and booster sessions to allow for a “check-in” opportunity. It is suspect that participants required assistance with
managing changes in their circumstances and to fine-tune their coping strategies (Hsieh et al., 2012). A survey of the outcome of survivors at five years after TBI found a persistence of physical difficulties and worsening of reported cognitive, behavioural and emotional changes, which indicates a need for intermittent life-long counselling (Olver, Ponsford and Curran, 1996).

*Client preference for involving a family member in counselling.*

In this study, a few participants discussed their desire to include a family member in therapy so that this family member could come to understand their care needs and symptoms. One participant also expressed that she felt that educational and emotional support for her spouse in coping with the effects of her brain injury was limited. This participant also described the need and lack of services assisting couples with repairing a relationship after brain injury.

Caregiver anxiety, feelings of loss, overwhelm, difficulties with the survivor’s anger and memory loss have been documented in qualitative research (Carlozzi et al., 2015; Saban, Hogan, Hogan, & Pape, 2014). Intimate relationships present with unique challenges of loneliness and marital tension (Saban et al., 2014). Clinical guides supporting family members of survivors of TBI has been well-described in the literature (Klonoff, 2014; Simpson, Pfeiffer, Keoge & Lane, 2016; Gagnon Lin & Stergiou-Kita, 2016). In Klonoff’s (2014) psychotherapy for families after brain injury, family members are supported with understanding and coping with the survivor’s changes in abilities. Backhaus and colleagues discussed a theoretical framework to support couples relationship following TBI (Backhaus et al. 2016). Though the clinical guides do exist, this study suggests there is a lack of accessible services to mediate strained intimate relationships for survivors and their spouses in the lower mainland of British Columbia, where the study was conducted.
Pre-morbid trauma processing. Another aspect of emotional processing work that is poorly described in the literature is the post-injury psychological processing of pre-morbid traumas. It was thought that exploring the past for survivors of brain injury would incorrectly suggest to a survivor that they might be able to return to their past functioning (Ruff & Chester, 2014). In addition, there is a bias towards the belief that brain damage can obfuscate introspection, rendering dynamically-oriented psychotherapy to be of limited utility (Ruff & Chester, 2014). The literature seemed to suggest that retrospective exploration is contraindicative and can be largely avoided (Ruff, 2013).

For some survivors in this study, they were too emotionally pre-occupied by the state of their new mind and body to be concerned by issues of the past. A sixty-one-year-old participant, who identified as being gay, stated in her interview: “you can't think straight, you can't do your laundry. I couldn't brush my teeth, you know? ... Like basic stuff. So, you're not gonna think about, you know, I lost a job 'cause I was gay and I'm not over that!” However, many survivors with complicated-mild to severe TBIs reported feeling helped by his or her therapist with processing pre-injury traumatic material. This data point was first described by a twenty-eight-year-old male survivor of severe TBI. When I asked him how his therapist was most helpful to him, he answered that his therapist was most helpful to him in helping him deal with the death of his father, with whom he carried a lot of childhood relational trauma. (This participant’s father was a drug user.) In the participants to follow, there was evidence to suggest that some survivors, particularly those who suffered pervasive relational traumas, still require the consideration of how these events from their pre-injury lives have and still continue to affect their concept of self post-injury, as well as how these events have increased their vulnerability to the emotional consequences of the TBI.
Further supporting research evidence which explores how past traumas shape the emotional landscape of post-injury functioning would be clinically valuable as there is a lack of available literature which describes the utility of such past exploration. In clinical treatment, it is suggested that therapists should not dismiss the importance of weaving the narrative of pre-morbid relational, childhood trauma into the treatment of the emotional recovery post-injury.  

*Expression of grief through art.* Several participants in this study talked about the need to grieve and the need for someone to validate the enormity of their losses before they could move onto cognitive behavioural work. In the psychotherapeutic treatment of survivors of brain injury, there is a large emphasis on ‘grief work’ (Klonoff, 2010; Ruff & Chester, 2014). Grief processing, or ‘grief work,’ is traditionally seen as an adaptive process that is aimed at letting go of one’s attachment to the perceived loss (Freud, 1917/2005). Findings in this study correspond with the research literature’s conclusion that grief in survivors is complex and long-term (Chamberlain, 2006; Carroll & Coetzer, 2011). Two participants have talked about the use of drawings in therapy to more thoroughly express and explore their feelings. Drawings, metaphors and music are all thought to be ways in which individuals can work through grief (Wolfelt, 2013; Jantz et al., 2015) and have been described by participants in this study as a means for grief expression. In the existing literature, survivors have described pictorially and in poetry their feelings of loneliness and isolation after brain injury (Klonoff, 2005; Douglas 2007). Deeper exploration on whether drawings are an effective in-session compensation for verbal communication deficits is suggested.  

*Client preference for personalized compensatory tools with follow-up.* There were several recommendations made for the teaching and acquisition of compensatory skills in TBI survivors. The first is that some survivors may need help with accepting that they need to use
compensatory tools. The second recommendation made is that the acquisition of tools is better retained when a survivor had learned distress-regulation skills. The study also described a need for tools to feel applicable to individual needs, rather than being derived from a standardized list. A barrier to acquiring compensatory tools is the inability to accept that compensatory tools are required. Finally, support with problem-solving the use of compensatory tools may be a life-long requirement from therapists. One survivor suggested that home-visits to address problems in the home may be of incredible value.

Psychotherapists’ teaching of compensatory tools is well described in the TBI literature. Compensatory strategies involve the substitution of new strategies to carry out functions that can no longer be performed using the same neural substrates (Levy, Berner & Bendixen, 2005). The theory is that through task analysis, memorizing sequencing, over-learning and generalization, a survivor may remediate issues of cognitive functioning (Condeluci, Cooperman & Seif, 1987; Martelli, Nicholson, & Zasler, 2008). Klonoff (2010) writes that psychotherapists should take an instrumental role in the establishment of compensatory tools required for home independence. Ideally, a psychotherapist would collaborate with an occupational therapist with expertise in the functional deficits in the home and community environment to achieve this goal (Landa-Gonzalez, 2001). Klonoff (2010) also suggested that home-visits from a psychotherapist may be required when challenges and failures with compensatory skills occur. Compensatory instructions may be too lengthy or complex or perhaps the survivor is struggling with the initiative to use the tool. Klonoff (2010) describes in her book that psychotherapists may need to help survivors learn to develop acceptance of a tool. In conclusion, this study added necessary qualitative data to the acquisition of compensatory tools in TBI survivors.
Interventions to help with feeling discriminated. This study illuminated attitudes of prejudice and discrimination as a major barrier to societal participation for TBI survivors. Many participants in this study complained that even close friends and family members fail to acknowledge their “invisible injuries”. People’s attitudes at home and in the community, including prejudice and discrimination, have been reported to be a barrier for TBI survivors to navigate (Whiteneck et al., 2004). As described by one participant in this study, therapists can offer refuge from this experience by offering validation and assisting survivors with role-playing effective communication to counter prejudiced and discriminatory behaviours. Another way survivors appear to reclaim dignity is when therapists provide support in requesting consideration in the work or school environment by writing letters delineating required accommodations. Although accommodations prescribed and coordinated by psychotherapists such as environmental manipulations, job-shadowing, education for employers and co-workers, and progressive modification of supports to assist survivors with re-entry into work and school placements are described (Oppermann, 2004; Sherer et al., 1998; Willer & Corrigan, 1994; Klonoff, 2010), there is a paucity of literature describing the vindictive feeling that such actions inspire for survivors.

Limitations of the study

One major limitation of the study was the limited timeline. A longer timeline may have allowed for data to be collected on the changes in attitudes towards counselling across time. Given the time for a longitudinal study, participants could have been interviewed at various stages in the counselling relationship, the beginning of the counselling relationship, the middle of the counselling relationship and after terminations of the counselling relationship. Although it is conceivable that those who had a terminated counselling relationship could have different
experiences, opinions and responses from those who are currently in counselling, this was not observed in the data. Of the seven participants who had a terminated counselling relationship, there was mix of positive and negative experiences about counselling. Those who were still in counselling at the time of the interview did provide meaningful feedback about what was encountered in the counselling process. I had ensured that participants understood that the responses that they made were confidential and any identifying information would be removed so to mitigate any concerns that their responses would not be made identifiable to their therapist. Thus, participants ought to have felt free to speak as honestly as possible.

This study achieved a culturally diverse sample. Participants in this study identified as Italian (1), Punjabi (1), Caucasian (4), Chinese (2), Caribbean (1), and Irish (1). (The values in brackets represent the number of participants in that category.) It was beyond the parameters of the study to investigate how culture shaped experiences of TBI in counselling but some of the participants’ responses suggests that it plays a factor. One participant proclaimed that her Irish background meant that she was expected to be “stoic” and that she was “not allowed to feel things”. Future studies could investigate the influences that culture plays on TBI survivors in their help-seeking behaviours or views of the therapeutic relationship.

This study included participants who received their counselling therapy in large metropolitan areas in the eastern and western parts of Canada, particularly, the greater Vancouver area in British Columbia and the greater Toronto, Ontario area. Thus, many of the pragmatic recommendations will be of relevance only to practitioners in these two cities. Although practicing clinicians in other regions may find it difficult to apply all the findings in this study, it may still allow them to critically evaluate the way they practice.
Another limitation of the study was that nine out of the ten participants had an insurance claim from a road accident (either as a driver, pedestrian, motorcyclist or bicyclist). Six of these individuals had an active legal claim, which might have influenced the way they expressed their experiences in counselling. Although I had hoped for a more varied population, it was expected that the majority of participants relied on an insurance claim to pay for counselling. 60.4% of survivors of TBI were unemployed at two-years post-injury (Cuthbert et al., 2015). Given the reduced income and ambiguous prognoses, it can be hard for survivors to afford counselling. Only one participant received pro-bono counselling. It would be interesting to survey why there has not been more survivors accessing pro-bono or low-cost counselling in the greater Vancouver area.

While there are limitations to this study due to geographical variance and method of payment for counselling, the in-depth nature of this small-scale study allows for the breadth of experience to be extracted from the study participants. Although a larger scale study may reveal more meaningful statistical measures, the value in small sample sizes is the freedom that is given to participant to talk about their most meaningful and elucidative experiences in therapy (Robinson, 2013). Combined with the flexibility of the ground-up, iterative approach to sampling that ID allows, a smaller sample size has proven to be quite powerful in the results that it has manifested.

**Future Research Directions**

The use of qualitative interview data to describe and interpret the current counselling experiences of survivors of TBI is a novel addition to the field of mental health and TBI survivors. This exploratory research study provides a descriptive foundation that indicates a need for more qualitative and quantitative research on the experiences that TBI survivors have in
counselling. There are many directions in which this preliminary qualitative investigation into the experiences of survivors in counselling can be further expanded which will be discussed in the following paragraphs.

One area which requires a larger scale investigation is the research question involving the exploration of various counselling interventions and approaches and the ways they were delivered. As the study progressed, participants discussed specific “things” that therapist did “that were helpful or unhelpful” such as including a family member into session, discussing a drawing, or assisting with problem-solving compensatory tool acquisition rather than whether a particular modality as a whole was useful for survivors. One reason for this is that survivors often did not know which modality or intervention was being used. Although survivors had some opinions about interventions which they did not find helpful, such as Prolonged-Exposure Therapy (2), Systematic Desensitization (1), Eye-movement Desensitization and Reprocessing (1), and Acceptance and Commitment Therapy (1). Due to the small sample size, it is hard to make inferences about what these figures in brackets represent. Thus, a large-scale study surveying positive and negative experiences with certain modalities of work may be revelatory.

Another direction in which to expand on this research is to initiate a deeper qualitative exploration into a select parameter of this study’s findings. For instance, a more in-depth look at the factors which support or hinder a therapeutic alliance between survivors and therapists is extremely necessary. This study found that about half of the participants had a strong therapeutic alliance with their counsellor while the other half had a more ambivalent or mistrusting connection with their therapist. As there is a paucity of literature on therapeutic relationships between survivors and therapists. As this preliminary investigation revealed several important factors such as the survivor need for autonomy around intervention selection, the need for a
hope-oriented approach, and the need for additional support between sessions. It would be of value to explore other factors which support the development of the therapeutic relationship.

Another direction for deeper qualitative investigation can explore survivor perceptions of involving family members in one or more sessions. Participants in this study expressed a wish to involve a family member in therapy so that the family member can understand the “invisible” symptoms of the brain injury. Participants in this study reported that family sessions helped decrease their personal levels of stress in the home. However, there are many important aspects of family therapy that were not explored in this study. In the literature, it is theoretically postulated that family members are to be included in therapy to provide important historical information that survivors fail to mention independently but we have yet to ask what are survivor’s experiences of bringing family members into therapy for this purpose? What were some instances in which including a family member became a barrier? The answers to these questions lie beyond the parameters of this study.

Another suggested area for further exploration is the environmental barriers that survivors experience in counselling. A larger sample size would produce more recommendations towards the mitigation of visual disturbances in counselling, the management of pain and fatigue in counselling, solutions for light and noise sensitivity, and recommendations for managing communication issues in counselling. The findings in this study are an excellent starting place for clinicians to begin to think critically of how the counselling environmental or therapist behaviours create barriers for survivors.

Ultimately, future researchers can take any theme discussed in this thesis and expand on it in a more detailed qualitative exploration. It is hoped that a close reading will inspire other clinical researchers to continue to explore the experiences survivors of brain injury have in
counselling through further research. Moreover, individuals who suffer from other chronic neurological disorders such as stroke, multiple sclerosis, dementia, Parkinson’s disease, Huntington’s disease, epilepsy, cerebral palsy, or meningitis may also find that this research is applicable to them and while it may be tempting to use these results to make generalizations about the experiences of survivors of other neurological disorders, it would be prudent to seek to discover whether other neurological disorders have any unique needs that differ from those with TBI. This returns us to the main guiding principal of this study, which is, that aside from clinical expertise and scientific evidence, the third factor which informs true ‘evidence-based practice’ is the inclusion of client perspectives in the form of feedback.
References


Publication of the American Occupational Therapy Association, 63(5), 559-568.
doi:10.5014/ajot.63.5.559


doi:10.1080/09602011.2017.1307767


doi:10.1177/1525822X05279903


doi:10.1080/09581590802294296


Supportive Care in Cancer: Official Journal of the Multinational Association of Supportive Care in Cancer, 23(10), 2855-2859. doi:10.1007/s00520-015-2804-8


Physical Medicine and Rehabilitation, 94(7), 1386-1397.
doi:10.1016/j.apmr.2013.02.013

dysfunction and emotional changes. Journal of Consulting and Clinical Psychology, 60(3),
349-359.


noncategorical qualitative alternative for developing nursing knowledge. Research in
Nursing & Health, 20(2), 169-177. doi:10.1002/(SICI)1098-240X(199704)20:2<169::AID-
NUR9>3.0.CO;2-I

interpretive description. International Journal of Qualitative Methods, 3(1).

Thorne, S. (2016). Interpretive Description: Qualitative Research for Applied Practice (2nd ed.).
New York: Routledge.

Disability in young people and adults one year after head injury: Prospective cohort


Appendices

Appendix A: Pre Pre-screening Phone Interview

1. Have you acquired a traumatic brain injury?
2. Have you had counselling in the past year?
Appendix B: Pre-Screening Form

Identifying Information

Participant Number:____________  Date:____________________________________________

Traumatic Brain Injury

Date of Injury:________________________________________________________

For the following three questions use Appendix B:

1. Duration of Loss of Consciousness:____________________________________

2. Duration of post-traumatic amnesia:____________________________________

3. Abnormalities on anatomical neuroimaging (i.e.: MRI, CT) __________ (Yes/No)

Indicate which: __________________________________________________________________

Classification of Brain Injury:_____________________________________________________

(mild, complicated-mild, moderate, severe)

Diagnoses of any of the following: anosognosia, severe deficits in reasoning, global aphasia, receptive aphasia or severe amnesia __________ (Yes/No)

Indicate which: __________________________________________________________________

Counselling History

a. Dates:____________________________________________(day/month/year to day/month/year)

Counsellor degree held:___________________________________________________________

(social worker, psychologist, bachelor’s, master’s, medical doctor, unknown)

Location of service:_____________________________________________________________

(non-profit agency, hospital, private practice, university counselling centre)

Payment of Service:_____________________________________________________________

(full coverage (indicate which: ICBC, WorkSafe, EAP, other), partial coverage, out-of-pocket)
TBI COUNSELLING EXPERIENCE

b. Dates: ______________________________________ (day/month/year to day/month/year)

Counsellor degree held: ________________________________________________________________

Location of service: ________________________________________________________________

Payment of Service: ________________________________________________________________

c. Dates: ______________________________________ (day/month/year to day/month/year)

Counsellor degree held: ________________________________________________________________

Location of service: ________________________________________________________________

Payment of Service: ________________________________________________________________

Counselling Therapy within the last year? __________(Yes/No)

Currently undergoing counselling: __________ (Yes/No)

Use of interpreter in counselling: __________ (Yes/No)

Demographic Information:

Gender: _________________________(M/F/Other)

Date of Birth: _________________________ (month/day/year) Age: __________

Fluent in English: __________ (Yes/No)

First language: ________________________________________________________________

Highest level of education completed: _________________________________________________

Current employment status: __________________________________________________________
Employment before injury:__________________________________________________________

Current housing status:__________________________________________________________

(family home, independently, supported housing, etc.)

Members in household:___________________________________________________________

Marital status:__________________________ (single, married, common-law, divorced)

Ethnic background:______________________________________________________________

Psychological diagnoses:________________________________________________________
                          ________________________________________________________________

Pre-Morbid:______________________________________________________________

Other existing health conditions:______________________________________________
Appendix C: Injury Severity Assessment Interview Guide

Based on what others have told you, how long were you unconscious for? (Loss of consciousness):

A ☐ Less than 30 minutes  
B ☐ Around 30 minutes  
C ☐ Between 30 minutes to 24 hours  
D ☐ More than 24 hours

How long was your complete or patchy memory loss after the impact? (Posttraumatic amnesia):

A ☐ Less than 24 hours  
B ☐ Around 24 hours  
C ☐ Between 24 hours and 7 days  
D ☐ More than 7 days

Did you have any anatomical neuro-imaging (e.g.: CT or MRI) done at the time of injury?  
Yes ☐   No ☐

If yes, are you aware of any abnormal findings (e.g.: brain bleed, shear) in imaging?  
Yes ☐   No ☐

Describe your areas of difficulty in your day-to-day functioning.

<table>
<thead>
<tr>
<th>Injury Characteristic</th>
<th>Category A: Mild TBI</th>
<th>Category B: Complicated-mild TBI</th>
<th>Category C: Moderate TBI</th>
<th>Category D: Severe TBI</th>
</tr>
</thead>
<tbody>
<tr>
<td>LOC</td>
<td>&lt; 30 min.</td>
<td>&lt; 30 min.</td>
<td>30 min. - 24 hours</td>
<td>&gt; 24 hours</td>
</tr>
<tr>
<td>PTA</td>
<td>&lt; 24 hours</td>
<td>&lt; 24 hours</td>
<td>24 hours - 7 days</td>
<td>&gt; 7 days</td>
</tr>
<tr>
<td>Abnormalities in Neuroimaging (CT, MRI)</td>
<td>No</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
</tbody>
</table>

TBI COUNSELLING EXPERIENCE 152
Appendix D: Semi-Structured Interview Guide

Instructions for respondents: If the question is unclear, please ask for clarification. The goal is to obtain information about your experiences in counselling that was helpful or unhelpful to you. Ultimately, this information will help researchers and clinicians provide a better counselling experience for individuals with TBI. It’s okay if you don’t remember everything, just reconstruct the experience as who you are now and what you sense is important in the past.

1. Tell me about the characteristics of your therapist.
2. What were some of the things your therapist did that were unhelpful?
3. What were some of the things your therapist did that were helpful?
4. Tell me about your experience with how the therapy sessions were structured (i.e.: pacing, length of session, frequency of sessions)?
5. Tell me about your experience with the therapy environment.
6. Tell me about a typical session in counselling therapy.
   a. What was the name or the style of counselling your therapist did?
7. Tell me about some specific interventions (i.e.: psychoeducation, mindfulness) that were unhelpful.
8. Tell me about some specific interventions that were unhelpful.
9. Do you have any other feedback you would like to give to researchers and clinicians who treat those with TBI?
Appendix E: Consent Form

An Interpretive Description of Individuals with Complicated-mild and Moderate Traumatic Brain Injury (TBI) in Counselling

I. Who is conducting the study?

Principal Investigator:
Dr. Izabela Schultz, Registered Psychologist, UBC Department of Educational and Counselling Psychology and Special Education, 604–822–5251, ischultz@telus.net

Co-investigators:
Angela Leong, Master’s candidate in Counselling Psychology, UBC Department of Educational and Counselling Psychology and Special Education, 778-988-1889, angela.leong@alumni.ubc.ca

Dr. Jennifer L. Baumbusch, PhD, RN, Department of Nursing, UBC, 604-822-7496, jennifer.baumbusch@nursing.ubc.ca

Dr. Richard Young, PhD, Department of Education and Counselling Psychology and Special Education, UBC, 604-822-6380, richard.young@ubc.ca

Dr. Ronald Ruff, PhD, Department of Psychiatry, University of California, San Francisco, 415-476-3860, ronruff@mindspring.com

II. Why are we doing this study?

I want to learn more about how to help people with traumatic brain injuries (TBIs) have a better experience in counselling. This study will help me learn more about people with TBIs and their experiences in counselling. From previous research, we already know that counselling needs to be adjusted to fit specific population needs, but how it needs to be adjusted needs further exploration, gained through by asking for feedback from clients. I am inviting people like you who have a TBI to help us.

This study is being conducted for the thesis component of a graduate program. A thesis is a public document. The University of British Columbia requires that the thesis is submitted to cIRcle, an open access digital repository for published and unpublished material created by the UBC community and its partners. I, graduate student and co-investigator, Angela Leong, is
conducting this study to fulfill part of the degree requirements for the Master of Arts in Counselling Psychology degree.

III. What happens if you say, “Yes, I want to be a part of this study”?

Signing this form provides written consent for the initial pre-screening interview and the main interview of the study. However, signing this consent form does not guarantee that you will be able to participate in the main interview. Depending on your answers to the pre-screening, you may be politely asked to not participate in the main portion of the study. This may be because the severity of your injury does not meet our target population, or it may be because you are demographically too similar to previous participants.

If you consent to participate in this study, I will start with asking some questions about the severity of your brain injury and the history of the counselling services you have had. You will also be asked some demographical questions concerning your gender, age, employment, household information, education completed, ethnic background, first language and other health conditions. These questions comprise the pre-screening interview. This part of the study should only take 30 minutes.

The main portion of the study, the interview, asks you to give your account of your past experiences of counselling. The goal is to gain an understanding of what was helpful and what was hindering about your past counselling experiences in order that we can use this information to provide better counselling services to individuals with traumatic brain injuries. The interview may be broken up into several sessions, should you require it. I anticipate the total interview to take between 60 to 90 minutes.

With your consent, the interview will be audio recorded. The audio will then be transcribed into a written document. When the interview is transcribed, information that may identify you or others (such as places of work, city of birth, names) will be removed. Your interview data will be kept confidential and will only be viewed by myself and the other members of the research team, which are listed at the beginning of this document. The audio files, the transcribed files, and any identifying information will be stored in a locked cabinet in a locked room in the Principal Investigator’s office on UBC Vancouver Campus. The files will be destroyed five years after completion of the study.

IV. How you can see the results of this study

The results of this study will be reported in a graduate thesis and may become published in a journal article or book. If you would like to be contacted regarding the results of the study, please provide an email address and mailing address in the space at the bottom of this document for a report on the findings.

V. What are the risks of participation?
We do not think there is anything in this study that could harm you or be bad for you. However, some of the questions we ask may evoke painful memories of past experiences with counselling. However, it is not our intention to make this an unpleasant experience. You do not have to answer any questions you do not wish to. We understand if these experiences are difficult to discuss. You have the option to stop the study altogether or resume the study at another time. If you require it, counselling referrals can be made.

We are collecting interview responses that may contain sensitive and personal information. Your confidentiality will be respected. All documents will be identified only by code number and kept in a locked filing cabinet in a locked office at the UBC Vancouver campus. Subjects will not be identified by name in any reports of the completed study. Data records will be kept on an external hard drive. No data will enter any non-secure online storage systems. The files will be destroyed five years after completion of the study. Information that discloses your identity will not be released without your consent unless required by law. There are legal limits to confidentiality. At any point in the study, if you revealed that there has been an incident that involves abuse and/or neglect of a child or an elderly person (or that there is a risk of such occurring) please be advised that the researcher must, by law, report this information to the appropriate authorities.

VI. What are the benefits of participation?

The majority of individuals who participated in a study, which asked about their experiences in counselling reported that it had been beneficial and thought-provoking. The participation in this study may help you synthesize your thoughts and may inspire you to take a new direction in your life.

In addition, you are contributing an important cause which many benefit the lives of other individuals with traumatic brain injuries, which may evoke feelings of reward and being part of something bigger.

It is our hope that you benefit from participating in this study about your experiences in counselling. However, we cannot guarantee a positive experience. To compensate you for the time that you spend participating in this study, you will be awarded $10 in cash upon completion of the study interviews.

VII. Who can you contact if you have complaints or concerns about the study?

If you have any questions or concerns about what we are asking of you, please contact the study leader or one of the study staff. The names and telephone numbers are listed at the top of the first page of this form.

If you have any concerns or complaints about your rights as a research participant and/or your experiences while participating in this study, contact the Research Participant Complaint Line in the UBC Office of Research Ethics at 604-822-8598 or if long distance e-mail RSIL@ors.ubc.ca or call toll free 1-877-822-8598.
VIII. Participant Consent and Signature

Taking part in this study is entirely up to you. You have the right to refuse to participate in this study. If you decide to take part, you may choose to pull out of the study at any time without giving a reason and without any negative impact on your access to further services from the hospital, community centre, support group, drop-in centre, rehabilitation facility, or clinic.

- Your signature below indicates that you have received a copy of this consent form for your own records.
- Your signature indicates that you consent to participate in this study.

☐ I consent to participate in this study

__________________________________________________________
Participant Signature                                                                                      Date

__________________________________________________________
Participant Name (Print)

IX: Additional Information for Disseminating Report on Findings

Participant Email:__________________________________________________________
Mailing Address:__________________________________________________________
Appendix F: Transcriber Confidentiality Agreement

I agree to prepare transcriptions of audiotaped interviews for Angela Leong for a rate of $_____/minute. I understand that the audiotapes contain confidential information. As part of this contract, I agree to keep this information confidential and to not disclose or discuss the participants’ names or the content of the interviews. Maintenance of confidentiality entails that the user of confidential files to hold confidential files in a flash drive or a computer with local storage only.

Instructions to the transcriber:
• Each interview is anticipated to last between 60 to 90 minutes.
• The transcript will be transcribed verbatim (i.e.: including ‘umm”, “uhh”, “ah”, “uh-huh”, “er”, “mm-hmm”, etc.)
• Include any overt non-verbal signals such as coughs, laughs, sighs, pauses, outside noise, telephone rings, interruptions that are caught on tape.

Your signature denotes your understanding and agreement to these terms.

______________________________________________________________________________
Transcriber signature Transcriber full name (Print)
Appendix G: Script for Group Announcements

My name is Angela Leong and I am a graduate student in the Counselling Psychology department at UBC. I’m conducting a study on individuals with traumatic brain injury and their experiences in counselling therapy.

The findings may help clinicians and researchers such as myself to be able to provide better counselling services to individuals with traumatic brain injury in the future.

Participants will be asked to participate in an interview about their experiences in counselling. $10 compensation will be offered.

If you are interested in participating, please come find me at the end of this ______________ (session, meeting, seminar, program). I will be at ________________________________ (this part of the building). I will be handing out handouts and answering questions.
Appendix H: Recruitment Poster

DO YOU HAVE A
TRAUMATIC BRAIN INJURY?

Have you had Counselling?

Take part in a research study which will interview you about your experiences in counselling therapy. This research study may help counsellors better understand your experience in counselling. This will result in improved treatment practices. You will be asked to volunteer a few hours of your time spread out over two meetings. Interviews will be conducted in a convenient location of your choice. $10 cash will be provided for compensation. Your confidentiality will be maintained. Participation in this study will not affect your access to this facility and will be conducted outside of program times.

If interested, please contact Angela, to hear more about the study.
Angela Leong,
778-988-1889 or angela.leong@alumni.ubc.ca

Project Title: An Interpretive Description of Individuals with Complicated Mild and Moderate Traumatic Brain Injury in Counselling
Principal Investigator: Dr. Izabela Schultz, Registered Psychologist, UBC Department of Educational and Counselling Psychology and Special Education
Co-investigator: Angela Leong, Masters Candidate in UBC Department of Educational and Counselling Psychology and Special Education
Committee Members: Dr. Ronald Ruff, UC San Fran; Dr. Jennifer Baumbusch, UBC Nursing; Dr. Richard Young, UBC ECPS
Appendix I: Recruitment Handout

Participate in a traumatic brain injury research study.

My name is Angela Leong and I am a master’s student in the Counselling Psychology department at UBC. I’m conducting a study on individuals with traumatic brain injury and their experiences in counselling therapy.

The findings may help counsellors and therapists be able to provide better counselling services to people with traumatic brain injury in the future.

Participants will be asked to participate in a 30-minute pre-screening interview, followed by a full 90-minute interview about their experiences in counselling. The full interview will be audio recorded. Interviews are conducted in a quiet and convenient location of the participant’s choice. Confidentiality will be maintained. Names of therapists or identifying information such as place of residence, place of work, names of others will be removed. Participants will receive $10 as compensation for their time.

If you are interested in participating, contact Angela at 778-988-1889 or at angela.leong@alumni.ubc.ca

Study title: An Interpretive Description of Individuals with Complicated Mild and Moderate Traumatic Brain Injury in Counselling

Principal Investigator: Dr. Izabela Schultz, R. Psych, UBC Department of Educational and Counselling Psychology and Special Education (EPSE), 604–822–5251, ischultz@telus.net

Co-investigator: Angela Leong, BA, Master’s candidate in Counselling Psychology, UBC EPSE