ABSTRACT

Through explicit attention to diversity and a positive psychology frame, this phenomenological inquiry investigated the experience of career decision-making for women with brain injury. This group has been previously ignored in the career development and counselling, vocational psychology, and psychology literatures. There is a paucity of information about the subjective experience of career decision-making. The purpose of this study was to give women with brain injury a greater priority in career research and to illuminate the lived experience and meaning of career decision-making from the perspective of women with brain injury.

Eight volunteers, involved in the community as a worker, volunteer, or student, described their career decision-making experiences through in-depth audio-taped interviews. Notwithstanding the initial severity of brain injury, participants richly articulated and illuminated their personal experience and meaning of career decision-making. Six common themes and five sub-themes emerged from a thematic analysis of the interview data. These were: (1) Continued Centrality of Career comprised of two interrelated sub-themes: the intensified meaning of paid work career, and the influence of rehabilitation in career decision-making; (2) Continued Centrality of the Relational in Career; (3) Sense of Life Purpose and Altered Life Perspective with a concomitant sub-theme of increased agency in career decision-making; (4) Sense of Continuity and Change in Identity; (5) Sense of Increased Vulnerability in Interactions comprised of two inversely related sub-themes: the sense of being devalued, and the sense of equality; and (6) Sense of Insecurity and Emotionality.
The findings of this study revealed the experience of career-decision making to be a highly complex ongoing experience imbued with emotion and subjective meaning. Social interactions and the societal context, giving rise to positive or negative emotions, facilitated or obstructed the women's experience of career decision-making. These findings point to a critical need for training about the potential of women with brain injury for rehabilitation and counselling professionals. The theoretical implications of the findings are discussed as they relate to research in brain injury and career. The implications for career counselling process, in relation to models of career-decision making and career counselling, are discussed and recommendations for future research are provided.
TABLE OF CONTENTS

ABSTRACT ........................................................................................................................ ii

TABLE OF CONTENTS ........................................................................................................ iv

LIST OF TABLES ................................................................................................................ vii

ACKNOWLEDGEMENTS .................................................................................................... viii

CHAPTER ONE: INTRODUCTION .................................................................................... 1
   Incidence of Disability ................................................................................................. 2
   Statement of the Problem ........................................................................................... 3
   Social Model of Disability ......................................................................................... 7
   Overview of Acquired Brain Injury .......................................................................... 9
   Purpose of the Study ................................................................................................. 17

CHAPTER TWO: LITERATURE REVIEW ......................................................................... 18
   Return to Work and Quality of Life ......................................................................... 19
   Positive Meaning and Growth in Brain Injury ....................................................... 24
   Career Theories and Persons with Disabilities ....................................................... 29
   The Societal Context of the Changing Workplace ............................................... 34
      Effects of the Changing Workplace .................................................................. 35
      Implications for Career Counselling .................................................................. 40
   The Social Context of Changing Identity .............................................................. 43
   Barriers to Women’s Career Development ............................................................ 50
   Models of Career Decision-Making ........................................................................ 53
   Contextual and Constructivist Approaches to Career ........................................... 57
      Systems Theory Framework of Career Development ...................................... 60
      Peavy’s Constructivist Career Counselling ....................................................... 63
      Cochran’s Career Project .................................................................................... 64
      Contextualist Action Theory .............................................................................. 65
   Summary and Conclusions ..................................................................................... 68

CHAPTER THREE: METHODOLOGY ............................................................................. 72
   Research Design ....................................................................................................... 72
      Phenomenological Methodology in Psychology ............................................... 72
      Suitability for this Research .............................................................................. 78
      Bracketing ............................................................................................................. 80
   Research Procedure ................................................................................................. 83
      Participants ........................................................................................................... 84
      Criteria ................................................................................................................ 86
      Recruitment ......................................................................................................... 87
   Data Collection ....................................................................................................... 88
CHAPTER FOUR: RESULTS ......................................................... 103

The Participants ............................................................... 103
Sarah, 42, Age at Brain Injury 35 ........................................ 103
Lucy, 43, Age at Brain Injury 40 .......................................... 105
Ramona, 43, Age at Brain Injury 39 ..................................... 108
Jane, 48, Age at Brain Injury 38 .......................................... 110
Rylan, 45, Age at Brain Injury 39 ........................................ 112
Katherine, 61, Age at Brain Injury 54 ................................. 115
Elisabeth, 40, Age at Brain Injury 36 ................................. 118
Sophie, 33, Age at Brain Injury 24 ....................................... 120

The Themes ............................................................................ 123
Theme 1: Continued Centrality of Career .............................. 126
  Intensified meaning of a paid work career ......................... 126
  Influence of rehabilitation in career decision-making .......... 130
Theme 2: Continued Centrality of the Relational in Career .... 134
Theme 3: Sense of Life Purpose and Altered Perspective .... 140
  Increased agency in career decision-making ................. 146
Theme 4: Sense of Continuity and Change in Identity .......... 149
Theme 5: Sense of Increased Vulnerability in Interactions .... 154
  Sense of being devalued .................................................. 155
  Sense of equality .......................................................... 162
Theme 6: Sense of insecurity and emotionality ................... 167

CHAPTER FIVE: DISCUSSION ............................................... 179

Restatement of the Purpose of the Study ............................. 179

Theoretical Implications ....................................................... 179
  Theoretical Implications of Individual Themes .................. 183
    Continued centrality of career .................................. 183
    Continued centrality of the relational in career .......... 185
    Sense of life purpose and altered perspective ........... 186
    Sense of continuity and change in identity .............. 191
    Sense of increased vulnerability in interactions ....... 192
    Sense of insecurity and emotionality .................... 196

Implications for Counselling .............................................. 200
Limitations of the Study ..................................................... 211
Implications for Future Research ...................................... 214
LIST OF TABLES

Table 1  Descriptive Summary of the Participants ........................................ 85
Table 2  Descriptive Summary of the Themes .............................................. 125
ACKNOWLEDGEMENTS

I was blessed with the support of many people as I completed this thesis.

I am very grateful to the eight women who so generously shared their experiences with me. I am deeply honored by their openness and inspired by their courage and wisdom. This thesis would not have been possible without their participation.

I would like to extend particular appreciation to Dr. Norman Amundson, my thesis supervisor, for his support, insightful suggestions, and guidance throughout the research and writing of this thesis. I would also like to thank Dr. William Borgen and Dr. Marvin Westwood, members of my thesis committee, for their advice, encouragement and support.

I am especially indebted to Dr. Norman Amundson and Dr. William Borgen for the inclusion of this research within the context of their larger investigation. Their expert guidance and mentoring in this larger context made an invaluable contribution to this thesis and to my development as a researcher.

My heartfelt thanks and appreciation go to the many friends and colleagues who provided important support throughout the process of this thesis.

Most of all, I want to thank my family for their unswerving support and belief in me.
CHAPTER 1: INTRODUCTION

The perspective that career is “something that we all have but often fail to recognize” (Van Maanen & Schein, as cited in Woodd, 2000) is especially relevant to this study. My interest in the area of career was sparked by individuals who did not view themselves as having a career. They frequently commented that they had a career before they became unemployed or before disability or that they came to college to get a career. I have been particularly interested in the meaning of career decisions made by persons with brain injury. Perhaps because unemployment is an especially significant concern for women with brain injury, their career decisions seemed more urgent to me. Many times, the decisions made by my students with brain injury did not seem feasible to me. Yet despite many setbacks and challenges, the students persisted and a good number succeeded. This high persistence and firm resolve intrigued me and fuelled my desire to better understand the personal meaning of these career decisions. This study realizes my desire to better understand the experience and meaning of career decision-making for women with brain injury.

It is not surprising that there is much confusion about the meaning of the term career. The counselling psychology, vocational psychology, and organizational psychology literatures contain many and divergent definitions of career (Woodd, 2000). Some definitions of career, such as evolving “sequences of work experiences over time” (Arthur & Rousseau, 1996, p. 3) and “dependant on jobs with a hierarchy of prestige” provide a very limited view of career not ascribed to in this study. Such limiting definitions of career lead individuals to believe they do not have a career.
Savickas (2002) defines career as the "reflection on the course of one's vocational behavior. The reflection can focus on actual events such as one's occupations (objective career) or on biographical themes (subjective career) that explain one's occupations" (p. 383). Savickas further suggests that we use career with an adjective such as vocational, parental or leisure career. The Nelson Canadian Dictionary (Green, 1998) defines career as both "a chosen pursuit" and "the general course or progression of one's working life." In this study, the term career denotes a reflection on the objective and subjective course of chosen pursuits including occupational, avocational, parental, familial and other pursuits as are significant for the women with brain injury.

**Incidence of Disability**

Arguably the largest minority group in the population (Herr, 1997; Noonan et al., 2004), persons with disabilities constitute at least 12.4% of the Canadian population and 14% of the population in British Columbia (Cossette & Duclos, 2002). When persons with mild disabilities are included, as is done in American surveys, persons with disabilities constitute from 18.7% (Stoddard, Jans, Ripple, & Krause, 1998) to 20% (LaPlante & Carlson, 1996) of the population.

The number of people with invisible disabilities is increasing rapidly (Kaye, LaPlante, Carlson, & Wegner, 1996) constituting 40% of all persons with disabilities (Matthews & Harrington, 2000). An invisible disability is hidden and cannot be immediately noticed by an observer except under unusual circumstances or with disclosure. Examples of invisible disabilities include heart disease, epilepsy, learning disabilities, diabetes, asthma, mental health disorders, brain injuries, and some forms of arthritis. Persons with invisible
disabilities may not self-report disability in census surveys thus further underestimating population incidence of disability.

Persons with disabilities, wanting to be accepted as persons first, utilize communication strategies such as establishing normalcy and delaying self-disclosure (Braithwaite, 1990). Indeed, persons with invisible disabilities do not disclose disability unless there are practical reasons to do so (Matthews & Harrington, 2000). The decision not to disclose can be made in any of the person’s life roles. Thus, researchers may not always be fully aware of individual and contextual factors related to disability in their research.

Paid employment is one way of measuring inclusion in society for adult Canadians (Government of Canada, 2004). The Canadian workforce participation rate for women with disabilities is 32% versus 70% for women without disabilities and 41% for men with disabilities versus 83% for men without disabilities. Women with severe disabilities have the lowest workforce participation rate of all Canadians. In fact, women with disabilities, with an average income in 1998 of $7190, are three times more likely than women without disabilities to rely on government programs as their main source of income. This significant under representation in the workforce, most pronounced for women with disabilities, is one impact of social barriers for persons with disabilities.

Statement of the Problem

Although persons with disabilities represent the largest minority group in the American population (LaPlante & Carlson, 1996; Stoddard et al., 1998), they have been ignored in the mainstream of psychology (Tate & Pledger, 2003), vocational psychology (Betz, 2001) and career development and counselling (Flores et al., 2003; Whiston & Brecheisen, 2002). Most research on persons with disability has been relegated to
subspecialties such as rehabilitation psychology, rehabilitation counselling and focused primarily to acute stages, patient populations, and intrapsychic phenomena (Olkin & Pledger, 2003).

Vocational psychology has applied a narrow lens to the study of work and its central importance in the lives of individuals (Fouad, 2001; Vondracek, 2001). In particular, an over reliance on quantitative research methods and assessment has overlooked the contextual and individual complexity of human lives (Savickas, 2001). Furthermore, research in the discipline based on middle class values, has been predominantly focused on a white male middle class (Blustein, 2001; Fouad, 2001; Subich, 2001) resulting in theories and measures whose relevance for members of diverse racial and cultural groups is unknown (Betz, 2001).

Some vocational psychologists have recommended the use of qualitative methods (Blustein, 2001; Fouad, 2001; Richardson, 1993) to develop theory based on an understanding of the work lives of individuals and have espoused the need to enlarge the focus of vocational psychology to include diversity and social justice (Betz, 2001; Savickas, 2001). Proper contextualization of the individual (Vondracek, 2001) views vocational development from the perspective of the whole person who is developing in multiple interconnected contexts. Contextualization makes explicit that large segments of the population must make work decisions within the constraints of their lives and with less free choice than is assumed in current theories of vocational choice and development (Blustein, 2001, Fouad, 2001). Following Richardson, Blustein suggests that replacing the current theoretical emphasis on the study of careers with the study of the psychology of work will result in inclusion and an integrated perspective on the work lives of individuals. Given social barriers to labour force participation, an expanded focus that includes work outside the
occupational structure and qualitative research methods that attend to context are needed to ensure the future relevance of career theories for persons with disabilities.

Subich (2001, as cited in Walsh, 2001) viewing race, ethnicity, and social class as important individual differences, has called for explicit recognition of the diversity of personal and contextual characteristics in vocational psychology. Few vocational psychologists, however, have explicitly included disability within the framework of diversity (e.g., Betz, 2001; Blustein, 2001; Lent, 2001; Walsh, 2001); thus, there is the distinct potential that vocational psychology will continue to exclude persons with disabilities.

Similarly, the career development literature has been marked by a lack of comprehensiveness and coherence particularly with respect to diversity and integrating constructs (Blustein & Noumair, 1996; Fitzgerald & Betz, 1994; Leong & Hartung, 2000; Patton & McMahon, 1999; Richardson, 1993; Savickas & Lent, 1994). Much of the career decision-making literature, specifically, has neither attended to social issues nor incorporated differences in access to social and economic opportunities (Hartung & Blustein, 2002). Although counselling psychology purports commitment to issues of diversity (Neimeyer & Diamond, 2001), the broader career development and counselling literature has not included disability within the framework of diversity. Following an exhaustive review of the career development and counselling literature, Whiston and Brecheisen (2002) noted that there were very few studies (n = 2) investigating the career development of persons with disabilities. Such exclusion has far reaching consequences not only for our understanding of the career development of persons with disabilities in the larger context (Gill, Kewman, & Brannon, 2003; Pledger, 2003; Szymanski, Hershenson, Enright, & Ettinger, 1996) but also for our
understanding of the career development of other groups in the population (Richardson, 1993).

Extant research in rehabilitation and disability, assuming the irrelevance and noninfluence of gender (Hanna & Rogovskv, 1991; Traustadottir, as cited in Fulton & Sabornie, 1994), has paid insufficient attention to the interplay and synergy of disability and gender (Dunn, 2000; Fulton & Sabornie; Hanna & Rogovskv; Olkin & Pledger, 2003) thus allowing disability to become an overriding characteristic. Yet there is compelling evidence that women with disabilities are dually disadvantaged in employment (Conyers, Koch, & Syzmanski, 1998; Fulton & Sabornie; O’Hara, 2004) and in social participation (Hanna & Rogovskv) when gender intersects with disability. The findings from the few studies that have investigated women with disabilities resonate with Richardson’s (1993) contention: “But women’s perspective is not univocal. One is never only a woman. Gender is always closely entwined with class, race, ethnicity, and other identities” (p. 429). In this study, I aimed to conduct research that revealed the experience of women with brain injuries from their own perspective. A qualitative research approach is necessary to understand how women with brain injuries experience and construct meaning in their lives.

Specific to this study, little is known about the career development (Noonan et al., 2004) and the experience of career decision-making of women with disabilities. Less is known about the career decision-making of women with brain injury whom are seldom acknowledged in the rehabilitation literature itself (Banks et al., 2002). Vocational rehabilitation research in brain injury, almost exclusively focused on return to work rates (e.g., Athanasou, 2003; Watt & Penn, 2000) and work adjustment (e.g., Kendall & Murphy, 2003; Power & Hershenson, 2003; Sherer et al., 1998), assumes the noninfluence of gender.
Very little has been written about the everyday life experiences of women with brain injury. All but one (Howes, Benton, & Edwards, 2005) of the few existing qualitative studies focused on the experience of brain injury (e.g., Crisp, 1993; Inkmann, 2001; Lewington, 1997; Nochi, 1998; Paskiewicz, 1988; Secrest & Thomas, 1999) have also assumed the noninfluence of gender. Thus there is an urgent need to give women with brain injury a greater priority in career research that seeks to better understand the lived personal experiences, challenges, and emotions experienced in career decision-making.

**Social Model of Disability**

Our current understanding of disability differs markedly from the early definitions and understandings of disability, then a product of the traditional medical model emphasizing cure, impairment, and deficits. Recent revisions to the International Classification of Impairments, Disabilities, and Handicaps (WHO, 1980) are based on a new-paradigm-of-disability (Pledger, 2003) that conceptualizes disability as a social issue. The revised International Classification of Functioning, Disability, and Health (ICIDH-2, WHO, 2001), accepted by 191 countries including Canada (Government of Canada, 2004), uses neutral, standardized language and context for measuring and classifying health, health-related issues and disability. This revised framework, taking into account physical, social, attitudinal, and personal factors, recognizes the role of environmental factors in facilitating functioning or in erecting barriers. Activity or function, previously termed disability, refers to abnormalities, changes or restrictions in the interaction between a person and his or her environment. Participation, previously termed handicap, refers to changes, limitations, or abnormalities in the position of the person in their social context. Within this framework, disability refers to externally imposed impairments, activity limitations, or participation restrictions.
acknowledging that the extent to which an individual is able to perform may fluctuate from one situation or environment to another. This fluctuation of participation and performance has been identified as the enablement/disablement phenomenon (US Dept of Education, as cited in Pledger, 2003). Acceptance of the ICIDH-2 has facilitated a change of emphasis within rehabilitation from a medically driven process of physical medicine to a comprehensive, more socially driven form of rehabilitation (Wade & de Jong, 2000). However, the failure to consider explicitly the subjective experiences of the person is a significant weakness of the ICIDH-2.

In Canada, the social concept of disability (Government of Canada, 2004) maintains that persons with disabilities are restricted in performing daily activities because of a complex set of extrinsic interrelated factors including the immediate social environment and social/political arrangements. This social concept informs current legislation and supports aimed at inclusion for persons with disabilities and at eradicating societal barriers, physical and attitudinal, which affect persons with disabilities.

The social model of disability, presupposing that the environment is a major determinant of disability (Olkin & Pledger, 2003), treats both disability and normality ontologically as socially constructed statuses (Gill et al., 2003). Physical or mental impairment is acknowledged as a common aspect of human experience. Persons with disabilities are viewed as hindered primarily not by their intrinsic differences but by society’s responses to these differences. The social model of disability emphasizes the relational nature of the disabiling condition and the environment such that disability is experienced at the intersection of person and environment (Brandt & Pope, 1997). Qualitative research stresses
the socially constructed nature of reality while capturing individual perspectives and can thus contribute to an understanding of the social construction of disability.

Focusing on the social context, the National Institute of Health (NIH, 1998) identifies three important concerns regarding the rehabilitation of persons with traumatic brain injury (TBI). First, enablement approaches, which provide environmental modification, are not common in the field for TBI. Rather, the focus of rehabilitation has been on helping people adapt to intraindividual changes. Second, there has been limited recognition that TBI is frequently a lifetime disability with varying rehabilitation needs over the lifetime. Finally, there are limited opportunities for decision-making by persons with TBI and their families. These limitations in the rehabilitation of persons with TBI are likely to adversely impact career decision-making and career development following TBI.

Overview of Acquired Brain Injury

An acquired brain injury may be traumatic or non-traumatic in nature and is not related to a congenital or degenerative disease. Studies of the incidence, causes and consequences of TBI have established that it is a major health problem with heterogeneous epidemiology and consequences (NIH, 1998; Thurman, 2001), which results in life-long impairment of physical, cognitive, and psychosocial functions. Traumatic brain damage is a result of direct, immediate mechanical disruption of brain tissue, and indirect, delayed, mechanisms. The major causes of TBI are vehicle accidents, falls, acts of violence, and sports injuries (NIH, 1998). Non traumatic brain damage which occurs from near drowning, heart attacks, aneurysms, lung problems, infections, and chemical and drug reactions produces residual effects similar to those seen in TBI even though the mechanisms of damage are different (Swiercinsky, as cited in Golden, Smith, & Golden, 1993). The causes
of the brain injury sustained by the participants in this study included TBI, stroke, ruptured aneurysm, and benign brain tumor.

There is a lack of current and comprehensive brain injury statistics in Canada. In 2003-2004, there were 16,811 hospitalizations and an 8% mortality rate for severe traumatic brain injury in Canada which equates to 46 hospital admissions per day (Canadian Institute for Health Information, 2006). A population based study in the Calgary Health Region (Zygun et al., 2005) identified the annual population incidence of severe traumatic brain injury as 11.4 per 100,000. In 1998, 24,000 persons in British Columbia and 185,000 persons in Canada sustained a traumatic brain injury (Iverson, 1998). Using data from the 1986-87 Canadian Health and Activity Limitation Survey, Moscato, Trevisan, and Willer (1994) estimated that the prevalence rates of traumatic brain injury for men are 81.3 per 100,000 and 44.2 per 100,000 for women. The highest incidence of TBI is among those aged 15-24 followed by those over 75 and younger than 5 with a 2:1 incidence for males versus females. That TBI is a most prominent health concern for males between the age of 15 and 24 suggests one possible explanation for the neglect of women with TBI in the rehabilitation literature (Banks et al., 2002).

Evidence from the few studies that have examined TBI-related disability indicate prevalence rates of disability resulting from TBI of 74 per 100,000 (Willer, Abosch, & Dahmer, 1990) in Canada. However, it is likely that these figures underestimate the prevalence of TBI related disability (Thurman, 2001). First, they do not account for disability among those not admitted to hospital. Second, mild TBI, an estimated 80% of TBI, is also significantly under diagnosed (NIH, 1998). For example, ninety per cent of sports related TBI, occurring most commonly among 5-24 year olds, are mild and unreported. Cassidy et
al. (2004) estimate the actual population-based rate of mild TBI at 600 per 100,000.

Although the majority of mild TBI is expected to resolve, about 10% of those sustaining a mild TBI continue to report ongoing problems and may be evaluated for Post Concussive Syndrome, a DSM-IV classification.

Stroke, with an annual incidence of more than 700,000 individuals and 150,000 deaths in the US, is among the leading causes of death and of acute and chronic disability and is a major health problem for women (Society for Neuroscience, 2005). Approximately 80% of strokes are ischemic strokes which occur when blood flowing to a region of the brain is reduced or blocked by a blood clot or by a narrowing of a blood vessel supplying blood to the brain. Approximately 20% of strokes are hemorrhagic strokes in which a blood vessel ruptures and leaks blood into brain tissue (Penn, 2002). The rupture of a cerebral aneurysm, a weak spot in a blood vessel in the brain that fills with blood and places pressure on a nerve or surrounding brain tissue, is one cause of hemorrhagic stroke (National Institute of Neurological Disorders and Stroke, 2005). A cerebral aneurysm may leak or rupture causing a hemorrhagic stroke, permanent nerve damage, or death. In the US, the incidence of ruptured aneurysms is 10 in 100,000 with 27,000 patients per year. A minority of individuals have a warning headache, frequently described as “the worst headache of my life.” About 65% of persons who sustain a ruptured aneurysm do not survive the first 6 months after rupture. A rupture may cause a subarachnoid hemorrhage which causes bleeding into the space between the skull bone and the brain. A serious complication of a subarachnoid hemorrhage includes vasospasm in which other blood vessels in the brain contract thus limiting blood flow and causing stroke or brain tissue damage.
Consequences following TBI are many and complex affecting physical and cognitive abilities and emotional and behavioral capacities. “The consequences of TBI often influence human functions along a continuum from altered physiological functions of cells through neurological and psychological impairments, to medical problems and disabilities that affect the individual with TBI as well as family, friends, community, and society in general” (NIH, 1998, p. 11). Any sensory, motor, and autonomic function may be compromised and long-term consequences can include movement disorders, seizures, headaches, visual deficits, or sleep disorders.

Deficits in neuropsychological functioning after TBI are related to the region of cerebral damage (Brown & Levin, 2001) with a considerable degree of heterogeneity in long-term neuropsychological outcome across individuals (Millis et al., 2001). Neither severity of injury nor pre-injury personality traits explain functional outcome following injury (Rush, Malec, Brown, & Moessner, 2006). The most common cognitive consequence is the residual impairment of memory. Deficits in attention, speed of information processing, and concentration are the second most frequently reported complaints limiting the individual’s ability to perform well in stressful environments. Frontal lobe functions, such as the executive skills of problem solving, abstract reasoning, insight, judgment, planning, information processing, and organization, are vulnerable to TBI. However, the cognitive consequences of TBI change in severity and presentation over time and cannot always be reliably predicted. Furthermore, Millis et al. found that a substantial subgroup of individuals continued to show improvement in neuropsychological functioning at 5 years post-injury and that functioning was not invariably related to severity of injury. They concluded that, for
some individuals, the process of neuropsychological recovery continues beyond the commonly expected 6 to 18 month time period.

Survivors of acquired brain injury (ABI) are at risk for a range of behavioural and neuropsychiatric disorders (Williams & Evans, 2003). The disturbance of neural tissues may lead to immediate and permanent personality change with additional possibility of indirect effects on emotional and motivational responding (Brown & Levin, 2001). Such disturbance may manifest as irritability, agitation, belligerence, anger, lability, violence, impulsiveness, impatience, mania, spontaneity, loss of interest, loss of drive, and depression. However, Rush et al. (2006), emphasizing a trait state distinction, distinguish between personality change, which is rare in TBI, and behavior change which has implications for intervention. For example, an early report on the treatment of an individual with PTSD indicated that changes in personality originally believed to be due to brain injury were in fact mediated by stress and modified by treatment (McMillan, 1991). Emotional disturbance with reactive elements of mood disorders, such as depression and anxiety, are common in ABI and pain syndromes are especially common in TBI. Individuals with ABI are at an elevated risk of developing mental health disorders; these may be subclinical and expressed in the context of additional stressors or lack of protective factors.

Multiple biological, psychological and social factors are involved in the onset and maintenance of depression in brain injury (Khan-Bourne & Brown, 2003). The diagnosis of depression is complicated because of the overlap between the cognitive and somatic symptoms of depression and the sequelae of stroke and TBI. Depressive symptoms such as irritability, frustration, fatigue, poor concentration and apathy may occur as a direct result of injury and independently of depression (Fleminger, Oliver, Williams, & Evans, 2003).
Furthermore, there is no clear pattern distinguishing depression for persons with brain injury from depression for persons without brain injury. There is also no evidence of specific vulnerability related to the location of brain lesion. In a review of the literature, Khan-Bourne and Brown found a wide ranging variability, from 24 to 70%, in the prevalence of depression in brain injury. They hypothesize that the prevalence of depression in brain injury may be overestimated if too much emphasis in diagnosis is given to physical symptoms and may be underestimated when depressive symptoms are seen as sequelae of brain injury. Brown and Levin (2001) estimate that 33-77% of persons with TBI experience a major depressive episode shown to be related to poor social functioning. Fleminger et al., also noting the considerable variation in the course of depressive symptoms in stroke and TBI, identified a 50% prevalence rate for depression.

In a review of the research, Fleminger et al. (2003) find support for the argument that the prevalence of depression in TBI increases with time post-injury possibly as a result of increased insight or awareness of disability. For example, Lezak and O'Brien (1988) hypothesized that lack of insight about post-injury potential contributes to withdrawal and depression. Individuals with TBI, misjudging the severity of their deficits, attempt to return to work and resume their social activities too soon. This misjudgment of deficits may result from denial as a psychological defense mechanism or from an organically based failure to appreciate the nature and impact of the deficits. If occupational and social demands exceed post-injury cognitive and physical capabilities, individuals become frustrated and unable to cope. Furthermore, the work and social environment places increasing demands on individuals, thus uncovering additional psychosocial consequences. This experience of failure in the social and work environment leads individuals to then withdraw to a safer and
more restricted environment. However, while studies support an association between depression and insight in brain injury, it is not established whether the relationship is causal. Compromised cognitive skills may be a trigger for depressive symptoms and problems related to depression may be superimposed on primary cognitive deficits following brain injury (Khan-Bourne & Brown, 2003). Significantly, depression has consistently emerged as a correlate of poor outcome in brain injury (Rush et al., 2006).

Anxiety may also be under diagnosed due to the difficulties in identifying symptoms and may be associated with the adjustment process to injury (Williams & Evans, 2003). Only recently has the psychological impact of brain injury trauma received attention in brain injury research (McMillan, Williams, & Bryant, 2003). It is now more generally accepted that post traumatic stress disorder (PTSD) is possible in the context of brain injury. While the incidence of PTSD in brain injury remains uncertain, McMillan et al. note that several studies have shown that PTSD can occur in mild TBI and that PTSD can occur despite post traumatic amnesia. If left untreated, PTSD may severely limit a person’s ability to function and lead to the adoption of maladaptive coping mechanisms.

The importance of addressing the emotional needs of individuals with ABI is now generally acknowledged (Cope, 94; Khan-Bourne & Brown, 2003; Miller, 1993; Morton & Wehman, 1995); however, the majority of persons with ABI do not receive psychotherapy (Folzer, 2001). Furthermore, there is limited empirical evidence to guide the psychotherapeutic treatment of emotional problems in brain injury. Khan-Bourne and Brown (2003), noting that psychotherapeutic treatment may improve neuropsychological outcome, suggest that cognitive behavioral therapy may be valuable in addressing emotional disorders in brain injury. Prigatano (2005) maintains that a broad psychotherapeutic model offered in
post-acute stages is necessary. Prigatano (1999, as cited in Prigatano, 2005) found that the inclusion of a broad psychotherapeutic model within a post-acute neuropsychological rehabilitation program ameliorated emotional disturbances and increased the incidence of employment. Emphasizing that cognitive, emotional, and behavioral issues are rarely separable in real life, Miller (1993) maintains that no clear line demarcates cognitive rehabilitation from psychotherapy. Miller also recommends a multimodal approach to therapy which includes remedial instruction, manipulation and structuring of the environment, supportive, behavioral, cognitive, and psychodynamic approaches. Bennett and Raymond (1997) make a distinction between the initial more directive action oriented phases of therapy which focus on practical ways of dealing with the consequences of brain injury and the later stages of therapy which address feelings, relationship issues, and insight.

Prigatano (2005) and Miller (1993) further identify the therapeutic relationship as an important ingredient of therapy that helps guide the individual to effective choices and may increase the effectiveness of rehabilitation. Prigatano identifies the following goals of psychotherapy: improving the individual’s understanding of the effects of brain injury, reestablishing a sense of normality, and restoring a sense of purpose and meaning in life. Miller (1993) also emphasizes the reconstruction of a viable sense of meaning as an important component of psychotherapy for the individual with brain injury but cautions that the extraction of existential meaning from adversity should ultimately come from the client. Miller rather views the role of the therapist as a sounding board and facilitator for the reconstruction of meaning.


**Purpose of the Study**

The purpose of the present study was to increase knowledge about the career decision-making experiences of women with brain injury. The present study used a phenomenological approach to answer the question: "What is the personal experience and meaning of career decision-making for women who have sustained a brain injury in mid-career?" Data from in-depth open-ended interviews were analyzed to explicate the women's experience and meaning of career decision-making and to identify common themes in the women's experiences.

Qualitative methodologies have emerged as an important tool in understanding the complexities of disability in a social context and can clarify how the impairment, societal attitudes, and social environments work in combination to affect an individual's experiences (O'Day & Killeen, 2002). Qualitative methodology is further suited to this study because the career decision-making experience of women with brain injury is unknown (Polkinghorne, 1989; Osborne, 1990; McLeod, 2001); a phenomenological research strategy is ideally suited because it facilitates the discovery of lived experiences and meaning structures of these experiences (Colaizzi, 1978).

As no study to date has investigated the phenomenon of career decision-making from the subjective perspective of women with brain injury, this exploratory study is expected to offer important, clinically relevant insights into the meaning of career and the experiences that influenced career decisions for this group. Important applications of this study are to delineate decisional processes and choice as specific dimensions in the women's career development and to inform career counselling approaches for women with brain injury.
CHAPTER 2: LITERATURE REVIEW

Very little is known about the career development or unique career concerns of women with acquired brain injury (ABI), dually disadvantaged when gender intersects with disability (Conyers et al., 1998; Fulton & Sabornie, 1994; O’Hara, 2004), and seldom acknowledged in the rehabilitation literature (Banks et al., 2002). An exhaustive literature search revealed no available literature on the career development, career decision-making, or vocational development of women with ABI specifically. Furthermore, knowledge about transitions and changes in women’s vocational lives is also limited (Phillips & Imhoff, 1997). Because acquired brain injury represents a significant life change marked by protracted altered functioning (Brown & Levin, 2001; Lezak & O’Brien, 1988; NIH, 1998) and altered identity (Nochi, 1998), I anticipate that acquired brain injury is also significant in the career development and career decision-making of women. I further anticipate that understanding derived from research on the career development of women with ABI will be important to our understanding of the career development of all individuals (Fitzgerald & Betz, 1994).

In this literature review, by way of introduction, I will first review the recent rehabilitation literature on return to work and quality of life focused on the subjective perspectives of persons with brain injury. I will then review qualitative studies in the rehabilitation literature, focused on positive meaning and growth in brain injury, from the perspective of the theory of cognitive adaptation. I will next discuss the application of career theories to persons with disabilities, highlighting limitations with respect to conceptualization of the environment and subjective processes. Next, I will discuss three aspects of the societal
and social environment that I believe are significant to the career decision-making of women with ABI. First, I will discuss the societal context of the changing workplace in interaction with the individual, emphasizing significant career issues for women with ABI. As there is no extant literature on women with ABI or disabilities in the organizational and career literatures in the changing workplace, I will extrapolate from the literature focusing on those disadvantaged by the changes to women with ABI. Second, I will discuss the social context of changing identity in relation with others, emphasizing the unique career issues created by identity changes for women with ABI. Third, I will briefly discuss other potential contextual influences for women with ABI by drawing on the small emerging literature on the career development of women with physical and sensory disabilities (e.g., Conyers et al., 1998; Noonan et al., 2004; Trevino & Szymanski, 1996) and the literature on the career development of women. However, I will keep in mind that women are not univocal (Richardson, 1993), that disability is not homogeneous, and that disability from brain injuries, varying in severity and visibility, is also not unitary. Finally, I will discuss recent career decision-making models and career theories and examine the relevance of their underlying assumptions to the unique career issues and needs of women with ABI. Among these, I include the career decision-making models of Gelatt (1989, 1995) and Krumboltz (1992), the Systems Theory Framework of Career Development (Patton & McMahon, 1999), Peavy’s constructivist model of career counselling (1996), Cochran’s Career Project (1992) and Contextualist Action Theory (Young, Valach, & Collin, 1996, 2002).

**Return to Work and Quality of Life**

In the last 10 years, the return to work field has increasingly attended to work, fulfilling the social and economic needs of persons with brain injuries, as therapeutic
Wehman, Targett, West & Kregel, 2005). Indeed, persons who work have also demonstrated improvement in nonvocational areas such as reduced depression and reduced likelihood of substance abuse. Wehman et al. concluded from a review of the return to work literature that individuals with TBI, including those with severe TBI, can work competitively. Multiple factors have been associated with favorable employment outcome including accurate self-awareness (Sherer et al., 1998; Watt & Penn, 2000; Ben-Yishay, Silver, Piatesky, & Rattock, 1987); insight and acceptance of disability (Wehman et al., 2005); social support (Kendall & Murphy, 2003; Kreutzer et al. 2003); and high school and college education (Kreutzer et al. 2003).

Return-to-work rates in individual studies vary greatly from 10-70% (Athanasou, 2003). Athanasou estimated the overall return to work rate for international studies combined (S = 3192) at about 45%. Time post-injury and changes in the workplace may be two factors responsible for the wide variability in return to work rates. In a longitudinal study investigating job stability and factors moderating return to work for 186 individuals with TBI, Kreutzer et al. (2003) found that the proportion of those employed increased each year. At 4 years post-injury, 42% of the study participants were employed. Pössl, Jürgensmeyer, Karlbauer, Wenz, and Goldenberg (2001) investigated the stability of long term employment, defined as 7 to 8 years following acquired brain injury, for 43 individuals who had received inpatient rehabilitation and who had completed successful work trials. They found that two thirds of their sample had been competitively employed over many years. A substantial proportion of study participants, however, had made modifications to their pre-injury work including changes to type of work, change of employer, reduction in work hours and a lowered work status.
Pössl et al. (2001) noted that vocational outcome was not related to severity of injury. Indeed, three study participants with severe brain injury and a poor prognosis successfully returned to their pre-injury positions. Furthermore, difficulties in maintaining employment and long term vocational income were hard to predict from objective cognitive measures which had an uncertain relationship to real work activities. Rather, changes over time in working conditions such as changed work duties, diminishing employer support, new colleagues or superiors, or private problems contributed to vocational difficulties. That participants had difficulty adjusting to such changes highlighted a need for long term counselling yet professional help during times of change was not available to the participants. Pössl et al. concluded that the provision of long term counselling is needed to ameliorate vocational outcome in the long term.

Recently, a small number of qualitative studies have illuminated the individuals' perspectives on the suitability of return to work as an outcome variable. Levack, McPherson, and McNaughton (2004) examined the perceptions of 7 individuals with moderate to severe TBI on issues of success or failure in the workplace. The participants confirmed that return to work is an important goal and a source of personal fulfillment and satisfaction. However, participants noted dissatisfaction, related to fatigue, with full time work hours because full time work required alterations to their personal life which could not be sustained in the long term. The costs of full time work were identified as depression, feelings of defeat and frustration, and disciplinary actions including being fired. Participants endorsed the achievement of a positive and ongoing journey through life over hours worked or pay earned. Furthermore, feelings of success or failure were influenced by the impact of work on non-working lives, feelings of meaningful productivity, and personal value and enjoyment.
Similar to Pössl et al. (2001), Levack et al. concluded, from the participants' descriptions of the personal costs of work, that there is an ongoing need for vocational support during times of organizational or individual change.

Oppermann (2004) interviewed 2 women with TBI on the meaning of return to work. The women endorsed self worth and personal fulfillment as the subjective meaning of return to work and financial remuneration as the objective meaning of return to work. The search for work after injury was associated with multiple dilemmas including limited self awareness, limited knowledge about brain injury in the general public, and restrictive social security rules. Additionally, non visible disability was problematic because employers maintained high expectations. Oppermann likewise concluded the necessity of meeting the long term needs of individuals with brain injury.

Power and Hershenson (2003) examined the effects of mid-career TBI on work adjustment and the meaning of work for 10 individuals. They concluded that in persons with a well developed work ethic, the loss of work led to loss of value as a person, loss of self confidence, and lowered self-esteem. However, for some individuals the head injury provided an opportunity for restoration and responsibility. Five participants reported lack of confidence in work-related interpersonal skills and inability to handle stress and to follow orders. They expressed concern with being found out for "faking it" at work and experienced depression, anxiety, and withdrawal. For these participants, career development became a redevelopment and planning process. Work adjustment was experienced as a process of negotiation in an attempt to balance perceived strengths and weaknesses with the demands of paid work, volunteer work, or school. Furthermore, families and rehabilitation personnel were described as major influences for the support or obstruction of career development.
The identification of emotional consequences such as depression and anxiety (Levack et al., 2004; Oppermann, 2004; Power & Hershenson, 2003) and the contribution of workplace changes and personal changes to vocational difficulties (Pössl et al., 2001) point to the ongoing need for vocational support within a counselling based process. Insight into the process of negotiation in work adjustment (Power & Hershenson, 2003), however, cannot be developed in counselling in the absence of real life work experiences over time (Wehman et al., 2005). Thus ongoing vocational support and guidance within a counselling process is required as individuals encounter difficulties in real life settings over time.

Qualitative studies in the return to work literature point to the need for more subjective and life based outcome variables. Accordingly, the recent literature on quality of life following brain injury has increasingly focused on quality of life as a subjective holistic judgment by the individual concerning his or her overall level of life satisfaction (Vickery, Gontkovsky, & Caroselli, 2005). Studies have consistently found that quality of life is associated with the level of perceived available support, community integration, mental health, and the ability to resume employment or studies (Kalpakjian, Lam, Toussaint, & Hansen Merbitz, 2004; Kreuter, Sullivan, Dahlöf, & Siösteen, 1998; O’Neill et al., 1998; Steadman-Pare, Colantonio, Ratcliff, Chase, & Vernich, 2001; Vickery et al., 2005).

In a retrospective cohort study 8 to 24 years after TBI, Steadman-Pare et al. (2001) found that general mental health was the primary predictor of perceived quality of life while depression was strongly associated with a lowered quality of life. Furthermore, they found that the availability of emotional support, especially in the context of a partner relationship, was the element of support most associated with quality of life. In an investigation of quality of life 1 to 20 years after TBI, Kreuter et al. (1998) also found that quality of life was
correlated to being in a partner relationship, to the lack of depressive feelings, and to being employed or engaged in studies. O’Neill et al. (1998) found that individuals in part-time employment had fewer unmet needs, were more socially integrated, and more engaged in home activities than individuals in full time employment. The findings in O’Neill et al. and in Levack et al. (2004) suggest that part-time employment may afford a better quality of life than full time employment for some individuals. Furthermore, the strong association between mental health, lack of depressive feelings, and social support to quality of life indicate that the conceptualization of employment as an outcome measure must be considered within the individuals’ life context.

Positive Meaning and Growth in Brain Injury

Although the literature has emphasized negative effects following ABI, a few quantitative studies have indicated that a good quality of life and positive psychological changes are not precluded by severe brain injury and that time since injury is an important factor. For example, Kreuter et al. (1998) found that quality of life was significantly and positively correlated to time since injury suggesting that the adaptation to brain injury occurs over an extended period of time. While Kalpakjian et al. (2004) found a wide range of quality of life among 50 individuals with TBI, they emphasized that 50 % reported normal to high quality of life reflecting happiness and fulfillment in life. Notwithstanding the challenges in living with TBI, Kalpakjian et al. note that individuals also have the meaningful capacity to experience positive emotions. They suggest that recognition of the capacity for experiencing positive emotions may facilitate quality of life and that a good quality of life may bolster resolve when facing difficult realities. Furthermore, findings of good quality of life after TBI suggest that external circumstances alone do not determine quality of life.
In a small study of individuals in early (Median at 7 months) and late (Median at 10 years) post ABI, McGrath and Linley (2006) found that the late post ABI participants reported significantly higher levels of positive psychological change and anxiety than early post ABI participants. The results of this exploratory study indicate that positive psychological change occurs slowly in brain injury and does not reflect denial of difficulties. Furthermore, positive psychological growth does not preclude moderate levels of psychological distress. McGrath and Linley suggest that if key predictors and temporal course of positive growth can be delineated, psychotherapeutic approaches focused on hope and potential for positive change may be advanced.

These quantitative studies, however, have not captured subjective meanings of quality of life or positive psychological changes. Studies which have examined benefit finding and adaptation in medical problems inform us that the meanings individuals ascribe to their illnesses are an important aspect of adaptation. Taylor, Kemeny, Reed, Bower and Grunewald (2000) have defined meaning as a major shift in values, priorities, or perspective in response to loss. Their research program suggests that psychological beliefs such as meaning, control, and optimism act as resources, which preserve mental health but may also be protective of physical health.

Taylor (1983) developed the theory of cognitive adaptation from an analysis of interviews with 78 women with breast cancer. Taylor argued that adjustment following a threatening event centered around three themes: 1) the search for meaning in the adverse experience; 2) the attempt to regain mastery over the event and one’s life; and, 3) the effort to restore self-esteem through self-enhancing self-evaluations. Fifty percent cent of the women indicated that cancer caused them to reappraise their lives, providing them with a new
attitude toward life, and to reorder priorities with high priority for relationships and lowered priorities for mundane concerns. Many of the women viewed cancer as a catalyst for restructuring lives along more meaningful lines. Furthermore, the women perceived themselves as better adjusted following cancer. The women described engagement in downward comparisons in a process of self-enhancement. Taylor concluded that finding a positive meaning in the illness produced significantly better psychological adjustment.

Helgeson, Reynolds, and Tomich (2006) examined the relations of benefit finding, defined as positive benefits following a traumatic event, in a meta-analysis of 87 cross-sectional studies. They concluded that benefit finding was related to less depression and more positive well being and was not simply the lack of distress. In a review of the literature of benefit finding in medical problems including stroke, Affleck and Tennen (1996) noted that the majority cited benefits or gains from their medical adversity. The common themes which cut across the medical problems included a strengthening of relationships with family and friends; valued changes in life priorities and life goals; and the perception of positive personality changes such as empathy, tolerance, courage, and patience. Affleck and Tennen concluded that the research on the adaptational correlates of benefit finding is beginning to document its unique ability to predict emotional well being.

Viewed from the perspective of the theory of cognitive adaptation (Taylor, 1983), qualitative studies focused on meaning and experience in brain injury, inform us that meaning expressed as major shifts in values, priorities, and perspectives (Taylor et al., 2000) and self-enhancing self-evaluations are also found in brain injury. For example, Biderman, Daniels-Zide, Reyes, and Marks’ (2006) case studies of 3 men with ABI illustrate that the men found new meaning, fulfillment, and self-esteem in being of service to others with brain
injury. Themes of finding meaning in adverse events and of the restoration of self-esteem through self-enhancing self-evaluations are evident in the case studies.

Thompson (1991) interviewed 40 individuals in a qualitative study on meaning after stroke. Fifty percent of the participants, finding meaning in the experience of stroke, indicated that the stroke had caused them to reevaluate their priorities and to appreciate areas of their lives that they had taken for granted. These individuals reported becoming more compassionate and growing personally as a result of the experience of stroke. Thompson viewed the adjustment of those who found meaning in their experience of stroke as more than a byproduct of the lack of depression. Thompson concluded that some active learning or resolution had taken place for individuals who found meaning so that they now saw their lives differently than they had prior to stroke. Thompson further concluded that the development of meaning following stroke was consistent with the theory of cognitive adaptation.

In a grounded theory study, Nochi (2000) interviewed 10 individuals, at ease with their current situation, about the experience of coping with TBI. Nochi found that the focus of the participants' self narratives shifted from "in spite of TBI" to "because of TBI." The experience of coping with or adjusting to disability was represented in reconstructed narratives that conceptualized the self as intact and worthwhile and reflected renewed ways to view the self. The narrative of "the grown self" presented TBI as a momentum for growth and stressed that the experience of TBI had contributed to the development of positive characteristics in the self. For example, the participants expressed an expanded appreciation of others. The narrative of "the self better than others" contrasted the present self downward with worse comparable images such as individuals with more severe TBI. Nochi suggested
that such downward comparisons might allow the individual to acquire greater motivation for future planning. These downward comparisons may be further understood as self-enhancing self-evaluations which serve to restore self-esteem (Taylor, 1983). Nochi suggested that the use of a repertoire of self-narratives in counselling might facilitate the coping process and assist the client to develop expanded possibilities and roles in the community.

Chamberlain (2006) interviewed 60 individuals at 1 year post-injury about the experience of surviving TBI. Similar to Nochi (2000), she found that self narratives reflected renewed ways to view the self which were conceptualized to be intact “in spite of TBI” or to be worthwhile “because of TBI”. She identified the narrative of “the recovering self” which stressed a change of values and dissociation from other people’s values so that the participants could find meaning in what was important to them. Similar to Nochi, Chamberlain concluded that self-narratives can serve as the focus of therapy.

Howes et al. (2005) interviewed 6 women in a phenomenological study about the experience of brain injury. Three participants were at least 6 months post TBI and three participants were at 3 to 5 years post TBI. The theme of “adaptation and acceptance” described the participants’ meaning making in the experience of brain injury. The women identified positive lessons in the experience of brain injury such as the ability to value life in a different, more meaningful way. They described a reevaluation of life goals, a reevaluation of what was important to them, and a greater appreciation for life. Howes et al. highlighted the function of meaning and positive appraisal within the process of adaptation as helping the participants to cope with ongoing stressful situations.

But Frank (2003), whose current research investigates long term survivorship after illness, states that viewing meaning after illness as coping misses the point. Rather, Frank
envisions meaning for illness survivors, especially those who engage in service to other ill people, as imbued with a self-consciousness of purpose. He views long term survivors as self conscious craft workers of their lives and of the worlds their lives touch. He explains that survivors have a moral calling, centered on telling their story, to offer hope and reciprocity to others. They are seized with an unquestionable sense of what they need to do and simultaneously drift into lives of service. Survivors of illness have an unquestioned conviction of the need to help people. Narratives which stress growth "because of TBI" (Nochi, 2000) or stroke (Thompson, 1991), the re-evaluation of what is important (Chamberlain, 2006; Howes et al., 2005), and finding fulfillment in service to others (Biderman et al., 2006) may reflect the self-consciousness of purpose described by Frank.

Subjective meanings after brain injury, such as self-consciousness of purpose, finding fulfillment in service to others, and reordered priorities have significant implications for career decision-making.

**Career Theories and Persons with Disabilities**

In the rehabilitation literature, career development has been defined as a life-long process of preparing to choose, choosing, and continuing to choose vocational roles (Szymanski & Hershenson, 1998). Despite limitations of the application of current theories to people with disabilities (see e.g., Conte, 1983; Curnow, 1989; Szymanski et al., 1996), there is an emerging consensus in vocational rehabilitation that there is neither the need nor the possibility of a separate theory of career development for persons with disabilities (Beveridge, Craddock, Liesener, Stapleton, & Hershenson, 2002; Szymanski, 2000). First, people with disabilities are not that different from persons without disabilities. Second, the heterogeneity and diversity among persons with disabilities preclude the possibility of a
single theory common to all persons with disabilities. Third, disability itself does not
determine career development; rather disability is a risk factor that may or may not influence
an individual’s career development. Furthermore, the complex interaction of race, gender,
and disability preclude the simple application or nonapplication of any theory. Rather,
theories are seen as guiding lines of inquiry in clinical practice, providing conceptual
frameworks that must be adjusted for use according to the circumstances of the individuals.
The responsibility for this adjustment rests with the counsellor who must be well versed in
the limitations of current theories, the impact of contextual and personal factors on the person
with a disability, and the potential for accommodation.

However, a most significant limitation of traditional career theories, especially for
individuals with disabilities, is their limited conceptualization of the environment that
influences individuals’ careers (Collin, 1997). Traditional theories have particularly focused
on intra-individual and job characteristics and the process of matching the individual and
occupation. Although a large number of contextual influences, occurring at the social context
and the societal context have been identified (Blustein, 1994), conceptualization of the
environment has been limited to specific aspects of the individual’s environment. Psathas’s
(as cited in Patton & McMahon, 1999) criticism, that theoretical frameworks were limited by
failure to focus attention on social and economic factors that influence the psychological act
of choosing, is still valid today. Traditional theories are, therefore, inconsistent with our
current conceptualization of disability as a social issue (Pledger, 2003) occurring at the
intersection of person and an environment (Brandt & Pope, 1997), which is a major
determinant of disability (Olkin & Pledger, 2003).
Current understanding and definition of disability (Government of Canada, 2004; WHO, 2001) and nondiscriminatory practice require that career theories include a conceptualization of the interaction between the individual and broader environment. Furthermore, changes in the environment, such as globalization and technology, discussed in the next section, with potential for major impact on career, also necessitate a broader conceptualization of the environment. Rapid change in the broader environment and the social model of disability (WHO, 2001) both refocus the attention of the career counsellor to the environment of careers. A limitation of traditional career theories, then, is that they provide neither the foundation upon which to build an understanding of the impact of the broader environment nor suggest ways to help clients, with or without disabilities, address the impacts of rapid change.

According to some theorists (Savickas, 1994; Patton & McMahon, 1999), career theories provide lenses through which selected segments of vocational behaviour can be viewed such that each theory addresses distinct problems. This suggests that ecological models, which converge or integrate constructs from traditional career theories, may present one way to overcome a limited conceptualization of the environment. Thus, vocational rehabilitation theorists (e.g., Beveridge et al., 2002; Szymanski, 2000; Szymanski & Hershenson, 1998) have developed and refined conceptual models that converge theories from the perspective of practice. These models, intended for use with persons with and without disabilities, specify the interaction of individual, environmental, and cultural factors. One prominent model, developed by Szymanski and Hershenson, is the ecological model of vocational behaviour. This model encompasses the constructs and processes of major career theories to guide the selection of career services.
The ecological model (Szymanski & Hershenson, 1998) posits that career
development is the interaction of five interrelated groups of constructs and six groups of
processes. The five constructs are: a) contextual (e.g., legislation, SES, family); b) individual
physical and psychological attributes (e.g., gender, race, physical abilities, cognitive traits,
interests); c) mediating constructs consisting of individual, cultural, or societal beliefs that
affect relationship of persons and environment (e.g., self-efficacy, acculturation,
discrimination); d) environmental construct consisting of aspects of the work environment
(e.g., physical access, organizational culture); and e) outcome describing the behaviour
resulting from interactions of four previous constructs (e.g., job satisfaction, job stress). It is
important to note that only the aspect of disability that is a personal attribute is included in
the individual construct. The six groups of processes are development, decision-making,
congruence, socialization, allocation, and chance. Key to this model is the knowledge that
contextual factors both limit and facilitate career development such that the counsellor must
understand the contexts of individual clients and the potential effects of these contexts on
career development. Such conceptual models ensure counsellor attention to the impact of
contextual factors upon the person and guide the development of strategy, accommodation,
and advocacy (e.g., Strauser & Lustig, 2001). However, ecological models, similar to the
traditional theories from which they are derived, neither include a subjective perspective nor
inform the counselling process. Furthermore, ecological models view individuals and the
environment, although in interaction, as independent of each other (Collin, 1997).

Thus the application of traditional theories to guide career counselling services for
persons with disabilities remains problematic. Despite the emerging consensus that there is
neither the need nor the possibility of a separate theory of career development for people
with disabilities (Beveridge et al., 2002; Szymanski, 2000), the relevance of traditional career theories to persons with disabilities is unknown (Betz, 2001). Furthermore, the relevance of traditional career theories to the broader population in a rapidly changing context has also been criticized (Blustein & Noumair, 1996; Patton & McMahon, 1999). Traditional career theories assume stability of the person and environment, linear career development, and rational career decision making; these assumptions are neither tenable in today’s dynamic context nor in application to women with ABI who are themselves experiencing ongoing functional and identity change (Nochi, 1998).

The social model of disability recognizes that disability is experienced at the intersection of person and environment (Brandt & Pope, 1997) and that the barriers experienced by people with disabilities permeate every aspect of the physical and social environment. Yet, the starting point for understanding disability in much of the counselling literature has been as a condition of the individual without attention to the sociopolitical environment (Swain, Griffiths, & Heyman, 2003). Within career theories, disability, when mentioned, has been identified as an intraindividual difference (e.g., Mitchell & Krumboltz, 1990; Patton & McMahon, 1999). But it is evident that external influences affect employment opportunity (Herr, 1999) and the career decisions available to the individual. Physical access, job conditions, personnel management practices, management attitudes and behaviour, employer relations practices, and the extent to which affirmative action practices, law enforcement, and protection of rights are present are among the external influences that have a significant bearing on the career decisions and employment opportunities available to individuals with disabilities.
The application of traditional career theories to persons with disabilities is limited by the narrow conceptualization of contextual influences and a lack of subjective perspective. Increased emphasis on contextual influences and a subjective perspective are necessary to understand how aspects of the social context interact with individual behavior and career theories and counselling practice for all individuals (Herr, 1999). That emerging career theories are increasingly attending to subjective experience and contextual influences with increasing emphasis on the person and context as co-existing and jointly defining each other (Patton & McMahon, 1999) suggests that emerging career theories may highlight the role of the environment as a determinant of disability.

The Societal Context of the Changing Workplace

There is general agreement that workers in developed countries are facing radical and ongoing changes in the workplace (Hall & Moss, 1998; Gelatt, 1989, 1995; Grezda, 1999; Krumboltz, 1998). The impact of new technology and the globalization of the economy are revolutionizing the structures of work organization (Collin & Watts, 1996) and changing the way in which organizations are structured and managed (Kanter, 1989; Arthur, Inkson, & Pringle, 1999). Many organizations, aiming to operate in more flexible ways in an increasingly competitive global marketplace, are reducing layers of management and supervision, downsizing the number of core workers while increasing outsourcing and the number of contingent workers. These changes in the economy and workplace have fostered the emergence of a new self-reliant career variously described as the “portfolio career”, the “intelligent career”, the “post-corporate career”, the “post-entrepreneurial career” (Kanter, 1989), the “protean career” (Hall & Moss, 1998), and the “boundaryless career” (Arthur & Rousseau, 1996). What these concepts have in common are the assumptions that the
individual, not facing any barriers to career choice, has ownership of her career, is responsible for taking appropriate career actions suited to ongoing organizational change, and makes more frequent career decisions. Elements of the “new career” include increased self-employment, increased lateral career movements, and a requirement for life-long learning. In a complex changing environment, self reliance replaces loyalty in understandings between employers and employees (Arthur et al., 1999; Krumboltz, 1998). For example, the individual with a boundaryless career moves frequently among organizations developing portable skills that can be applied to a variety of employment settings (Sullivan, 1999). In this changing workplace, security for the individual in the “new career” lies not in employment but in employability, a redefined employer-employee relationship (Grezda, 1999; Kanter, 1989). Knowledge has replaced experience as the primary prerequisite for employability.

The protean career, defined as a contract with the self and one’s work, is marked by a lifelong series of experiences, skills, learnings, transitions, and identity changes (Hall & Moss, 1998). Self-knowledge and adaptability constitute the meta-competencies that the individual requires to find a good fit with work that is needed in a complex, changing environment. While some workers appreciate the autonomy of the protean career, many others are terrified by a freedom experienced as a lack of external support.

**Effects of the Changing Workplace**

Much of the literature on the boundaryless careers emphasizes positive aspects while neglecting potential problems associated with the new career patterns such as underemployment, increased isolation, and dysfunctional career outcomes (Sullivan, 1999). Moreover, the themes of continuous change and uncertainty conditions are consistent with
boundaryless career patterns (Arthur & Rousseau, 1996; Kanter, 1989; Krumboltz, 1998). Individuals with minimal training or capability of learning are at greatest risk of being permanently dislocated or unemployed or constantly on the move to find jobs (Herr, 1993a). Arthur et al. (1999) remind us that “we should not allow the rhetoric of the new self-reliant careers cause us to lose sight of the casualties that the new employment era brings to the economically disadvantaged and those marginalized in low skill insecure jobs” (p. 11). Kanter (1989), glossing over the individual psychological impact on people, says “People at all levels, of course, are affected by massive dislocations that accompany restructuring, and the costs are often much higher for those in lower-income and lower-skill categories” (p. 300). Indeed, Hutton (as cited in Collin & Watts, 1996) described the emergence of the 30/30/40 society in which 30% are disadvantaged, 30% are marginalized and insecure, and only 40% have reasonably secure employment or self-employment. Women, primarily employed in lower-income and lower-skill categories (Patton & McMahon, 1999), are at greater risk for unemployment and underemployment. One can further assume that women with disabilities, who already have the lowest workforce participation rate (Government of Canada, 2004), will continue at greatest risk for unemployment.

More recently, some authors, recognizing the presence of environmental barriers to opportunity and career outcomes have proposed that environmental factors be considered within career theory. King’s (2001) self-management framework admits to structural constraints and barriers to opportunity such that career outcomes are not always within the individual’s direct control. Citing the inattention to environmental factors as a shortcoming of traditional career theories, Grezda proposes career motivation theory (London, as cited in Grezda, 1999) as a framework for understanding career changes as functional adaptations. He
describes career motivation as “an individual level construct consisting of three dimensions: a) career resilience, the ability to overcome career setbacks; b) career insight, the extent to which the individual has realistic career perceptions; and c) career identity, factors reflecting career decisions and behaviors” (p. 235). However, neither a self-management framework nor career motivation theory suggest counselling approaches that assist individuals, particularly those that are disadvantaged or marginalized, to develop the skills and resources needed in the self-reliant career.

Consistent with Axelrod (1999), Sonnenberg (1997), and Wehman et al. (2005), I believe that satisfying involvement in work is therapeutic, potentially increasing self-esteem and feelings of efficacy that serve to combat sense of isolation and depression for women with ABI. However, persons with disabilities, often facing social stigma and restricted choices, are more vulnerable to the psychological and economic consequences of the changing workplace (Herr, 1997). The changing workplace further intensifies the cognitive and psychosocial consequences of brain injury for women with ABI. The new economy imposes continuous learning requirements: to integrate an increasingly diverse set of facts, interest, and claims (Hirschhorn, as cited in Axelrod, 1999); to manage more information and activity (Kanter, 1989); and to continually prove one’s value in a project-by-project basis. These continuous learning requirements strain reduced memory abilities and slowed information processing. Additionally, external factors, outside the control of the individual with disabilities, can serve to mitigate or exacerbate the consequences of the changing workplace. “Personal flexibility,” comprised of affective, intellectual, and academic skills, required in the changing workplace does not occur spontaneously in people (Herr, 1993b). Thus, the absence of efforts to ensure the development of personal flexibility for women with
ABI represents a structural barrier to employment in the workplace. Furthermore, a decreased organizational commitment to individual employees and increased use of contingent workers makes it unlikely that accommodations will be available to lessen the adverse impact of the changing workplace.

Axelrod (1999) suggests “that there will be marked variability by personality type in how productive people will be in the face of the anxiety, uncertainty, and insecurity of the new economy” (p. 124). Axelrod maintains that workers, not having access to the external structures that some need to feel secure, will face increased stress, which may be manifested in increased disability claims. Sonnenberg (1997), citing a lag in people’s actual ability to respond to the requirements for flexibility, autonomy, and independence in the workplace, posits increased anxiety, uncertainty, and greater isolation for workers. In fact, indicators are pointing to increased stress-related and psycho-social absences in the knowledge-based economy as a result of organizational factors and role overload (Bauer, 2000; Disability Management, 2001; Dorrell, 2000; Keeping employees at work, 2001). Mental health claims, primarily for depression, are the fastest growing category of disability claims in Canada. The World Health Organization estimates that depression will reach epochal levels in developed countries by the year 2020. In sum, many individuals are facing significant life challenges as a result of the changing workplace. Persons with ABI are especially at risk for increased sense of uncertainty, anxiety, and isolation in the changing workplace because they are already facing a most uncertain future due to changes in functioning subsequent to injury (Lewington, 1993).

There is a growing awareness of linkages between positive or negative career experiences and mental health, self-esteem, purposefulness, physical well-being, and the
ability to support and maintain a family (Herr, 1999). It can be argued that the anxieties and effects of the changing workplace are similar to the effects of unemployment. Murphy and Athanasou (1999) examined 16 longitudinal studies on the psychological effects of unemployment. The criteria for inclusion in their review were: 1) use of standardized psychological tests; 2) published in the last ten years in English-language journals; and 3) conducted within a longitudinal design. The results of these studies, taken as a whole, demonstrated that unemployment had reliable negative effect on the psychological well-being of the unemployed. A meta-analysis, based on a subset of ten studies, of effect sizes indicated that the negative effect on mental health is of practical clinical significance. Moreover, decreased distress levels following re-employment are also of real practical significance, which suggests that it is the job loss that provokes the psychological distress rather the reverse.

Borgen and Amundson’s (1984) research on the effects of unemployment demonstrated that interactions of mental health and the state of the economy and unemployment are likely to include multiple variables such that mental health outcomes can be precipitated by factors in the environment or within individuals. In their research with workers anticipating job loss prior to plant closings, Hurst and Shepherd (as cited in Herr, 1999) found that those handicapped by physical, skill, and age barriers and low self-esteem are most likely to experience prolonged depression. Women with physical disabilities have far higher rates of depression than other groups including men with disabilities, women without disabilities and men without disabilities (Nosek & Hughes, 2003). Furthermore, depression related to poor social functioning or as an indirect effect of the disturbance of neural tissue is frequently concomitant with TBI (Brown & Levin, 2001; NIH, 1998). This
suggests that women with ABI are most likely at increased risk for depression from work-related stresses and unemployment in the changing workplace. Converging with the qualitative return-to-work in brain injury literature (Levack et al., 2004; Oppermann, 2004; Power & Hershenson, 2003), the effects of the changing work place, contributing to work stress, depression, and unemployment, point to the ongoing need for vocational support and guidance within a counselling process as individuals with brain injuries encounter difficulties in real life settings. Furthermore, the social model of disability identifies the sociopolitical environment as a major contributor (Swain et al., 2003) to the effects of the changing workplace for individuals with brain injury and highlights the role of government (Government of Canada, 2004) in ameliorating the negative effects of the changing workplace.

**Implications for Career Counselling**

Traditional career theories, minimizing contextual influences, assume the opportunity to progress within a career path in a stable labor market and the ability to enter an occupation once the person has made an informed decision about the best personal job match (Borgen, 1997). Furthermore, extant traditional career theories fail to adequately address feelings of isolation and insecurity that are common in the changing workplace. Thus, current career counselling practice is still mainly driven by rational and cognitive processes with little attention to contextual influences. However, models of career counselling that continue to emphasize the rational, informational aspects of career decision-making and overlook the affective aspects of the career decision-making process are not helpful in a changing economy. The simple matching of career decision and measured interests and abilities, as indicated by traditional career theories, is no longer defensible as an outcome measure for
Taking a psychoanalytic perspective, Sonnenberg (1997) proposes that counsellor actions such as the increased provision of concrete career information are a defense against counsellor anxieties produced by uncertainty in the workplace.

Given the changes in career patterns, the anxiety (Axelrod, 1999; Sonnenberg, 1997), increased isolation (Gore, Leuwerke, & Krumboltz, 2002), and insecurity faced by many workers, Krumboltz (1998) suggests it is time for counsellors to review their actions and modify them to produce positive outcomes for an increasingly diverse and complex workforce. Krumboltz proposes that career counsellors, assuming a broad role in dealing with client concerns, should facilitate continuous learning aimed to help people create satisfying lives for themselves. In enlarging the vision of career counselling to the broader context of people's lives, Krumboltz echoes the writings of others (e.g., Amundson, 1995; Axelrod, 1999; Borgen 1997, 2002; Collin, 1997; Manuele-Adkins, 1993; Peavy, 1996; Richardson, 2000) who argue that attending to either vocational or personal concerns in isolation, ignores the complexity and interdependency of life contexts. Women with ABI, at greatest risk for unemployment, an uncertain future, and depression in a rapidly changing environment, also bring additional unique personal concerns, discussed in the next section, to the career counselling setting.

There is growing evidence that career counselling is critical to reconnecting unemployed and underemployed people to a sense of purposefulness and self-efficacy and in so doing to a diminution of stress-related side effects of hopelessness and despair (Herr, 1999). Given the complexity of the current context in which individuals make career decisions, Borgen (2002) has recommended that counselling based processes be made
available to more individuals and be available earlier in the help seeking process. Moreover, he recommends that vocational guidance be embedded as a tool within a counselling process to ensure that information and action planning are considered within the context of a person’s life. Herr (1997) explicitly acknowledges the need to consider the interaction of individual and contextual influences within career counselling. He views career counselling as a multifaceted process whose principal content is the perceptions, anxieties, information deficits, work personalities, competencies, and motives that persons experience in their interactions with the external environment. Thus career counselling interventions exist along a continuum of intervention foci, with different career problems requiring different emphases.

Within vocational rehabilitation, traditionally focused on placement in a job and return to work, there is the recognition that new approaches are necessary to promote self-sufficiency in continuous work transitions (Rumrill, Phillip, & Roessler, 1999; Ryan, 1995; Shahnasarian, 2001; Szymanski et al., 1996) and that long-term plans are necessary to assured continued employment in the current work environment. Shahnasarian (2001) proposed a new paradigm, career rehabilitation, integrating perspectives from vocational rehabilitation and career development, to encourage counsellors to adopt a life-span approach to the career decision-making of persons with disabilities. Rumrill et al. (1999) proposed changes from “closure” towards “career” in current vocational rehabilitation policies to facilitate the ongoing career development needs of persons with disabilities. Szymanski (1999) recommended strategies for career planning defined as “a process in which consumers must become active, informed participants who learn and control a planning process that they use for short-and long term career development” (Szymanski et al., 1996, p. 272). These
emerging trends in vocational rehabilitation resemble King's (2001) self-management framework and career motivation theory as proposed by Grezda (1999) in that they attend to requirements for a self-reliant career. However, similar to King's and Grezda's framework, they do not suggest counselling based processes to assist individuals with the psychosocial impact of the changing workplace. Thus, while it is recognized that career counselling in today's context must include counselling based processes, this counselling may not be available to women with ABI and other persons with disabilities. One may consider the lack of counselling based processes a significant contextual influence in the career development and decision-making of women with ABI.

**The Social Context of Changing Identity**

Most career theories include constructs to address issues of self and identity thus reflecting the importance of intrapersonal or self experiences in career development (Blustein, 1994). However, identity constructs in traditional career theories describe relatively stable aspects of self and identity devoid of connections to culture and others and are not relevant within the current social context (Blustein & Noumair, 1996). Changes in the labour market, described in an earlier section, necessitating repeated transitions with accompanying career exploration, decision-making, and retraining compromise a stable sense of self or identity (Marshall & Tucker, as cited in Blustein & Noumair, 1996). Counselling for change requires constructs that describe a changing identity within a rapidly changing environment. Moreover, the meta-competencies of identity growth and self-knowledge required for a successful self-reliant career are likely to be particularly challenging for women with ABI who suddenly experience multidimensional changes of the self in the world. Thus, constructs of identity that incorporate an ongoing process of identity
development and that integrate relational and contextual factors within this process are especially salient for women with ABI.

Identity status researchers have defined identity as a coherent sense of one’s meaning to oneself and to others within a social context. Recently identity theorists (Kroger, 2000; Marcia, 2002; Sorell & Montgomery, 2001) have reconceptualized identity development from a stage based process (Erikson, 1980) to a lifelong process of construction and transformation in which identity for women is greatly saturated with intimacy issues. This reconceptualization recognizes that adults are constantly experiencing change, either deliberately, because it is chosen, or inadvertently, because of external events (Herr, 1993b). According to Marcia (2002), identity reformulation in adulthood occurs as the individual is confronted with identity disequilibrating events such as job loss, job promotion, job change, loss of loved ones, and discontinuity. The individual’s subjective experience determines whether an event is disequilibrating. Accommodation of changes resulting from such disequilibrating events occurs in a cyclical process and the time required for identity reformulation varies according to the social context. Within the identity reformulation framework, ABI can be understood as an identity disequilibrating event requiring protracted accommodation lasting up to 10 years.

However, identity is more bound by context than has been suggested by developmental theorists and identity status researchers (Raskin, 2002). Gender, connectedness, role conflict, and barriers have been identified as issues especially relevant to the identity development of women (Josselson, 1992; Raskin, 2002; Yoder, 2000). Phillips and Imhoff (1997) concluded, from their review of literature on the vocational experiences of women, that interpersonal and familial domains appear to be uniquely central to the
development of identity for women. Women consider themselves in a broader array of life domains such that work is one of many life roles. Women’s identity boundaries, in particular, are likely to be more permeable across the life span because occupational identity and identity as a mother are activated simultaneously with either more salient in a given moment (Raskin, 2002). Thus Raskin suggests that commitment and conflict coexist in women. It is now recognized that while women’s social context imposes limitations, women also derive benefits from connectedness and centrality of the social, relational context (Phillips & Imhoff, 1997). Within the current social and employment context, in which one is not expected to remain in the same occupation for a lifetime, nonoccupational domains become more crucial to an individual’s self-definition. Thus in the current context, women may derive additional benefit from social connectedness.

The subjective experience of persons with ABI has received scant attention in the scholarly literature (Crisp, 1993, Nochi, 1998). A few studies on the personal experiences of persons with TBI, focusing on the meaning of recovery and identity, are found in the dissertation literature (Inkmann, 2001; Lewington, 1997; Paskiewicz, 1988; Stewart, 2002). This emerging literature increases our understanding that living with a TBI carries a variety of meanings and occurs in different situations for individuals (Crisp, 1993). Within these studies, the experience of TBI is understood as a changed self variously described as the sense of shattered self (Inkmann, 2001), the loss of self (Nochi, 1998), a changed and impaired sense of self (Lewington, 1997), and the disconnections and detachment from a cohesive sense of self (Paskiewicz, 1988) necessitating the renegotiation of identity in a social context (Nochi; 1998, Stewart, 2002). The experience of the “loss of self,” a critical issue in the lives of persons with TBI, is intensified when they compare their present selves
with their pre-injury selves and when they interact with others (Nochi, 1998). Concurrent with the “loss of self” is the maintenance of former identity achieved by distinguishing functional changes from the “self” and keeping functional changes hidden from others. In much of the TBI literature, attempts to maintain a former identity are identified as a masking of deficits (Lewington, 1993) without reference to the role of identity maintenance described by Nochi.

However, Kroger (2000) suggests that identity development following loss involves not only readjustment to the loss and finding new life meanings but also retaining important identity elements thus establishing visible forms of continuity. Secrest and Thomas (1999) examined the meaning of life following stroke for 14 individuals in a phenomenological study. Their findings demonstrated that their participants simultaneously experienced a paradoxical and coexisting sense of continuity and of discontinuity of self. Themes of independence, connection with others, and control such as learning new skills or modifying the environment contributed to a sense of continuity. Themes of dependence, disconnection with others, and lack of control contributed to a sense of discontinuity. Some participants experienced disability only in interaction with others; unhelpful help, in particular, served to disconnect them from others. Furthermore, memory loss and inabilities broke connections with others, thus contributing to the sense of disability and discontinuity with self. Secrest and Thomas’ findings resonate with Josselson’s (1992) view of identity as occurring in the context of relation to others and as emerging from a continually redefined capacity to make use of and respond to others.

Thus the experience of “loss of self” (Nochi, 1998) and discontinuity may also be intensified in relation with others thus impeding the retention of important identity elements.
and of meaning (Kroger, 2000). O’Callaghan, Powell, and Oyebode (2006) describe the process of gaining self awareness of deficits for 10 individuals with TBI. Participants described stigma and the invisibility of injury, leading to incorrect expectations from others, as obstacles to self-awareness. In contrast, respectful environments and shared experiences with others with TBI facilitated the awareness and acceptance of changes. In the only qualitative study focused on women’s experience of brain injury (Howes et al., 2005), participants described perceptions of changes as a social being and experiences of social fear as significant elements in decreased social interactions. Chamberlain (2006) identified a theme of “invisibility,” endorsed by 45 of 60 participants with TBI, in which the participants perceived themselves as disappearing as a person, becoming a number, and withdrawing from society. In contrast the theme of “the recovering self,” endorsed by 50 participants, suggested that meaning, understood as a change of values, was significant in the development of a new identity. Connecting new life meanings, following loss in brain injury, to identity development (Kroger, 2000) deepens our understanding of findings of positive meaning following brain injury (Chamberlain, 2006; Howes et al., 2005; Nochi, 2000; Thompson, 1991) and resonates with Frank’s (2003) self-consciousness of purpose. The available literature suggests that women with ABI experience and bring ongoing identity concerns such as co-existing sense of discontinuity and continuity in self; concerns about identity in relations to others; and finding new life meanings to the career decision-making process. Furthermore, disconnection and connection with others are significant identity concerns for women with ABI because women’s identity emerges in relation to others (Josselson, 1992; Phillips & Imhoff, 1997).
The career development of women with disabilities is a complex phenomenon at an early phase of inquiry (Conyers et al., 1998) with no extant studies on the career development of women with ABI. Extrapolation from the limited studies on the career development of women with disabilities permits a tentative understanding of the career development of women with ABI. Conyers et al. investigated the life-span perspectives of employed college graduates with physical and sensory disabilities on disability and work in a qualitative study. Participants in the Conyers et al. study identified the interaction of disability and female gender as one of four key factors that mediated or impeded a sense of self in relation to disability. Participants noted that self-perceptions of disability varied according to physical and social surroundings, such that having a disability was central to self-concept in some situations but not in others. The positive expectations of others, especially during times of self-doubt, were especially potent leading to renewed focus and commitment to educational and career related goals. Work played a central role in the lives of the participants contributing a sense of identity and of purpose and reducing the self-perception of being “disabled” and the sense of dependency frequently associated with disability.

In a modified grounded theory study, Noonan et al. (2004) investigated the career development of women with physical and sensory disabilities. Noting the paucity of literature in the career development of women with disabilities, Noonan et al. suggest that many of the barriers that negatively affect women’s career development may also affect vocational processes for women with disabilities in very specific ways. Documenting the poor record of vocational rehabilitation for women with disabilities, they further suggest that low expectations based on disability interact with restrictive gender roles to lead to nonwork
roles for women. Turning their attention to highly successful women, Noonan et al. sought to identify facilitative factors in the career development of the women. Their resulting model of the vocational experiences of the women is a dynamic system, organized around the core category of the Dynamic Self containing interconnected identity constructs of disability, gender, and racial/ethnic/cultural identities. Similar to the Conyers et al. (1998) study, disability identity was mediated by the social context. The women spoke of the importance of accepting disability as part of identity and developing an integrated view of self and of disability adjustment as an ongoing process within a social context. The disability adjustment process was an important distinction between women with acquired versus congenital disabilities; women with congenital disabilities stated that they had not experienced an adjustment process. As in the Conyers et al. study, social support emerged as critical to the development of and implementation of a sense of self as a worker with a disability.

Groups of persons, for example, those suddenly unemployed or thrust into mid career change, bring not only general career concerns but also unique problems that may not be shared by other groups to the career counselling process (Herr, 1997). Several studies (Conyers et al., 1998; Noonan et al., 2004, Trevino & Szymanski, 1996) point to the fact that women with disabilities face unique concerns such as the lack of role models with disability; the interaction of gender, racial, and disability issues; the need for positive coping mechanisms in dealing with antidisability prejudice; and the role of educational and family experiences in expectations regarding paid employment.

For women with ABI, however, additional unique concerns about identity are also invariably embedded within unique career concerns of women with disabilities. First, concerns about concurrent maintenance and change in identity, although shared by persons
with acquired disabilities, are unique to women with TBI because “loss of self” (Nochi, 1998) is sudden and experienced as multidimensional encompassing physical, cognitive, emotional, and relational aspects of the self. Second, concerns about varying centrality of disability to self-concept (Conyers et al., 1998), although shared with other persons with disabilities, are unique because resolution of physical and cognitive functioning is protracted and uncertain in ABI. Third, the literature has consistently shown that interpersonal and familial domains are uniquely central to the development of identity for women (Phillips & Imhoff, 1997). Although shared by women in general, concerns about the centrality of relational domains presented by women with ABI are unique because the experience of “loss of self” (Nochi, 1998) and discontinuity (Secrest & Thomas, 1999) is intensified in interaction with others. Therefore, counselling for change (Savickas, 1994; Tyler, as cited in Herr, 1997) is integral to each concern that women with ABI bring to the career counselling process.

Barriers to Women’s Career Development

Women in the current work context lead increasingly nonlinear work lives marked by unpredictable changes in position, employer, and working conditions necessitating career planning as a lifetime task rather than as a good initial choice. Many variables, both internal and external, operate to inhibit or facilitate women’s career behaviour (Patton & McMahon, 1999). This discussion of contextual influences, focused on barriers to women’s career choices, follows on Noonan et al.’s suggestion that the negative barriers that affect women’s career development may also affect the vocational process of women with disabilities.

Fitzgerald and Betz (1994) view the disregard of constraints as a major limitation of the traditional career theories. They maintain that theoretical models need to be specifically
focused on women’s issues so as not to neglect any important variables. Gender-role stereotypes, occupational stereotypes, bias in education, lack of role models and mentors, biased career assessment and counselling, pay inequities, sexual harassment, barriers to advancement and the null environment give rise to internal barriers. For example, women’s career self-efficacy is hindered and undermined by perceived and real barriers that originate from individual socialization and social discrimination (Swanson & Woitke, 1997). Thus, Fassinger (2000) argues that all barriers to women’s vocational development can be viewed as contextual or environmental because the barriers arise out of societal structures and institutions that serve to limit access and options for females.

Fitzgerald and Betz (1994) further criticize major theories of career development because “all seem to adopt some type of “matching” or person-environment fit approach to career development yet this matching often fails to describe women’s career choices” (p. 109). These theories ignore the powerful nature of gender role socialization in limiting choices for women and in concentrating women in low-level jobs. Fitzgerald and Harmon (2001) further describe the expectation that women will cope simultaneously with two full time jobs – one outside the home and one inside the home - as one of the most intransigent conditions affecting women’s career development today. Indeed, most women select careers that they assume will allow them to be more actively and fully engaged in managing a house and mothering children (Betz, 1994; Gutek, 2001).

According to Fitzgerald and Betz (1994), structural and cultural factors, disregarded in the traditional theories, affect women’s behaviour in systematic and predictable ways and serve as risk factors in career choice and to the implementation of desirable career choices. Structural factors are defined characteristics of society or organizations that limit access to or
opportunities in the occupational and organizational environments. Examples of structural factors are discrimination and poverty, most relevant to women with disabilities. Cultural factors are defined as beliefs and attitudes commonly found among group members that serve as self perpetuating barriers. Examples of cultural factors are occupational and gender stereotypes. Structural and cultural factors can serve as either a barrier or facilitator to career choice depending on whether they are present or absent (Betz, 1994). Barriers to choice are factors that lead to the tendency to make gender stereotypic choices while facilitators to choice are factors related to broadened career options. Lack of role models, presence of stereotypes, and lack of childcare are examples of barriers to choice. Stereotypes, a major mechanism that puts women at disadvantage, are particularly insidious because they give rise to discrimination. Further, subordinates at work, usually women, are more likely to be subject to stereotyping (Gutek, 2001). A recent study of several hundred successful women in Canada and Finland (Yewchuk, Äystö, & Schlosser, 2001) highlights the continued presence of barriers in the career development of all women. Eminent women in this study named stereotypical attitudes of others, being female, having children, nonavailability of childcare and parental SES as the five most detrimental influences on career development. Thus, there is no question that gender importantly and complexly influences career development and that women see their personal and career lives as inextricably linked (Hackett, 1997).

In the previous sections, I emphasized that traditional career theories have failed to take account of broader contextual influences in career development and as a contextual medium for individual career decision-making (Patton & McMahon, 1999). I, further, have emphasized that models of career counselling limited to the rational, informational aspects of
career decision-making while overlooking contextual influences and the affective aspects of
the career decision-making process are not helpful for women with ABI. Ongoing change
pervades the lives of women with ABI simultaneously at many levels; functional abilities
change during a protracted recovery and in the context of changing environments, identity
changes in relation to others, and the changing economy brings its own changes to those
created by ABI. In the next two sections, I describe models of career decision-making and
career counselling more appropriate for counselling individuals in an environment of
constant velocity.

Models of Career Decision-Making

Major theories of career development, choice, and vocational behavior, endorsing a
fully rational model, assume the superiority of decision-making behavior that is logical,
methodical, and objective and that is based on a thorough consideration of knowable facts
about oneself and one’s alternatives (Phillips, 1994). The decision-maker herself is
characterized as methodical, systematic, independent, and unimpulsive throughout the
decision-making process. The theories further advise a firm commitment and tolerate little
tentativeness on the part of the decider. Indeed, Krumboltz (1992) maintains that career
counsellors, informed by major career theories, have treated career indecision almost as a
mental disorder. Researchers in vocational psychology and career counselling, arguing that
fully rational models of career decision-making are insufficient in a rapidly changing
environment, have called for the integration of rational and intuitive career decision-making
approaches (Gelatt, 1989, 1995; Hartung & Blustein, 2002; Krumboltz, 1992; Mitchell,
Levin, & Krumboltz, 1999; Phillips, 1994, 1997). Rational models assume that careers are
predictable; the field of options is stable; that information about those options is readily
available; and that the decider is clear and consistent. In a cogent argument, Phillips (1997) demonstrates that such assumptions are not valid in a context marked by rapid change and uncertainty. Given the inevitability of change, maintaining a tentative posture toward one’s choices is essential. Most salient for women with ABI is that rational decision-making requires two accurate guesses on the part of the decider; what will happen and how one will like the decision (March, as cited in Phillips, 1997). Women with ABI cannot make accurate predictions about career and work. They can neither predict the career choices available to them, the effect of changing abilities and identity on functioning, nor the presence or absence of environmental influences that facilitate or create barriers to functioning. In sum, women with ABI must make career decisions with considerable uncertainty and tentativeness because a thorough consideration of knowable facts about oneself and one’s alternatives is not available at time of decision-making.

Major theories endorse decision-making in an unbiased, comprehensive systematic manner and treat “emotion, intuition, affect, and consultation as nonrational phenomena that need to be controlled, rather than “other-than-rational” resources that might serve as sources of creativity, imagination, and decisional assistance” (Phillips, 1994, p.158). Yet rational strategies do not correspond to the decider’s reality and capacity and do not necessarily yield better decisions. Krieshok (2001) convincingly demonstrates that actual decision-making is far removed from the completely rational and conscious process typically embraced in practice. Furthermore, objectivity and predictability have been severely questioned as new perspectives emerge in the philosophy of science (Gergen, 1985). Gelatt (1989) argued that the objectivity of individuals and the predictability of events can no longer be considered as givens. Furthermore, the extent to which a given choice is rational or irrational depends on
the point of view, including beliefs and private rules, of the person judging it (Krumboltz, as cited in Gelatt, 1989). In fact, relatively little is known about career decision-making from the decider's perspective and experience (Phillips, 1997) and nothing is known about career decision-making from the perspective and experience of women with ABI.

Gelatt (1989) proposes that we make a commonly practiced strategy of decision-making, the nonsequential, nonsystematic, nonscientific human process, a legitimate strategy. His framework of "positive uncertainty," promoting positive attitudes and paradoxical methods in the presence of increasing uncertainty, provides a suitable career decision-making model for women with ABI whose experience of ongoing identity and functional changes creates a uniquely uncertain future. Gelatt exhorts the career counsellor to adopt a broader view of decision-making that utilizes the decision maker's nonobjective role and incorporates the constant presence of uncertainty. This broader view acknowledges that information is limited, changing, and subjectively perceived and that decision-making is a process that both facilitates and creates goals. In Gelatt's framework, decision-making, defined as the process of arranging or rearranging into choice or action, becomes a process for discovering goals. The four paradoxical principles of "positive uncertainty" are: 1) Be focused and flexible in what you want; 2) Be aware and wary of what you know; 3) Be objective and optimistic in what you believe; 4) Be practical and magical in what you do. Each of the four principles integrates rationality with imagination, intuition or flexibility and conveys the importance of attitude in making decisions. This attitude of feeling uncertain about the future yet feeling positive about uncertainty helps individuals, such as women with ABI, deal with ongoing change and ambiguity.
Gelatt’s (1989; 1995) perspective, that changing one’s mind is an essential decision-making skill and that provisional commitments are necessary in an uncertain world, recasts the return-to-work experiences of individuals with ABI into a more positive light. Krumboltz (1992) succinctly argues that indecision about making definite long range plans is actually more sensible than making a firm commitment when the future is so uncertain. Krumboltz advocates for more positive terminology to describe indecision such as being open-minded, considering multiple options and keeping alternatives open. In a rapidly changing context, being undecided, dancing to use Gelatt’s (1995) evocative metaphor of managing change, is more adaptive that making a firm commitment. The advantages of open-mindedness are that one is not bound to a plan that becomes obsolete and that one has the opportunity to be curious. Tentative commitments facilitate sensible career decision-making strategies, such as avoiding a foreclosure, looking for alternatives and considering many options. Encouraging tentative decisions to try out alternatives stimulates learning and helps reduce feelings of guilt and failure for women with ABI. Thus, making tentative decisions based on the alternatives before them, while keeping one’s options open, is a philosophical perspective that can promote the mental health of women with ABI.

Planned happenstance theory (Mitchell et al., 1999) suggests career counsellor practices that will further create an optimistic outlook and prepare women with ABI to maximize the beneficial effects of chance in career choice and development. The theory includes two concepts: a) exploration generates chance opportunities for increasing the quality of life, and b) skills enable people to seize opportunities. Skills are required to recognize, create, and use chance as career opportunity. Mitchell et al. suggest that counsellors adopt a counselling intervention that views unplanned events as both inevitable
and desirable and as opportunities for learning. The role of career counsellors is to teach clients to act in ways that generate a higher frequency of beneficial chance events on which clients can capitalize. Of particular significance for women with ABI are counsellor actions that engage the women in exploratory activities designed to increase probability of exposure to unexpected opportunities. Such actions have the potential to decrease the sense of isolation that is so prominent for women with disabilities.

**Contextual and Constructivist Approaches to Career**

Historically, theories rooted in the positivist tradition have dominated research, theory, and practice related to career decision-making (Brown, 2002). Major assumptions of logical positivism that have influenced traditional career theories include: 1) individuals can be studied separately from their environment, 2) human behaviour operates in a lawful, linear fashion from which cause and effect can be inferred, 3) human behaviour can be objectively observed and measured, 4) the scientific method is the most acceptable paradigm for the study of human behaviour, and 5) the context in which people operate is relatively neutral.

More recent theories of career development, however, are influenced by the philosophy of social constructionism (Brown, 2002). Major assumptions of social constructionism that have influenced recent theories include: 1) the subjective frame of reference of human beings is the only legitimate source of knowledge, 2) individuals cannot be studied apart from the social systems to which they belong, 3) human functioning cannot be reduced to laws or principles, and 4) human beings actively construct their reality. In much of the career literature, constructivism and social constructionism have been subsumed under an undifferentiated "constructivism" (Young & Collin, 2004) resulting in ambiguity and little agreement beyond a basic definition as follows. Constructivism focuses on
meaning making and the constructing of the social and psychological worlds through individual, cognitive processes while social constructionism emphasizes that the social and psychological worlds are constructed through social processes and interaction. In this literature review, the terms social constructionism and constructivism will reflect the original author’s usage.

Career theories address one or more of the three properties of context: 1) the multiplicity and complexity of parts, 2) the inextricable weaving together of these parts, and 3) the meaning of events or phenomena (Young et al., 2002). Szymanski and Hershenson’s Ecological Model of Vocational Behavior (1998), discussed in an earlier section, incorporates context by including a multiplicity of interacting constructs thereby emphasizing the complexity of career development. The Systems Theory Framework of Career Development (Patton & McMahon, 1999) incorporates context through the interlocking nature of career systems. Peavy’s (1996) and Cochran’s (1992) models incorporate context by addressing the meaning of events. Contextual Action Theory (Young et al., 1996, 2002) incorporates the three properties of context in a contextualist explanation of career. In this section, I will highlight the relevance of the conceptualization of context, reflected in each of these theories and models to the career decision-making of women with ABI.

These recent career theories and models of career counselling, influenced by constructivist philosophy, view career development as non linear, intuitive, and influenced by perturbations, accident and chance, as much as by rational planning (Peavy, 1996). Constructivist approaches concentrate on meaning making to understand individual career decision-making and the structure of individual careers. A contextualist worldview is reflected in constructivist epistemology (Patton & McMahon, 1999). Contextualism
conceives development, not as unfolding in stages, but as an ongoing process of interaction between person and environment. Chance events contribute to an open-ended, unpredictable state of being. But, the individual is not passive to environmental forces but rather is seen as an active self-building and self-renewing system.

The application of constructivist philosophy to career counselling has been fostered by the perceived gulf between career development theory and research and everyday situations of practice and social policy (Young & Collin, 2004) and by discussion of fusion between career and personal counselling (Patton & McMahon, 1999). Constructivist philosophy provides a framework for guiding career counselling with life design as the overarching construct. The features of constructivism most salient to career are that meaning is constructed in a social, historical, and cultural context, through action and discourse in which we form relationships and community (Young & Collin, 2004). Within the constructivist framework, individuals are viewed as a part of social and environmental-societal systems and as involved in lifelong career development (Patton & McMahon, 1999).

Constructivist approaches to career counselling emphasize stories rather than scores from standardized tests and questionnaires, the plurality of perspectives, contextual impacts, social constructions of reality, and the importance of the meaning the individuals give to their experiences (Peavy, 1996; Richardson, 1993). When used, results of assessment measures are treated as a source of information to be considered jointly with the client. The importance of narrative in counselling is as a form of self construction (Bujold, 2004). What matters is not the factual authenticity of the story but rather the interpretation of events and the storyteller’s meaning making process. Thus, career counselling becomes an activity in which the counsellor and client socially construct the meaning of the client’s direction in life.
Importantly for women with ABI, constructivist approaches explore the relative amount of power individuals have in making career choices. Further, the cultural, social, political, and economic contexts that surround career choice would be key components of career counselling.

**Systems Theory Framework of Career Development**

Patton & McMahon (1999) propose an integrative framework based on systems theory as a coherent synthesis of concepts of career development from existing theories. Systems theory, focused on the unity of the system, posits that the individual and her context exist in a pattern of interrelationship. The pattern of interrelationship is found among the components of the human system and context system and within the subsystem components. Systems theory rejects linearity, mutuality of influence, and reciprocal interactions; therefore, career theory must account for individual and contextual patterns. Systems theory assumes that systems regulate themselves to maintain stability; thus, the human system is viewed as purposive, ever-changing and evolving toward equilibrium. Discontinuous change, a change to a new form of system functioning, occurs during major life crises. Systems theory places a greater focus on the process of change and on the nature and process of influences in the environment on human behaviour than do contextual approaches. Thus, systems theory’s broad conceptualization embraces the environment itself, the impact upon the individual’s career, and the individual’s impact upon the environment and also recognizes the subjective aspects of career.

The Systems Theory Framework of Career Development (STF; Patton & McMahon, 1999) presents a framework of influences to individual career development and shows the many complex and interrelated systems within which career development occurs. The
framework places the individual at the center of a system within a broad contextual system composed of two subsystems, the social contextual subsystem and the environmental/societal contextual system. Influences, viewed as subsystem components of the individual system, include influences identified in existing career theories such as self-concept, aptitudes, world-of-work-knowledge, values, health, and beliefs among others. A limitation of the individual system is that disability, although acknowledged, is conceptualized as an intraindividual influence rather than as occurring in interaction with the environment. The composition of the social system, consisting of “other people” systems, changes throughout life. The social structures within the social system include community groups, institutions, workplace peers, family, and media. These social structures convey values, beliefs, and attitudes to individuals in a variety of ways. Due to the uniqueness of an individual and her situation, it is essential to explore the exact nature of the social systems within the individual’s context. The environmental-societal system includes geographical location, political decisions, historical trends, the employment market, globalization, and socioeconomic status. This acknowledgement of the influence and restrictions imposed by the sociopolitical environment is especially critical in understanding the career development of women with ABI.

STF (Patton & McMahon, 1999) conceptualizes three process influences: recursiveness, change over time, and chance. The process of recursiveness stipulates that influences are nonlinear, acausal, mutual, and multidirectional; that many influences are not reciprocal in size or direction; and that past, present, and future influences have ongoing relevance. The acknowledgment that influences are not necessarily reciprocal is most significant for women with ABI. The process of change over time views the path of career
development as one of constant evolution involving ongoing decision-making. Change over time considers the process of career development in relation to the influences of the individual's stage of life and family life cycle. Finally, the process of chance acknowledges that unpredictable events, which can affect any part of the system, may have a profound influence on career development. Thus, the event, which resulted in ABI, is considered within STF as a chance event with a profound influence.

Most significant for women with ABI, is that STF (Patton & McMahon, 1999) provides adequate attention to the recursive nature of interaction among the variables that influence the differential opportunity structure. The interactionist and nonreductionist approach of the STF provides a broad conception of career. Furthermore, in defining career as the "life pattern determined by recursiveness of life influences" (Patton & McMahon, 1999, p.170), career decisions made by women with ABI are valid and can be explained in terms of systems influences.

According to Patton and McMahon (1999), STF brings congruence between the theory of career development and practice of career counselling. The role of the counsellor is not as expert but rather to assist the individual, through dialogue, to understand intrapersonal and systems influences and their relationships. The client, with the assistance of the counsellor, constructs the story that makes sense of these influences and their meaning. The counsellor assists the individual to construct her own career development process and to engage in relevant action. STF highlights the importance of a subjective perspective and context in career counselling and the need to adopt the most relevant career theories in tailoring interventions according to individual needs. However, a claim of congruence between STF and practice is not justified because the theory itself does not appear to be
directly related to a well defined practice. Rather it is the aspect of explicit focus on system
influences within counselling based processes that are most significant for women with ABI.

**Peavy’s Constructivist Career Counselling**

Asserting that most models of career development and counselling are still based on
logical positivism even though this concept has long been dead, Peavy (1996) advocated for
constructivist career counselling. The most profound implications of Peavy’s model are that
personal meaning and activity have replaced traits and mental mechanisms. The two primary
objectives of career counselling are to: 1) generate personal meaning and 2) to promote
reflection on the implications of both new and old self knowledge in relation to career
planning.

Peavy (1996) espouses a participatory view of reality, especially in social life, in
which individuals produce, create, and construct their own realities, both personal and social.
He posits that the development of self is a function of construction in the context of social
participation, relationships, and dialogue. Thus, a major tenet of the model is that counsellor
and client are co-constructors of client’s world, plans, and coping strategies. Peavy proposed
that the gap between life and career be eliminated; that career counselling be viewed as life
planning; and that the individual be approached as a whole being rather than simply as a
decider. Career counselling becomes a cooperative process with the client as expert on her
own life experience and the counsellor as expert on processes of communication and change.
In this model, clients, considering the many active influences in their career lives, decide
which influences are helpful and which require examination or modification in order to make
more informed choices.
Peavy’s (1996) emphasis on life planning, personal meaning, and the whole person are crucial for women with ABI who, through uncertainty, unemployment, poverty, or social isolation, may struggle to find and create meaning in their lives. As well, the constructivist belief that construction can only be understood within the context of meaning, which supports the construction, is beneficial for persons with ABI who have often been characterized as resistant or indecisive in rehabilitation and traditional career models. However, given the inherent power imbalance between the counsellor and women with ABI consensual co-constructions are unlikely. An unexamined assumption of co-construction can further entrench this inequality. Furthermore, it is crucial that career counselling models, in keeping with the social model of disability, acknowledge that social and political realities, which disadvantage and discriminate against women with ABI, do exist in reality.

**Cochran’s Career Project**

Cochran (1992), regarding meaning as the central subject of a career, uses narrative for understanding career decisions through grasping the story of which it forms a part. When organized through narrative into a unified whole, the significant influence of events and actions in a life can be seen. Cochran maintains that narrative makes human reality, as lived, represented, and explained, comprehensible and has the power to guide lives. For example, Cochran (as cited in Savickas, 1993) defines career indecision as wavering, a movement toward meaning rather than a goal. Career indecision is viewed as a sign of transformation in progress and as a normal experience that occurs when people are about to lose their space. Wavering hesitation offers a client the opportunity to review her life and focus her awareness to construct the whole that will clarify the parts and uncover a theme. A conceptualization of career indecision as a movement towards meaning depathologizes career indecision
(Krumboltz, 1992) and normalizes the experience of women with ABI who must make career
decisions in a context of uncertainty.

Cochran (1992) proposes the career project, thematically rich personal constructions
unique to individuals, as a framework for developing a “deeper form of career counseling,
one that is concerned with authoring life stories rather than just completing general tasks” (p. 196). The career project consists of a personal theme, the implicit meanings that pervade a
life history; and life tasks, and the voluntary activities that culminate in an outer
achievement. Life tasks are unified and endowed with significance by personal themes.
Cochran suggests that career projects have four kinds of significance for a career: 1)
successful projects yield a variety of achieved goods, 2) pursuing a project cultivates
personal qualities, 3) a person engaging in a career project constructs compositions that are
capable of integrating parts, and 4) an action, means to an end, may through a career project,
transform into an activity done for its own sake. The role of the counsellor is as “co-author of
a novel in progress, focusing upon the immediate action while emplotting its role in a larger
story” (p. 195). The framework of the career project may serve as an effective means for
understanding the meaning of career choices, such as persistence in returning to pre-injury
occupations, for women with ABI and for designing programs that support women with
significant life tasks. However, as with Peavy’s model, a description of the process as co-
authoring ignores the power differential between counsellor and women with ABI.

**Contextualist Action Theory**

Young et al. (1996, 2002) formulated a contextualist explanation of career based on
action theory to guide research and practice. Contextualism, interpreting the world in terms
of the complexity and interrelatedness of context, understands the individual and career as
embedded within context (Collin, 1997). Young et al. identify the aspects of contextualism, particularly relevant to their theory, as 1) an emphasis on the goals of actions; 2) actions are embedded in their context; 3) change has a prominent role in career; 4) analysis and interpretation are practical; and 5) the counsellor works from the clients' present outward. Young et al. (2002) propose goal-directed human action as a construct that facilitates understanding of behavior because it keeps pertinent context information together. Action or goal-directed behavior can be interpreted and understood only in context. Further, career behavior and associated contexts are salient only when understood in relation to the person's intentions. Action focuses on human intention, process, and change rather than on context (environment) as a setting for action. Actions, then, are human processes that produce each person's social and cultural world.

Action, being cognitively and conceptually regulated and steered, is organized as a system with hierarchical, sequential, and parallel dimensions. The main constructs of contextual action theory are organized within three contextual characteristics of action: action systems, perspectives on action, and levels of action organization. Each construct is related to all other constructs in complex and dynamic ways. The four constructs of action systems, action, joint action, project, and career, can be seen from the perspective of manifest behaviours, internal processes, and social meaning. Joint action is not the interaction of parties but rather the action that the dyad or group has taken together. Although co-constructed, not all parties necessarily have an equal role in the construction of joint action. Project and career are superordinate constructs that allow "people to construct connections among actions; to account for effort, plans, goals, and consequences; to frame internal cognitions and emotions; and to use feedback and feed-forward processes" (p. 217). In this
hierarchical system, career can extend over longer periods than a project and encompasses a
greater range of actions. The three levels of action, organized in ascending level, are
elements, functional steps, and goals. The meaning of elements (e.g., words, phrases, and
movements) is contextualized by functional steps, a series of contiguous behaviors such as a
statement in a sequence of statements and behaviors. Functional steps are further
contextualized by the actor's goals, representing the general intention of the actor.

Action theory posits that emotion and cognition, conceived as internal processes that
regulate and guide actions, are connected to the interpersonal and contextual. Emotion plays
a central role in the construction of career for three reasons: 1) Emotion motivates and
energizes action so that specific career action, which may be difficult or boring, can be
sustained; 2) Emotions regulate and control actions, projects, and careers in moment-to-
moment decisions; 3) Emotion, being associated with needs, desires, purposes, and goals, is
able to access, develop and orient narratives about project and career. Thus, emotion both
regulates action in a social process and is constructed by our actions, projects, and careers.

Its application to career counselling has been identified as a general strength of
Contextualist Action Theory (Brown, 1996; Chen, 2002; Patton & McMahon, 1999).
Counselling is thought about as a project on which counsellor and client work together and in
which joint goals can emerge. Career is constructed through everyday action and language in
conversation with others. Individuals, who discuss career issues with counsellors, are seen as
engaging in joint action. From such conversations, interests, values, and career identity may
be constructed socially as products of joint action. The perspective that concepts such as
interests are socially constructed in joint action provides a valuable new understanding of the
interrelationship between individual and context (Patton & McMahon, 1999).
Contextualist action theory also brings a new understanding to the interaction between counsellor and client, who are interwoven in a tapestry of joint action. Interpretation in action theory is defined as constructionist sense making of one’s experiences and goals. The interpretation of narratives serves to set up joint action between the client and counsellor. It is at the level of joint action, that Young et al. (2002) suggest that counselling overcomes the limitations of a strictly narrative approach. The concept of joint action, as a relational construct, makes a significant contribution to career counselling and career development (Chen, 2002).

Young et al. (1996, 2002) suggest that because action theory accounts for the context in which an action occurs, their theory accounts for cultural and gender factors in career. However, the approach of contextualist action theory precludes the identification of specific factors of influence in relation to culture and gender (Patton & McMahon, 1999). The nonidentification of specific influences and the lack of attention to past and future influences represent limitations of the approach in career counselling of women with ABI. The subjective frame of reference, especially the consideration of emotion in career, and the focus on complex experiences more attuned to a person’s life, are positive aspects of the model. Most significant for women with ABI is the explicit acknowledgment that co-construction does not presume an equal role.

**Summary and Conclusions**

This chapter has examined the recent rehabilitation literature on return to work and quality of life focused on the subjective perspectives of persons with brain injury; qualitative studies in brain injury from the perspective of the theory of cognitive adaptation; the limitations of career theories for persons with disabilities; the effects on individual and
implications for career counselling related to the societal context of the changing workplace; the social context of identity and career development for women with ABI and disability; and the relevance of recent models of career decision-making and career theories to the unique career issues and needs of women with ABI.

There is virtually no research documenting the career decision-making experiences of women with ABI. Indeed, women with disabilities have been mainly ignored in the mainstream vocational psychology and career development and counselling literatures. Thus the relevance of career theories for women with disabilities is unknown. The applicability of traditional career theories and models of career decision-making are limited within the current workplace context marked by rapid change and uncertainty. Indeed only theories that assume a constant velocity are useful in current context (Borgen, class communication March, 2004). Limitations include a focus on occupations, a disregard of constraints to choice, a disregard of subjective perspective, a limited conception of the environment, assumptions of a stable identity and environment, and a disregard of affective processes in decision-making.

A further limitation of traditional career theories and models of career decision-making for persons with disabilities specifically is the conceptualization of disability, when included, as an intraindividual difference. Such a conceptualization is inconsistent with our current understanding of disability as mediated in interaction with the environment and as occurring within a sociopolitical context. Moreover, the gulf between career theory and practice and the void in research are significant obstacles to a targeted career counselling practice for women with ABI. Practice based on traditional career theories, focused on a choice point and matching, fails to address feelings of uncertainty and isolation and
difficulties during time of personal or workplace change. Importantly, traditional practice overlooks the significant implications of subjective meaning to the career decision-making process.

Viewed together, recent models of career decision-making and recent career theories, influenced by contextual and constructivist philosophy, appear to have greater applicability for clinical practice with women with ABI. Most significant for practice are an expanded understanding of career decision making and of career development that includes subjective perspectives and meaning, affective processes, attention to the experience of uncertainty, and a focus on social and societal contextual influences in interaction with the individual. Importantly, recent models and theories based on constructivist theory espouse an enlarged focus of career counselling to include life design as the overarching context and a focus on meaning and narrative in life planning. This enlarged focus of career counselling is in line with indications in the qualitative return to work literature of the need for ongoing support during times of personal or workplace changes. Furthermore, a focus on narrative and meaning in career counselling dovetails with recommendations for therapy aimed at restoring meaning and purpose and expanding possibilities in life (Miller, 1993; Nochi, 2000; Prigatano, 2005).

However, a significant limitation in the application of career theories and models influenced by constructivist philosophy is a perspective of reality as constructed. It is critical that career counsellors acknowledge the differential opportunity structure and discrimination as real and as existing in the environment. While the STF (Patton & McMahon, 1999) explicitly acknowledges the real impact of environmental forces, there is the potential that

An expanded focus to include women with disabilities, work and chosen pursuits outside the occupational structure, and qualitative research methods are needed to develop inclusive career theories that account for the contextual complexity of career decision-making for women with disabilities and with ABI within the social context. Similarly, the emerging qualitative return to work literature points to the need for the conceptualization of employment within the context of individual lives that includes more subjective perspectives and life based outcome variables.

Therefore, this study aimed to address a void in the research literature by augmenting our understanding of career decision-making for women who have experienced ABI in mid-career. An understanding of the contextual complexity of career decision-making for women with ABI is needed to inform effective career counselling practice for this population and to contribute to the articulation of an inclusive theory of career development. Such an understanding can only be elucidated through research which elicits the subjective perspective. Accordingly, in order to understand how women construct meaning in career decision-making, the present research aimed to illuminate the lived experience and meaning of career decision-making of women with ABI through a phenomenological methodology. In addition, the present study is expected to augment subjective perspectives from the recent qualitative research in the brain injury literature. This research should add considerably to our knowledge of how women with ABI make career decisions within the context of their lives.
CHAPTER 3: METHODOLOGY

This qualitative study illuminates, through psychological phenomenology, the experience and meaning of career decision-making for 8 women who sustained an ABI in mid-career. Phenomenological interviews were used to obtain rich subjective descriptions of career decision-making experiences within the context of the participants’ lives. The participants’ descriptions were analyzed for deep meaning structures (Colaizzi, 1978; Osborne, 1990) and themes common across multiple cases were identified.

This chapter describes the methodology and procedures used for the current study. First, I present an overview of phenomenological methodology in psychology referencing Husserl’s phenomenology and the basic tenets of phenomenology. Then, I discuss the suitability of phenomenology for exploring my research question and reveal my biases and preconceptions about the research. Next, I describe the procedures used in collecting, analyzing, and transforming the data. Finally, I discuss the techniques used in establishing the trustworthiness of the study.

Research Design

Phenomenological Methodology in Psychology

The methodology of phenomenology as a human science and a western qualitative research method rests upon the phenomenological philosophy of Husserl (Colaizzi, 1978; Giorgi, 1975; Klein & Westcott, 1994; Osborne, 1990, 1994; van Manen, 1990). Focusing on the individual as the source of knowledge and ultimate truth (McLeod, 2001), Husserl reasoned that an understanding of human knowledge should be based upon an understanding
of consciousness (Osborne, 1990, 1994). He sought to describe the essence of everyday experience through an examination of human emotions, actions and perceptions. Focusing upon intentional acts of consciousness rather than upon external reality, Husserl sought to show the subjective character of conscious experience by careful description and critical reflection. For Husserl, intentionality was the essential feature of consciousness, always directed to an object that is not itself consciousness (Giorgi, 1997). The phenomenon of consciousness is intrinsically relational and refers to the totality of the lived experiences that belong to a single person. Thus, the focus of phenomenological research is the understanding of the persons’ experiences of their world rather than a generation of explanatory laws (Giorgi, as cited in Osborne, 1990).

Husserl’s famous dictum “unto the things themselves” characterized his attempts to examine the depths of consciousness and the focus on subjective reality and lived experience (Osborne, 1994). Following Husserl, the aim of phenomenological research is to understand a phenomenon by attempting to put aside one’s preconceptions and by allowing the data to speak for themselves (Osborne, 1990). Thus, phenomenological research is a descriptive science that endeavours to “contact phenomena as people experience it” (Colaizzi, 1978, p. 57). Knowledge cannot be separated from meanings the person brings to each experience; consequently knowledge is necessarily perspectival.

Husserl sought to identify the essence or essential structures, rather than the contents, of consciousness. “The term ‘essence’ may be understood as a linguistic construction, a description of the phenomenon” (van Manen, 1990, p.39) that allows us to grasp the nature and significance of the phenomenon in a new way. From a psychological perspective, essence refers to the “structure of meanings immanent in human experience” (Wertz, 2005, p.
170). For Husserl, knowledge of the structures of consciousness was a matter of eidetic seeing (McLeod, 2001; Polkinghorne, 1989). The process of going beyond the natural attitude, our network of everyday assumptions, and bracketing off these assumptions was described as eidetic seeing. In phenomenological research, essences are identified by intuitive seeing rather than derived through empirical abstraction (Giorgi, 1997; Osborne, 1994). Phenomenological psychology seeks to determine the psychological essences and their interrelationships or structure of a phenomenon that is the most invariant meaning for a context with respect to the perspective of a psychological discipline.

Phenomenology, viewing meaningful experiences as providing the basis for all knowledge and human behaviour, attempts to uncover and describe the internal meaning structures of lived experience (Polkinghorne, 1989). Lived experience involves an immediate pre-reflective consciousness of life. Opinions, for example, are not lived experiences. The goal, then, is to ascertain the essence of the individual's sense of the experience rather than to extract factual information (Osborne, 1994; van Manen, 1990). Identification of the essential structures of experience is usually based upon the explication of thematic meanings. Specifically, phenomenological psychology seeks to reveal the experiential world of the individual knower (Colaizzi, 1978) and structures of meaning that are general for groups of people (Polkinghorne, 1989).

The concept of intentionality, that consciousness always has an object, is similar to the view of existential-phenomenology that person and world constitute an interdependent unity (Colaizzi, 1978; Osborne, 1990). Colaizzi describes this unity as human and world "co-exist by reciprocal implication, each co-constituting, not creating or causing the other" (p. 54). The co-constitution of person and world is implicit in social models of disability (Olkin
& Pledger, 2003) which view disability as a socially constructed status (Brandt & Pope, 1997; Gill et al., 2003) and explicit in recent theories of career development influenced by constructivist philosophy (Brown, 2002) and contextualist worldviews (Patton & McMahon, 1999). Co-constitution has important implications for phenomenological research with women who have sustained an ABI. The most significant implication is that environments are not independent of the ways people construe their environments (Bandura, as cited in Osborne, 1990) nor can persons’ experiences of their environments be understood without understanding the ways in which environments have influenced persons’ experiences. Thus neither person nor world can be considered in isolation; objective realities cannot be separated from a person’s subjective experience. Importantly, this perspective will contribute, throughout my research, to a sensitivity and openness to the ways in which the environment may mediate participants’ varying concepts of self and disability.

Husserl developed the methodological reduction to make his research findings more precise (Giorgi, 1997). Husserl viewed the second epoché, breaking from the natural attitude, as a necessary condition for phenomenological research which focused on human experience and sought to apprehend subjective meanings (Wertz 2005). To enter the process of phenomenological reduction, one must continually bracket one’s presuppositions or past knowledge about the phenomenon in order to encounter it freshly and to describe it as intuited or experienced. The phenomenological psychological reduction describes an attitude that is highly empathic and free of value judgment in which the researcher strives to empathically enter, through written descriptions such as interview transcripts, the life world of the participants in order to focus on the meaning as given in the participant’s experience (Wertz, 2005).
However, “a complete reduction to presuppositionless knowing is impossible” (Osborne, 1994, p. 170). Indeed, the most important lesson to be learned from the reduction is the impossibility of a complete reduction (Merleau-Ponty, as cited in Colaizzi, 1978). Heidegger, believing that the reduction was dispensable and misleading (Osborne, 1994) and not believing in presuppositionless knowing, developed the hermeneutic method, an interpretive technique, which is contextualized by existence and seeks to bring out tacit meanings. According to Giorgi (1997), the debate about whether hermeneutic interpretations are necessary for human phenomenon has not yet been resolved at the philosophical level. Hermeneutic phenomenology asserts that the presence of interpretation is unavoidable (Osborne, 1994). Phenomenology acknowledges that personal descriptions of experiences are linguistic attempts to interpret and communicate consciousness in a form that is meaningful to participant and researcher (Osborne, 1994). Interpretation is therefore multilayered: the participant interprets her own experience and the researcher interprets experiences in terms of meaning structures.

The terms phenomenology and hermeneutics are often used interchangeably (van Manen, 1990) and the differences are blurred in contemporary research practice (Osborne, 1994). van Manen provides the following distinction: Phenomenology provides a pure description of lived experience while hermeneutics, seeking to bring out hidden meanings, provides an interpretation of the participant’s experience. Two broad categories, empirical and hermeneutic approaches, have been identified in contemporary phenomenological research in psychology (Hein & Austin, 2001; Klein & Westcott, 1994). The empirical approaches emphasize a reflection upon the actual experiences as described in the participants’ words while the hermeneutic approaches emphasize an uncovering, elaborating
extensively on the participant’s words, rather than an accurate analysis or description and
view understanding as occurring as a fusion of horizons. The empirical approaches
emphasize the structure (meaning) and commonality that is present in the phenomenon
whereas the hermeneutic approaches involve a process of contextualization. Despite a broad
categorization of phenomenological research as empirical or hermeneutic, Hein and Austin
remind us that in reality it is difficult to clearly distinguish between empirical and
hermeneutic approaches.

Phenomenological psychology acknowledges the unavoidable presence of the
researcher in all aspects of the research process (Osborne, 1990) and that interpretation is
inherent in all inquiry and understanding (Hein & Austin, 2001). In phenomenological
research, bracketing is a rigorous process of self-reflection in which the researcher explicitly
examines preconceptions and biases about the phenomenon in order to make such
assumptions explicit to oneself and reader thus demonstrating the rigor of the research
(Osborne, 1994). The reader is then in a better position to assess whether the phenomenon
has been articulated from particular perspectives. Through an ongoing process of self-
reflection the researcher strives to be as open and receptive as possible to the participants’
descriptions of their experiences. However, bracketing is always incomplete because it is not
truly possible to break with our way of seeing (Hein & Austin, 2001). It is only possible to
bracket what is in awareness; therefore, the ability to examine preconceptions and how they
may impinge on the research is a function of the researcher’s reflexivity (Ahern, 1999).
Nonetheless, bracketing is an important procedure for increasing our awareness of our role in
the research and for broadening our understanding of the research phenomenon.
McLeod (2001) maintains that, in practice, qualitative research is a matter of finding the right balance, according to the circumstances of a study, between phenomenology and hermeneutics. Since women with ABI have long been ignored in research (Banks et al., 2002; Tate & Pledger, 2003; Whiston & Brecheisen, 2002), my aim was to elucidate lived experience by giving a voice to the women themselves. I aimed to attain an empathic understanding in order to contribute to the development of a more thoughtful counselling and rehabilitation practice for women who have sustained an ABI. Women with ABI, whose inner reality plays a critical role in creating meaning and who are most consciously connected to their experience of career decision-making, are in the best position to describe their experience (Osborne, 1990). Accordingly, the primary goal of this study was to describe as accurately as possible the experience and meaning of career decision-making for women who had sustained an ABI from the subjective perspectives of the study participants. Therefore, the phenomenological psychological approach selected for this study was a more descriptive rather than hermeneutic approach (e.g., Colaizzi, 1978; Giorgi, 1997; Osborne, 1990; Polkinghorne, 1989). References to phenomenological research from this point will refer to the more descriptive approach (van Manen, 1990).

Suitability for This Research

Phenomenological psychology views meaningful experiences as providing the basis for all knowledge and behaviour (Hein & Austin, 2001). Phenomenology is used when the researcher wants to find out what certain phenomena mean to and how they are experienced from the perspective of the experiencing person. Phenomenology is discovery oriented which means that the researcher avoids a priori specifications and adopts an open attitude that permits unexpected meanings to emerge from the data (Giorgi, 1997). Phenomenology
facilitates depth of understanding and the opportunity to understand women with ABI as agentic beings. It is, therefore, useful for an inquiry that seeks to understand human experience (Osborne, 1994). Thus, phenomenology represents a useful approach for exploring my research question: “What is the personal experience and meaning of career-decision making for women who have sustained an acquired brain injury in mid-career?”

Phenomenology is also appropriate when little is known about a phenomenon (Colaizzi, 1978; Osborne, 1990). Extant research has not explored the subjective career decision-making experiences of women with ABI, therefore, nothing is known about the lived experience of career decision-making for women with ABI. Furthermore, the relevance of career theories and career decision-making models used with women with ABI in vocational rehabilitation and career counselling is unknown. Indeed, research on ABI ignores the topic of career decision-making other than to describe a persistence to return to pre-injury work as problematic (e.g., Stambrook, Moore, Peter, Deviane, & Hawryluk, 1990). Moreover, limited opportunities for decision-making have been identified as one of three important concerns regarding the rehabilitation of persons with ABI (NIH, 1998).

The implicit message is that women with ABI either are unable to or do not have the opportunity to make career decisions. Yet, although we may fail to recognize it, career is something we all have (Van Maanen & Schein, as cited in Woodd, 2000) and which continues to be a significant aspect of the lives of women with ABI. To address this gap in the extant literature, I invited participants to describe the experience of career decision-making and meaning making in their own voices. An understanding of the experience and meaning of career decision-making, grounded in the perspectives and words of women with ABI, is necessary to inform sensitive career counselling practice and future research.
Furthermore, the adoption of the phenomenological stance is necessary to make discoveries about ways in which personal and social worlds are constructed (McLeod, 2001). Current understanding of disability as socially constructed and mediated (Brandt & Pope, 1997; Government of Canada, 2004; Pledger, 2003) dictates attention to the environment. Though the phenomenological method does not make explicit strategies for contextualizing findings, it has been convincingly applied to cultural and historical material. Therefore, I attempted to come to a fuller grasp of the women’s experiences by also taking into account the social and societal environments, as described by the women, that gave meaning to the women’s career decision-making (van Manen, 1990).

Bracketing

Phenomenological knowledge is perspectival (Osborne, 1990) requiring a creative insight and meaning making by the researcher (Colaizzi, 1978). Presuppositions, therefore, influence formulation of research questions, collection, interpretation, and presentation of data. Indeed, presuppositions influence what emerges as data. The first step in the phenomenological reduction is the inductive method of bracketing with the goal of allowing the data to speak for themselves. Ashworth (1996) describes the criterion of bracketing in this way: “if the maintenance of a given type of assumption would subvert entry into the life-world, such presuppositions must be set aside” (p. 25). Giorgi (2004) emphasizes that “the psychological phenomenological reduction liberates us from judging our experiences on the basis of what we know to be real” (p.20). In this attitude, the researcher is maximally open to the experiences of the participants as they are given. In this study, explicating my assumptions served to stem an automatic search for principles and theories that organized my pre-understandings of career and of brain injury and to provide a space for coming to grips
with the significance of the women’s lived experience (van Manen, 1990). My pre-
understandings about the experience and meaning of career decision-making and ABI are
delineated in the remainder of this section.

My interest in and presuppositions about the career decision-making of women with
ABI are informed by clinical practice in a community college and in the community and by
my personal experiences. Professionally, I have had the opportunity to counsel and support
the career decisions of many persons who have sustained an ABI. Most persons participated
in funding programs that provided funding only to those who pursued career goals and plans
consistent with neuropsychological assessment results. For many, such funding programs
limited opportunity for decision-making. In the more open college environment, persons may
be relatively free to make career decisions regardless of assessment results or funding
requirements. Consequently, I have counseled and supported persons whose career decisions
were approved and funded by an external agency as well as those whose career decisions
have not been approved.

My clients, funded and not funded, often made career decisions and set goals that I
and other professionals did not consider feasible or realistic. Focusing on deficits, much of
the research literature on brain injury has viewed such decisions as forms of psychogenic or
organic denial (Armstrong, 1991; Stambrook et al., 1990). This clinical standpoint
contributed to the sense of frustration and of failure that I experienced when students failed
to achieve their goals. I have always felt, however, that the deeper significance of these
career decisions was obscured by a clinical standpoint. I have always been intensely
interested in the meaning of my clients’ career decisions and have long believed that
elucidation of the subjective meaning of these decisions would lead to a more empathic understanding and more thoughtful counselling.

From the literature (e.g., Crisp, 1993; Lewington, 1997; Nochi, 1998, 2000) and my professional experience, I assume that many women with ABI are indeed able to articulate subjective meanings and experiences of career decision-making in a coherent, insightful manner. Recent qualitative research suggested to me that the career decisions of women with ABI may serve to maintain identity (Nochi, 1998). Thus, my presuppositions are that the career decisions of women with ABI have a significant meaning that is not apparent to helping professionals, and that this meaning is inextricably linked with identity. I further assume that career decision-making for women with ABI is imbued with emotions and loss and greatly influenced and constrained by the social and societal contexts (Patton & McMahon, 1999; Young et al., 1996).

In my professional experience, funding programs for persons with ABI, focused on return to work, do not support the notion that women with ABI continue to have a career. Many of my clients exited such funding programs with the belief that they had no career options open to them. Thus, I expect that women with ABI will describe a more constrained and limited opportunity for career decision-making following participation in funding programs and that such participation serves to mediate the experience of disability. I further expect that women’s experience of career decision-making prior to ABI will contribute in significant ways to current meanings and experiences.

On a personal level, I have experienced physical injury from a motor vehicle accident in mid-career. This injury has constrained and influenced many subsequent career decisions. For example, although I returned to my pre-injury work, I found it physically difficult to
continue in this work and sought less physically demanding work. While I felt fortunate to easily find alternate satisfying professional work, I also experienced a sense of loss and sadness. I recognize though that I have also gained a greater compassion and humanity through this experience that facilitates my work as counsellor. From my personal and professional experiences and the literature on brain injury, I assume that brain injury will have a significant and profound impact on career decision-making, serving to constrain career decisions and to evoke a sense of loss.

The following presuppositions further reflect my personal and clinical experiences and a review of the brain injury literature. I expect that ABI is a significant influence in the career decision-making of the women that serves to constrain decisions in ways that are not usually spoken in everyday life. I also assume that the experience and meaning of career decisions is inextricably linked with the experience and meaning of ABI for each woman. I expect that the women’s experience includes loss and emotions of sadness and that these emotions can overshadow positive emotions. However, my clients in group counselling have shared that ABI has also been a freeing force in their lives enabling a more authentic life. Thus, I assume that some women may report mixed emotions and experiences. Nonetheless, I assume that stories of career decision-making will primarily reflect emotions and experiences associated with loss.

**Research Procedure**

This study is being conducted as part of a larger three-part investigation that aims to address the need that exists for a new developmental and self-sustaining counselling paradigm, which better reflects the radical and ongoing external changes that workers are facing. The principal investigators for the larger study are Dr. Borgen and Dr. Amundson,
professors in Counselling Psychology at the University of British Columbia (UBC). The larger study received approval from the UBC Behavioral Research Ethics Board in 2003.

My dissertation research is being conducted within the context of a larger investigation of how people make career decisions in their lives. The need for this investigation is based on the observation that people may be making career decisions in very different ways in today’s rapidly changing world than people did in the past. The larger investigation researches the career decision-making experiences of 60 persons in British Columbia and Australia. Eight of the participants in this investigation are women with ABI. Following a similar format as the larger investigation, my dissertation research is being conducted as a separate study. It is hoped that the results from this study will at some later time be compared with the data from the larger investigation.

Participants

Phenomenological research seeks to achieve a perspectival understanding of a phenomenon (Osborne, 1990) from the viewpoint of participants who have experienced and can illuminate the phenomenon. Although participants are selected for their ability to articulate the phenomenon of interest (Colaizzi, 1978), this does not necessarily mean a verbal person. Rather, it means participants who can provide “naive descriptions of the actuality of experience as it is lived” (Osborne, 1994, p. 171).

In phenomenological research, the sample size is not predetermined. The researcher needs as many participants as required to illuminate the phenomenon (Wertz, as cited in Osborne, 1990) which is generally estimated at six to eight participants (Colaizzi, 1978; Morse & Field, 1995). The 8 participants who participated in this study provided a rich description of their experiences of career decision-making and were thought to have
adequately illuminated the phenomenon. Table 1 below provides a descriptive summary of the 8 participants for this study.

**Table 1: Descriptive Summary of the Participants**

<table>
<thead>
<tr>
<th>Name/Age</th>
<th>Age/Injury</th>
<th>Careers at Injury</th>
<th>Careers at Interview</th>
<th>Education at Injury/Interview</th>
<th>Status at Injury/Interview</th>
<th>Family Income</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sarah/42</td>
<td>35</td>
<td>Bank services</td>
<td>Student, Volunteer</td>
<td>High School &amp; Esthetics program/College preparatory program</td>
<td>Single/Single</td>
<td>10,000</td>
</tr>
<tr>
<td>Lucy/43</td>
<td>40</td>
<td>Technician internet services</td>
<td>Writer, Musician</td>
<td>High school/High school</td>
<td>Partner/Single</td>
<td>31,000</td>
</tr>
<tr>
<td>Ramona/43</td>
<td>39</td>
<td>Legal assistant</td>
<td>Legal assistant, Stepmother</td>
<td>College diploma/College diploma</td>
<td>Single/Partner</td>
<td>declined</td>
</tr>
<tr>
<td>Jane/48</td>
<td>38</td>
<td>Single mother, Advocate, Secretarial</td>
<td>Mother, Student</td>
<td>High school/2nd year of College diploma</td>
<td>Single/Single &amp; Committed</td>
<td>declined</td>
</tr>
<tr>
<td>Rylan/45</td>
<td>39</td>
<td>Mother, Hairdresser, Sales, Volunteer</td>
<td>Mother, Hairdresser*</td>
<td>Grade 7 &amp; Hairdressing/Grade 7 &amp; Hairdressing</td>
<td>Married/Divorced &amp; Partner</td>
<td>10,000</td>
</tr>
<tr>
<td>Katherine/61</td>
<td>54</td>
<td>Manager, Volunteer, Mother</td>
<td>Manager,* Mother</td>
<td>Masters/ Masters</td>
<td>Married/Married</td>
<td>100,000</td>
</tr>
<tr>
<td>Elisabeth/40</td>
<td>36</td>
<td>Hairdresser</td>
<td>Student, Summer Job Language Translator</td>
<td>High school &amp; Hairdressing/3rd year, B. of Social Work</td>
<td>Partner/Partner</td>
<td>14,000</td>
</tr>
<tr>
<td>Sophie/33</td>
<td>24</td>
<td>Victim Services, Model, Server, Volunteer</td>
<td>Mother, Social Worker</td>
<td>Some College courses/Masters of Social Work</td>
<td>Single/Married</td>
<td>75,000</td>
</tr>
</tbody>
</table>

* Pre-injury position
Criteria

Purposeful sampling for information rich cases (Patton, 1990) was used to select the 8 volunteer female participants who had sustained an ABI in mid-career. The criteria of injury in mid-career served to facilitate selection of women who had pre-injury career decision-making experience and could thus provide a perspective which encompassed pre-injury and post-injury career decision-making. One participant, injured at age 24, was considered to have sufficient career decision-making experience prior to brain injury and was included in the study. Recovery following brain injury is protracted; thus participants were at a minimum of 2 years post injury. The participants were living independently in the community; working at the time of injury; and actively participating in the community as student, worker, parent, or volunteer at the time of interview. Individuals who self-identified as sustaining an ABI, actively participating in any of the above community contexts, and as having made career decisions were considered to have experienced the phenomenon of career decision-making.

The participant’s ability to articulate the experience and meaning of career decision-making is critical to phenomenological research (Colaizzi, 1978; Osborne 1990). Two pilot interviews conducted for this study demonstrated that women with ABI have the ability to reflect on and to articulate their conscious experience of career decision-making with insight. The pilot interviews confirmed that women with ABI can illuminate their experience and the meaning of career decision-making.

Finally, participant criteria and the focus on personal meaning, integrate a positive psychology approach within this study. Positive psychology, encompassing the study of personal meaning, positive individual traits, and positive experiences, broadens the focus of psychology and rehabilitation beyond the prevalent problem and disease models of human
functioning (Duckworth, Steen, & Seligman, 2005; Dunn & Dougherty, 2005; Elliot, 2002; Seligman & Csikszentmihalyi, 2000). Studies have consistently found that quality of life for persons with brain injury is associated with the level of perceived available support, community integration, and the ability to resume employment or studies (Kalpakjian et al., 2004; Kreuter et al., 1998; O’Neill et al., 1998; Steadman-Pare et al., 2001; Vickery et al., 2005). Thus, the women in this study may represent a group with a better quality of life than women who are not similarly involved. It is anticipated that the participants in this study are well placed to offer a window into the personal strengths and qualities which they bring to the career decision-making endeavour.

**Recruitment**

This research was subject to the University’s ethical review procedures. After receiving ethical approval, potential participants were recruited through purposive sampling in a variety of ways including the distribution of recruitment letters addressed to colleagues (Appendix A), poster advertisements (Appendix B), and recruitment letters addressed to potential participants (Appendix C) at the Canadian Association of Rehabilitation Professionals Convention; list serves of the BC Brain Injury Association, the BC Educational Association of Disabled Students, and of BC Postsecondary Disability Professionals; to vocational rehabilitation professionals at the Workers Compensation Board and GF Strong Rehabilitation Services; and to individual psychologists, lawyers, advocates, and other professionals providing services to adults with brain injuries. Professional colleagues were asked to forward in confidence the recruitment letter and poster to women, who in their estimation met the criteria outlined in the poster and would be able to articulate their experience. I was not given names or any other information about the recipients of the
recruitment letters or poster. The recruitment letters and poster indicated that women interested in participating should contact me directly by telephone or e-mail.

Informal telephone interviews were conducted at point of initial contact to provide information about the study and to answer questions from potential participants. Potential participants were asked screening questions, as outlined on the recruitment poster, to determine eligibility for inclusion in the study. Potential participants were also informed about confidentiality and the right to refuse to participate at any time.

Twelve women responded to the recruitment; nine volunteers met the criteria for inclusion and agreed to participate in the study. Arrangements were then made for a first interview in a quiet non-distracting private room at a location and time that was convenient for the participant. It was discovered at the time of first interview that one of the 9 volunteers, by virtue of not being actively involved in the community did not meet the criteria for inclusion in the study.

Data Collection

In phenomenological research, the data are descriptions of experience with the interview as the most common means of gathering data (Colaizzi, 1978; Kvale, 1996; Osborne, 1994; van Manen, 1990). Phenomenological interviews are a useful means for eliciting first person accounts of phenomena, such as the experience of career decision-making, which are complex in structure and extensive in scope (Wertz, 2005). The goal of the phenomenological interview is to get as close to the prereflective experience of the person by obtaining rich concrete descriptions of phenomena of interest (Osborne, 1994). Therefore, the phenomenological interview process is minimally intrusive in order to allow the person’s experience to present itself as spontaneously as possible.
In this study open-ended, minimally structured interviews were employed to elicit richly detailed descriptions of career decision-making as understood and experienced by the participants. I conducted four first and four validation interviews and, to prevent future potential dual relationships, four first and four validation interviews were conducted by a counsellor colleague experienced with phenomenological interviews. The interviewers, adhered to the tenets of the phenomenological interview (Kvale, 1996), and allowed the participants’ descriptions of their experiences and meanings to unfold through active listening without prejudice, use of rapport, minimal open-ended questions and probes, and with awareness of presuppositions. To get as close to the prereflective experience of the participants as possible, the interviewers emphasized that participants were to recount their experience, including feelings, as they are aware of it and not to worry about what they thought the interviewer might want to hear (Osborne, 1994). The interview guide (Appendix D) served to orient the interview process and to ensure that participants fully described their experiences of career decision-making. To be fully present to the participants during the interview, the interviewers did not take any field notes during the interviews but rather jotted down thoughts, impressions, and reactions after each interview. The interviewers listened with empathic understanding (Osborne, 1990) and were sensitive to the participants’ emotional reactions taking care not to create undue distress. One participant in the study experienced some distress which I contained in debriefing. Counselling contact information was offered to all participants.

**Interview Procedures**

The first interview began with a review of the purpose of the study and review of the consent form (Appendix E). Each participant was invited to read the consent form and ask
any questions she may have about the study prior to signing two copies of the consent form. When desired, the interviewer read the consent form aloud while the participant followed on her own copy. One copy of the consent was given to each participant while the interviewer retained one copy. A print copy of the orienting statement (Appendix D) was given to each participant and read to the participant so as to assist concentration and memory which may be impaired in brain injury (Brown & Levin, 2001). The orienting statement includes a statement of the purpose of research, the definition of career used in this study, and the main research question. The purpose of the orienting statement was to sensitize and focus the participant to the expanded definition of career used in this study and to the main interview question: What is your experience of making career decisions?

The audiotape was turned on at the point at which each participant was invited to tell the story of her career decision-making. The participant was permitted to tell her story spontaneously; minimal questions were asked only as needed to obtain a fuller, richer description of the experience. The story segment of the interview served an additional purpose; to help the participant recall and contextualize career decision-making events which the participant considered most significant in her life.

Once each participant had told her story, she was asked to mark key career decision points on a lifeline. The purpose of the lifeline was to encourage participant self-reflection in order to facilitate a deeper exploration of the experience and meaning of career decision-making events which the participant considered most significant in her life. The lifeline exercise has been used in research (Moran, 2003) and in career counselling (Heppner, O'Brien, Hinkelman, & Humphrey, 1994; Miller & Pugh, 1979). In this study, the participant was asked to represent chronologically on the lifeline at least three key career decision points in her life. The participant was given ample uninterrupted time to complete the lifeline. When
the participant indicated that her lifeline was completed, she was invited to talk about the experience of making each of the key career decisions. Additional questions and probes (Appendix F) were not rigidly followed but rather served as guidelines and utilized only as needed to encourage elaboration of the experience and meaning of each career decision. The duration of the first interviews, ranging from 1 ¾ to 2 ½ hours in length, was flexible; interviews continued until the participant felt that she had fully recounted her experience of career decision-making. The audiotape was turned off at the end of the interview, at which time, the participant was asked to complete a demographics form (Appendix E) in accordance with the larger investigation. These first interviews were transcribed verbatim by a transcriptionist experienced in the transcription of qualitative interviews.

Validation interviews were conducted after data had been subject to thematic analysis; this was approximately 12 months after the first interview. Each participant was first contacted by phone to explain the purpose and process of the validation interviews; to arrange for mailing or e-mailing of the themes and detailed biographical profile; and to schedule the validation interviews which were conducted in person, by telephone, or over e-mail as preferred by the participants. The purpose of the validation interviews was for the participants to review and confirm the biographic profile that the researcher had written based on the interview account and to validate the researcher’s description of individual themes developed in within person analysis (see Appendix H). Each participant was asked to examine the individual themes and to determine if they resonated with and accurately described her own experience of career decision-making. Each participant was also asked to confirm in writing her choice of a pseudonym which she wished the researcher to use in the write up of the results (Appendix I).
Validation interviews occurred after each participant had fully reviewed the biographical profiles and individual themes. The eight participants completed validation interviews as follows: one woman completed the interview in person, three women completed the interview by phone, and four completed the interview by e-mail correspondence. The eight participants also mailed or e-mailed any changes they wished the researcher to make. The participants did not request any changes to the individual themes; all indicated that the thematic descriptions accurately portrayed their experiences of career decision-making. Several participants requested changes, involving timing or sequence of events such as surgeries and divorce, to the biographical profiles. All changes requested were integrated in the detailed biographical profiles which served as the basis for the briefer profiles presented in chapter four.

**Data Analysis**

There are no definitive procedures with regards to phenomenological data analysis (Colaizzi, 1978; McLeod, 2001; Osborne, 1990; van Manen, 1990). McLeod argues that doing good qualitative research is not a matter of following a set of procedures but rather requires full engagement in the topic. Indeed, McLeod identifies over reliance on procedural manuals as a problem of contemporary phenomenological research. The purpose of the data analysis was to derive from the data a description of the essential structures, in terms of common themes, of the participants' experience of career decision-making (Polkinghorne, 1989). Polkinghorne identifies three common steps in data analysis: division of the transcribed interview into units; transforming these units into meanings expressed in psychological and phenomenological terms; and synthesizing the transformed units, by intuitive grasping, into essential meaning structures.
Colaizzi (1978) enjoins other researchers to view his procedural guidelines flexibly and freely and to modify them as appropriate to the purpose of the research. Accordingly, Colaizzi’s analytic procedures were adapted in order to faithfully elucidate the meaning of career decision-making as it existed in each participant’s experiences. Adaptations were prompted by a consideration of the considerable degree of heterogeneity in brain injury across individuals (Millis et al., 2001) and the perspective that women are not univocal (Richardson, 1993). In this study, a within persons analysis (Osborne, 1990, 1994) of each transcript culminated in an idiographic psychological structure (Wertz, 2005), an individual thematic analysis, of career decision-making that was validated by the respective participant.

In phenomenology, the researcher establishes a posteriori an emphatic generalizability which means that an interpreted structure obtained from one person should be found in the experience of other persons. Following validation, the individual themes were then compared, in across persons analysis, to identify and delineate commonalities in experience and meaning across persons. A sameness of meaning may exist even though there may not be a sameness of fact or context (Osborne, 1994) and structures may be general though not true in all cases. Wertz reminds us that typical variations, those that are general but not true for all, are most significant in psychology.

Although the procedure of formulating meanings and themes is presented in the next section in a sequential manner, it was a recursive but systematic process requiring a prolonged immersion in the text, questioning, and an open attitude (Colaizzi, 1978; McLeod, 2001; van Manen, 1990) and movement from the whole to part and from part to part (Wertz 2005). Ahern (1999) describes bracketing and reflexivity as “fruit from the same tree” (p. 410) which ensures that the researcher takes care to maintain the integrity of lived experience
from the participants' point of view. Osborne (1994) describes bracketing as a rigorous self-reflection on the part of the researcher in which the subjectivity of the participant is not bracketed but seen as an indication of what the participant was present to. Throughout data collection and analysis, I engaged in a continuous process of self-reflection, journaling to increase awareness of personal biases, so as to ensure that my preconceived notions or expectations did not guide the analysis (Morse & Field, 1995; van Manen, 1990).

The phenomenological approach is holistic; listening to the taped interview and reading the entire interview transcription facilitates a global sense of the data that is important for later determining how the meaning units are constituted (Giorgi, 1997). Accordingly, I first listened to all audio taped interviews shortly after the interview and before sending the audiotapes to a transcriptionist. This immersion and careful listening to the nuances of speech and language, without reading the text, sensitized me in a creative way to the lived experience of each participant. Then, once an audio taped interview was transcribed, I simultaneously read the transcript and listened to the audio taped interview to verify transcript accuracy and to further immerse myself in the data. At this point in the data analysis, I edited the computer transcripts as required to maintain accuracy with the audio taped interview.

**Thematic Analysis**

Following the analytic guidelines described by Colaizzi (1978), I began thematic analysis with a reflective and intensive review of each participant transcript, rereading the whole as necessary to get a feel for all the descriptions as a first step of "mining" (van Manen, 1990) meaning. Once I had a global sense of each participant account, I reread each transcript as necessary to extract significant statements that constituted meaning units
(Giorgi, 1997) from each account that seemed particularly essential or relevant to the participant’s experience of career decision-making. Using ATLAS.ti, I extracted these significant statements by creating a new quotation. I then wrote a detailed interview summary based on the interview transcript. This summary served as the basis of the detailed biographical profiles which were later validated by the participants.

To ensure accuracy in the procedure of identifying significant meaning statements, I asked the second interviewer to highlight statements relevant to the participant’s experience of career decision-making. A comparison of the transcripts revealed few differences overall. Importantly, however, through the comparison and discussion, we gained awareness that we had presumed that rehabilitation was not relevant to the study whereas the participant’s description indicated that the rehabilitation experience was inextricably linked with her experience of career decision-making. This awareness facilitated bracketing of preconceptions related to the relevance of rehabilitation experiences in the women’s accounts.

Next, I reread the entire interview transcript prior to articulating the meanings for each significant statement. Formulating meanings requires creative insight while maintaining a connection to the language and concrete experiences of the participants. Colaizzi (1979) emphasizes that this step represents a “precarious leap because while moving beyond the protocol statements, the meanings he arrives at and formulates should never server all connection with the original protocols” (p.59). Thus, the challenge is to simultaneously “go beyond what is given in the original data and at the same time, stay with it” (p. 59). Accordingly, I stayed close to the participant’s words in formulating a meaning for each
significant statement. Using the ATLAS.ti coding function, I linked the formulated meaning to the statement.

I then organized the significant statements with similar formulated meanings within an interview transcript into a cluster of individual themes. This process to create, to interrogate, and to validate the individual themes against the interview transcript involved a continual movement from whole transcript to part and from part to whole. Using the ATLAS.ti code family function, I clustered related significant statements together with formulated meanings within individual themes. To determine the accuracy of the formulated meanings for the significant statements and the accuracy of the clusters of individual themes, I asked a colleague to check whether the formulated meanings captured the women’s meanings and to organize significant statements into clusters of individual themes for two interview transcripts. There were few statements for which my colleague thought formulated meanings required rewording. Discussion following comparison of the clustered themes resulted in a few changes in organization of formulated meanings to emphasize within individual themes aspects of self-determination in career decision-making: the experience of being discounted by others; and the opportunity inherent in a return to a more creative self after brain injury.

I then completed a within persons analysis to identify individual themes (Wertz, 2005) for the remaining interview transcripts and prepared these for participant validation. Each of the eight women indicated that her respective individual themes accurately described her experience of career decision-making. Once the participants validated the individual themes, I then organized the individual themes, with aggregated meanings and original
statements, into phenomenological themes across participant accounts (Colaizzi, 1978; Osborne, 1990).

Although procedurally described in an inductive manner, the synthesis of individual and common themes was an intuitive process (McLeod, 2001) which required an insightful interpretation of the structure of the meaning of the participants' lived experiences. I frequently returned to the original interview transcripts to validate the individual and common themes and to ensure that the themes stayed close to the concrete experience described by the participants. I engaged in a careful process of examining the themes to ensure they did not imply anything not contained in the interview data and modified and refined the themes as needed. Once I was satisfied that the six common themes accurately represented the experience and meaning of career decision-making for the group, I wrote a thematic analysis of the experience staying as close as possible to the participants' accounts of lived experience (Osborne, 1990).

As a final validation step, I asked a counselling psychologist, who has phenomenological research experience and has long-term experience counselling persons who have brain injury, to review the thematic analysis for the coherence and non-redundancy of the themes and for the extent to which the themes resonated with her understandings (Osborne, 1990). The feedback from this review was discussed with the reviewer, checked against the original transcripts, and changes in understanding were incorporated into the thematic analysis. This final thematic presentation of the findings aimed to illuminate the shared meanings of the lived experience of career decision-making for a group of women with ABI.
Criteria for Trustworthiness of the Study

Multiple standards of quality, variously identified as trustworthiness, validity, credibility, and rigor have been applied to qualitative research (Morrow, 2005). While there is a general acknowledgment that the traditional frameworks of validity and reliability as applied in quantitative research are inappropriate for qualitative inquiry (e.g., Colaizzi, 1978; Osborne, 1990; Stiles, 1993), there is not a singular framework for the evaluation of qualitative inquiry. Within the discipline of counselling psychology, there is increasing dissatisfaction with the use of standards, such as Lincoln and Guba’s (1985) framework for evaluating trustworthiness, that mirror positivist traditions of validity and reliability (McLeod, 2001; Morrow, 2005; Smith, 2003). Distinguishing procedural trustworthiness from the trustworthiness of interpretation, Stiles (1993) suggests coherence, triangulation, testimonial validity, and reflexive validity for evaluating the trustworthiness of the interpretation. Morrow suggests alternate criteria for evaluating trustworthiness based on concerns that span qualitative inquiry including subjectivity and reflexivity, adequacy of data, and adequacy of interpretation.

In phenomenological research specifically, trustworthiness has been viewed from a general perspective requiring qualities of persuasiveness (Polkinghorne, 1989) and coherence (Osborne, 1990, 1994) and fidelity to the participants’ accounts of experience (Colaizzi, 1978). The goal of phenomenological research is elucidation of meaning and understanding of human existence from a participant’s perspective. Thus, respectful listening and description replace observation and measurement, and openness to participants replaces theory and measurement. Osborne considers the juridical process of presenting coherent and convincing arguments as the most crucial criterion. Similarly, Polkinghorne considers a
conclusion that inspires confidence because the argument in support of it has been persuasive as the most important criterion. In this study, trustworthiness depends on the extent to which the shared themes have illuminated for the reader the shared experience and meaning in career decision-making for the group of women with ABI who participated in the research. Trustworthiness of method and findings in this study was addressed by incorporating strategies that are specific to phenomenological research (Colaizzi, 1978; Osborne, 1990, 1994; Wertz, 2005) and that are general for qualitative research (Morrow, 2005; Stiles, 1993).

First, through bracketing, identifying presuppositions at the outset and throughout the research, I have provided the reader with an opportunity to understand my orientation and how I arrived at my interpretations (Osborne, 1990). A personal journal in which I recorded my thoughts and feelings enabled a continued awareness of assumptions, assisted efforts to examine and keep assumptions at bay, and assisted me to maintain fidelity (Colaizzi, 1978) to the women’s experiences as they were given to me. Peer review, discussing the emergent research findings with colleagues, similarly increased reflexivity of the researcher (Morrow, 2005) and facilitated bracketing. In this study, peer review occurred at three junctures in this study: during the selection of significant meaning statements; during the formulation of meanings and clustering of meanings into individual themes; and during the development of shared common themes. For example, I became aware that the predominant research and clinical focus on negative aspects of brain injury and my personal reactions to aspects of loss in the interviews had overly sensitized me to negative aspects such that I was not initially open to the full range of the women’s experiences. Moreover, through a more open attitude I determined that the experiences the participants viewed as intrinsic to the experience of
career decision-making, such as experience of rehabilitation, were much broader in scope than I had originally presumed. Furthermore, I became aware that I had not fully appreciated the women's descriptions of determination in career. Stiles (1993) refers to such evidence of changes in the researchers' fore understanding as indications of reflexive validity.

Second, the qualitative research literature reflects differing perspectives on the usefulness and purpose of participant checking. Sparkes (as cited in Morrow, 2005) has suggested participant checking as an opportunity for elaboration on emerging findings rather than as a validation of the interpretation. Frank (2005) does not advocate participant checking because the original experience recounted in the interview no longer exists. Stiles (1993), on the other hand, describes participant checking as a straightforward check on the accuracy of an interpretation which provides a "testimonial validity" (p. 610). Differing perspectives are similarly found in the phenomenological research literature (Colaizzi, 1978; Giorgi, 2004; Osborne, 1990). Osborne suggests that participant checking is suggestive rather than definitive because participants may reject interpretations for reasons other than incongruence with their experience. I obtained participant checks for the individual themes (Wertz, 2005) and biographical profiles as a check on the accuracy of my interpretations (Stiles, 1993) and on their goodness of fit (Osborne, 1990) with the participants' own accounts of their experience. In this study, participant reviews served to inform a trustworthy description of the experience and meaning of career decision-making.

Third, I have carefully described the procedures of data collection and analysis so that the reader may further understand how I arrived at my findings (Osborne, 1990). In making explicit the systematic framework and details through which the findings were derived, I have provided evidence of the dependability of the research (Lincoln & Guba, 1985). I have
maintained an audit trail including analytic memos, reflective memos about the research, and files documenting the stages of analysis of each transcript. Thus, other researchers, who examine the audit trail, may gain a more complete perspective on the integrity and adequacy of the interpretation (Morrow, 2005).

Fourth, the purpose of phenomenological research is not to generalize to other groups but rather to attain empathic generalizability (Giorgi, 1997). Osborne (1990) suggests that the extent to which the structure resonates with other people not in the study is the final check on trustworthiness. Thus, phenomenological research calls for a rich, vivid description of experience that brings understanding to an experience that the reader may previously have taken for granted (van Manen, 1990). Such a description may provide evidence of coherence, the extent to which the thematic presentation of this study makes sense to the reader and hangs together (Stiles, 1993). The inclusion of participant quotations, providing the reader with systematic evidence that assertions made are warranted (Stiles, 1993) and with experience-near description (Geertz, as cited in Maxwell, 1992), creates a powerful thematic presentation. Further evidence of coherence comes from the study’s ability to add to the reader’s understanding. The reviewer of the thematic presentation for this study, stated that the stories and themes rang true to her experience of counselling people with brain injury. Unfamiliar to the reviewer was the thematic description that portrayed a shared experience of the sense of purpose and altered perspective. This common theme posed interesting questions regarding the development of this perspective and whether this might be nurtured in counselling.

Finally, attention to ethical considerations contributed to the trustworthiness of this study. The construct of trustworthiness “captures the recognition that participants can be
vulnerable and that researchers carry a responsibility to promote their welfare and guard against harm" (Haverkamp, 2005, p. 146). Kvale (1996) asserts that the welfare of participants must be the primary concern in the production of qualitative data.

Several steps were taken to ensure that this study was conducted in an ethical manner that protected the rights of the participants. Among these were an ongoing process of informed consent; awareness of differences between qualitative research and counselling interviews (Kvale, 1996); use of a second interviewer to avoid any possibility of dual relationship; removal of identifying information from transcripts; participant checking of individual biographical profiles and themes; and the use of a pseudonym in the final write-up. I provided counselling contact information to all the women. In the single instance of distress during the interviews, I used counselling skills to manage the woman’s distress but did not enter into a counselling relationship with the woman. Importantly, this woman was receiving support from a rehabilitation counsellor and thus had access to counselling.

Summary

This phenomenological study aimed to elicit descriptions of the actuality of the lived experience of career decision-making as it was lived by 8 women with ABI. While recognizing the intersubjective nature of meaning, this study attempted to remain as close as possible to the women’s actual descriptions, to allow the data to speak for themselves (Osborne, 1994), in order to give the woman a voice and a presence in the research. In illuminating the lived experience and meaning of career decision-making for these women, the study aimed for an empathic generalizability which would resonate with the experiences of others who have experienced the phenomenon.
CHAPTER 4: RESULTS

This chapter includes: a) brief career and injury profiles of the eight participants; and b) descriptions of the six common themes and five sub-themes that were identified in the data analysis.

The Participants

The eight women who comprised the participant group for this study were British Columbia (BC) residents at time of interview and time of injury. Six participants lived in the Lower Mainland, one participant lived in the Fraser Valley, and one participant lived in the BC interior. Seven of the women identified as heterosexual and one as lesbian. It is noteworthy that six of the women had recently made or were considering a career change at the time of injury. After injury, although the specific plans were altered, four of the women continued with plans for career change. For all women, expected personal earnings decreased significantly after injury due to reduction to part-time work or loss of work.

Sarah, 42, Age at Brain Injury 35

Sarah’s strong work ethic and beliefs, that life was about working and maintaining independence, were instilled by her hardworking immigrant German family. Regard for her emotions, preferences, or personal circumstances did not come into play. Prior to brain surgery, Sarah held a number of front line service positions such as bank teller, customer service representative, cocktail waitress, and front desk hotel clerk. She intensely disliked working with the public and the routine, scripted nature of the work. She continued in these positions, however, because they were available; because as a single woman she had to
support herself; and because her work ethic did not permit any other option. Heavy drinking, which resulted in the beginning of epileptic seizures, was a factor in demotions and lay offs. At age 30 she became sober, completed an esthetics program, and went on to self-employment in the field. She loved the visual creativity in the work but because of the low income, she returned to banking.

In 1996 she was diagnosed with a brain tumour and had brain surgery. Due to cognitive changes she was unable to return to her position in bank member services. Due to her continued strong work ethic, not working was not an option. From ages 35-38, she did volunteer work in a number of settings. When she successfully completed a volunteer work-like position, she knew she was ready to return to work. With the assistance of employment services for persons with disabilities, she obtained a data entry project position. Here she learned that despite cognitive challenges and “no head for math,” she retained an eye for detail and was regarded as a good employee. When the project ended, she went on to clerical work for a busy police department. It was here that she experienced an emotional collapse and became fully aware of her workplace needs. She learned that she required a respectful office environment with one supportive, understanding superior; that she could no longer tolerate dealing with the public; and that her performance suffered when others were critical. Although she maintains a strong work ethic, she will no longer do work that she despises or that is too hard on her.

Sarah credits the brain tumour and surgery with some positive changes in her life. After brain surgery her passion for visual creativity intensified and she returned to the creative activities that she enjoyed. She had a good eye for antiques and developed a real love for restoring antique furniture and decorating in the Victorian period. The brain tumour
and surgery brought her to her lowest depths but also provided her with the opportunity to examine her life and deal with painful issues from her childhood. While becoming reclusive through her experience of dependence and of cognitive and physical challenges, she has also developed compassion and understanding for others. She has become less dogmatic and has developed the ability to perceive shades of gray in situations. Sarah has also developed a higher sense of taking true responsibility for the outcome or consequences of her actions. This is at the same time scary and freeing. Healing has taken a long time. Initially she felt awful but she realizes that although it is tough work, good can and does come out of the injury if one believes it to be so.

Sarah found the courage to return to school and is making career decisions based on her passions and life purpose. Career decision-making is considerably slower and very difficult at times. She is now more methodical and cautious which is of great benefit. Sarah has come to realize the importance of doing "something," if at all possible, whether it be volunteering, upgrading, or attending school, to counteract the depression that is a side effect of the brain surgery. Through volunteering and attending school, she has slowly learned to not be ashamed or feel guilt about her limitations.

Although spirituality has always been a part of her life, Sarah has become more spiritual and her bible study has deepened considerably since her surgery and death of her mother. Her private dream is of becoming a motivational speaker or assisting persons in need including persons whose injuries or illness have resulted in lifestyle change.

**Lucy, 43, Age at Brain Injury 40**

Lucy had wanted to attend art school after high school but coming from a poor family in a northern two company town, she applied for work as a telephone operator. Soon she
embarked on a company career aimed at advancement and earning more money. She describes her decision, to stay on at the company, as selling out and forgetting her creative self.

In her early 20s Lucy was married and enjoyed a fairly affluent northern lifestyle during a time of economic recession in the 80s. Turned down for a management position, she was compensated with on-loan assignments that provided exposure to diverse work opportunities and people within the company. She soon rose to a supervisor position.

At age 25, in the space of a few months, she divorced her husband, came out as a lesbian, and transferred to the lower mainland. This transfer, though a way to get a fresh start, was a difficult decision because she was stepping backwards to an operator position. In the late 80s, Lucy, wanting a position with the highest pay rate, chose the cable slicer position. Due to an equal opportunity policy for women, she was told that she could move into this position if she could pass the engineering math and physical tests. Athletic, confident in her learning ability, and viewing herself as someone who skipped steps, she prepared for and passed the tests. As the only woman in the cable slicer position within the company, she entered a male dominated area where women were hugely resented.

Her 4 years as cable slicer were overwhelming. During this time in 1991, she became sober. Sobriety, however, created a greater sense of alienation at work because she no longer participated in the after work bonding, drinking with the men. She later transferred to a position in cable pressure and was much happier there. The men were more accepting of women; she was no longer the only woman; and the work although just as complex was much easier for her. In 1997, seeking more challenge, Lucy made the leap into network, an emerging conceptual technology. This new position required she give up the almost absolute
freedom of her own truck to an office position with close supervision, something she had long resisted.

In 2002 Lucy’s plan to move into an emerging area, voice over internet technology, was stopped in its tracks when she was struck by a car while riding her bike. She realized, at six weeks post-injury, that she was having difficulty telling time; was forgetting to care for her cats; was no longer caring for herself; and was sleeping all the time. She was becoming really afraid that something was wrong but did not understand what was happening to her. She was first told that she had a brain injury by an occupational therapist. She still expected to return to her job and was distressed when six months came and went. In May 2003 she received long term disability benefits and her employer called her in to sign some documents. She was asked to hand in her ID; her phone was disconnected; and her job was posted. She was rattled by the realization that she would not be returning to her position and that they did not want her to return.

Learning, which before came so easily, now requires much repetition. Still Lucy is encouraged that she is healing. She has become aware that she would like to reclaim her creative self through writing and music careers, both as creative, joyful, and emotionally fulfilling endeavours. She views her brain injury as a gift which provided the impetus for the combination of creative and technical aspects in her future career. She is no longer motivated by the prospect of more money or the need to prove her abilities to others. She feels that she is more real to herself.

Lucy has taken charge of her own rehabilitation and training in preparation for her next career. This process, although it requires more repetition and fewer steps skipped than previously, is similar to her pre-injury career decision-making process. She selects a career
direction and engages in self study, learning both the practical and technical aspects of her subject. For example, she is teaching herself to play guitar and also learning how guitars produce sound. Whereas, she had great confidence in her abilities before the injury, she is much more tentative now. Feeling the need after brain injury to provide evidence of competence, she will not tell professional writers, for example, that she has embarked on a writing career.

**Ramona, 43, Age at Brain Injury 39**

As a young woman, Ramona was strongly discouraged from becoming a police officer by her father. At 19, she completed a college diploma in marketing and then managed a shoe store in her home town. At 22, she moved to the city in search of fun and a good paying job. She fell into law when she was told that legal assistants made good money. Trained on the job, she has over 20 years of experience as a legal assistant. She has worked for several firms, following one lawyer for 12 years and working 12 hour days over 2 years at a large busy firm. Although she had a reputation as an efficient multi-tasker who was very good at her work, she was fired from her last position through the actions of a colleague.

In December 2000 at age 39, soon after starting work with a smaller firm, Ramona was considering studying for an accounting degree, when she underwent surgery for a ruptured aneurysm. An angiogram also revealed a second small aneurysm too small to be clamped; Ramona experienced fear on a daily basis during the year this aneurysm was monitored. She underwent a craniotomy/clipping of the unruptured aneurysm in January 2002. A few weeks after this second surgery, Ramona began to behave strangely, developed major headaches, and then began to slide into unconsciousness. She had developed a subdural hemorrhage causing damage to her brain. The third brain surgery in March 2002
was a particularly frightening time. Because the surgery was performed under a “quasi” local anesthetic, Ramona vividly remembers the commotion in the emergency room and the surgeon operating on her. Though the neurosurgeon told Ramona’s family that she might not make it, the surgery was a success. Ramona got better and regained the ability to walk. Ramona describes the third surgery as a rebirth and made a decision to live life to the fullest.

Ramona is aware of some short term memory loss, chronic fatigue, and emotional changes following her surgeries. She has “cloudy days” when she requires a time out from all home and work responsibilities. She is more assertive, more emotional, and unable to sit still. She believes a compulsion to organize may serve to regain the sense of control she lost during the year and a half she was too ill to work.

Ramona received long term disability benefits and the services of a disability manager during her gradual return to work. Her employers, wanting her to return to full time work, put her under too much pressure and treated her like a child. The disability manager confirmed that this was not right environment for Ramona and also referred Ramona to a psychologist who treated her for post traumatic stress disorder.

Ramona quit her position to contract for a lawyer on a flexible part-time basis. As a single woman, she was taking a considerable risk because she was her sole support and did not know whether she would be successful as a contractor. This lawyer proved a sensitive employer whom she credits with mentoring her and getting her back to full legal assistant responsibilities. As her own boss, Ramona enjoys the flexibility to choose her contracts and to adjust her work hours as needed to care for herself. She works a major portion of her hours for a firm with a relaxed and respectful environment where she is appreciated and valued. She also does bookkeeping one day a week with a friend and occasional catering with
another friend. Ramona had already waived her right to partial long term disability benefits when she was told that she had also suffered a minor stroke. Ramona now realizes that she will never feel up to working a full week and that her health issues over the past 5 years have been incredibly serious.

At 40, Ramona took a second risk. She moved in with her partner and became a full time stepmother to a 12 year old boy with Attention Deficit and Hyperactivity Disorder. Due to her partner’s work, she is often the sole caregiver for this boy and his brother, who lives part-time with them. She did not know whether she could handle parenting a child with behavior problems and although it has been a struggle, things are pretty good now. Ramona is at a place in life where she wishes she had been 20 years ago: with a family and a job that she loves, and feeling secure in herself. Things have turned out well for her. She feels that people are what really matter in life and that paid work is secondary. Consequently, she would like to help others who have not been as lucky as she is. Post-injury, she makes decisions much more easily. She thinks about doing some other work in future when the boys are grown but is not certain about her capacity for new learning. She will not put herself in any high pressure situation nor does she feel that she has anything to prove to anyone. She would like to challenge and enjoy herself in future endeavours.

Jane, 48, Age at Brain Injury 38

Jane worked full time as a secretary until her daughter was born. She then worked as a temp because this gave her the flexibility to care for her daughter and her son, born 4 years after her daughter. When her son was diagnosed with multiple severe disabilities, including autism, and no supports were available, she needed more time to advocate for him, to take
him to appointments and to special schools. She left her temp position, started a small secretarial business in her home and advocating for her son became her primary career.

At 38, when her daughter was 14 and her son was 10, Jane was preparing to once again work outside the home. The Saturday before she was scheduled to start a court reporting program at a community college, she was struck by a car while crossing at a pedestrian crosswalk. She sustained a severe traumatic brain injury, spinal cord injury, and multiple physical injuries; she was not expected to live; if she lived she was not expected to walk or talk again. She developed post traumatic stress disorder, severe depression, memory loss, and experienced identity loss. Formal rehabilitation and litigation took 6 1/2 years; psychological therapy, instrumental in helping Jane to rebuild her identity and to grow as a person, required 4 years. Although Jane was burnt out and housebound, she continued as her son’s advocate and support person throughout the recovery period.

Jane was 44 at the end of this recovery period. She was determined to be normalized, to be part of society again, and to enjoy the freedom of a career. She entered a college preparation program for persons with brain injuries. Encouraged by her success in this program, she began a diploma program for classroom support workers. Her decision to enter the diploma program was based on her childhood experiences caring for an aunt who was wheelchair bound, and her experience as a parent advocate for her son. While volunteering in the field, she learned that the provincial government had cut funding for support workers and that in future most support workers would be self-employed contractors. She experienced significant anxiety and left the program because she had lost the abilities required for self-employment but did not give up her dream to be a woman working in the world.
Jane sought a college program that offered secure employment prospects and would recognize the coursework she had already completed. Exposed to the concept of client-centered care at an orientation for a rehabilitation program, she felt that she had been given a gift; providing client-centered care was the reason she had lived. The foremost influence to enter this program was her own negative experience in rehabilitation, where she felt that she was treated as an Insurance Corporation of British Columbia (ICBC) number rather than as a person. Today she is a part-time student halfway through a college program in a rehabilitation field. She looks forward to a career as a rehabilitation practitioner but plans to work part time because she wants a life that is more than work. She wants time to catch up on all that she has missed since the injury, to enjoy herself, and to continue to grow.

Jane’s son is about to move out of her home and into a care residence. This will leave her with much time to pursue her own desires. Among these are a love of decorative crafts such as toile painting, home decoration, and a partner relationship which is becoming more serious. As a result of her brain injury, Jane has learned how important it is to make room in her life for the people she loves, for hobbies and enjoyment, and to make decisions that will please her in the long term. She has learned that she can plan who she wants to be.

**Rylan, 45, Age at Brain Injury 39**

Rylan was “kicked out” of her home at age 14, and did not complete grade 9. She chose hairdressing because her boyfriend’s mother was a hairdresser and because she could earn while she learned at hairdressing school. She now has 28 years continuous experience as a hairdresser. Rylan left full time hairdressing to start a family. She fell into hairdressing in the home which proved the ideal arrangement for a busy mother with three children. She appreciated the flexibility and proximity to her children and the social interaction with her
clients which enabled her to be a "real mom" to her children. Her financial contribution to
the family provided Rylan with a sense of equality and balance.

Active in Parent Advisory Committees and as a parent member of the high school
Accreditation Committee, Rylan became known as someone who could be counted on to get
things done. Volunteering provided the opportunity to learn new skills without formal
education and employer expectations; recognition in the form of appreciation; and increased
involvement with her children.

When her youngest son was 10 years old, Rylan felt the time was right to seek work
outside the home. Rylan wanted to do something more professional and grown up. She fell
into an outside sales position that was an easy transition and "right up her alley" because it
was social, fun, and continuing to work with teachers and schools. The computer database
was easy to learn and the flexible schedule permitted Rylan to meet her family's needs.
Rylan was in this sales position for only one month when she sustained a traumatic brain
injury.

Six years ago while she was out for a run, Rylan was seriously injured in a hit and run
accident. Her family was told that she probably would not live. She sustained a number of
serious physical injuries and was unable to stand. Rylan has no recollection of the accident
nor did she understand all the subsequent cognitive and emotional changes. She was unable
to read; had significant memory problems; no longer remembered how to do simple things
like pay a bill; had become very confrontational; and started drinking. Rylan viewed
everything as doom or gloom. For example, when a bill arrived to the house and she did not
know how to pay it, she was certain that somebody would come and take the house away.
Consequently, Rylan's emotional reactions were "huge".
In a panic about family finances, Rylan returned to hairdressing in the home as soon as she could stand on crutches and raise her arms, and returned to her outside sales job as soon as physically able. She presented well but was not able to function in the sales position. She could not run the computer database; was having difficulty completing tasks; and was having difficulty staying awake. She was soon fired. She could no longer understand the meetings or the material to be read for the high school accreditation committee. She learned to use buzz words and carry binders to take part in the meetings. She was confrontational when working with other parents. Soon most of her volunteer work disappeared. She still does some volunteer work such as designing and sewing the costumes for her son’s drama club.

A year after the accident, Rylan, feeling unsupported in her marriage, made the decision to leave her marriage. Her husband would not agree to give her any money; consequently, working to support herself and her children became much more important.

Rylan was fired from a second sales job and from a salon hairdressing job. She was very distracted in busy and unpredictable environments and became defensive and argumentative when there were unexpected interactions with clients. Rylan’s internal conflict at taking work time to attend to medical needs was heightened when her employer expressed displeasure.

Rylan still enjoys the creative and social aspects and does well with hairdressing in the home. It is predictable with limited distractions and flexible so she can control her schedule. However, she can only hold her arms up and stand for limited periods of time; therefore, she is not able to earn sufficient income to support herself. Post-injury, Rylan developed a strong interest in home decorating. When she redecorated a client’s home, she
learned that though the redecoration was successful, she cannot earn enough to support herself. Partly due to her financial needs, Rylan’s partner moved in with Rylan and her children.

Presently, with the assistance of a vocational counsellor, Rylan is exploring what work she could do to supplement her hairdressing income. As a social person, Rylan wants to work in a social setting but difficulty retaining verbally presented information eliminates much of the social work she has considered for herself. She knows that work in a nonsocial setting without active social interaction would bring frustration and depression. Rylan has many fears about returning to work outside her home. She still has difficulty filtering thoughts, is easily distracted, has a quick temper, and is very sensitive to others’ judgments. She is afraid that she will hurt her co-workers with her defensive anger reactions and wants to protect them from her anger. She experiences a conflict between her work ethic and her need to rest and she fears she will not be aware of the need to rest in a timely way. She is afraid that she will not bounce back from failures.

**Katherine, 61, Age at Brain Injury 54**

Katherine, a stay-at-home-mom, raised her 2 children in an enriched environment. When her stay-at-home mother-in-law treated Katherine badly, she saw her potential future unhealthy self. She thought that she was likely stunting her children's growth and decided she needed outside interests for her health and for her sanity. Though she had a Bachelor's degree, she lacked work experience and self-confidence. Making a full commitment to a library technician college program, she had the support of her husband and her 5 and 7 year-old sons. Katherine, tending to home and achieving highly, took pride in being a master woman and noticed that her health improved significantly.
Katherine took a one year position as a library technician at a nonprofit disability center. The center was close to her home so that she could come home at lunch, feed her children and do whatever was needed in the home. Katherine then applied for a position as a library technician at a large institution where she made several lateral moves to broaden her horizons including a new service position. It was here that service work became “her place”. She was treated as an equal and given the freedom to develop the position. Through this experience and in observing professional staff at work, she developed a strong sense that she was as competent as they. She realized that she wanted to move up but would need credentials to do so.

Katherine’s children were now older so this became a time for her. Katherine’s decision to attend a Masters program at a foreign institution was her second key decision. The first year in the program, living in a dorm and with a different background from the other students, was a very difficult time for Katherine. She nonetheless resolved to return a second year; did much hard work in the interim so she would not be so overwhelmed in the program; and completed the program at age 50. At this time, Katherine moved to a new and more professional position at another institution. Katherine made many changes to the new position and to procedures which are still being followed today. Katherine then moved to a management position at a third institution.

While working late one evening, Katherine went to hospital because she was feeling very bad. In hospital for observation, she had a stroke and was told that she had had a first stroke six months previously. The second stroke left her with fatigue and initial paralysis of left arm. She and her husband worked very hard to regain use of her arm and hand. Katherine recounted her rehabilitation experience with much anger. Physiotherapy, the only service she
considered helpful, was stopped within 10 days of her rehabilitation admission. Katherine had thought she was “semi-losing” her mind until she was finally told that her weepiness was due to a secondary depression that could be controlled with medication. Rehabilitation professionals focused on deficits, did not observe confidentiality, and stressed that she could not return to her management position. Katherine told them that she would return to her work with or without their approval and was determined to prove them wrong. Her own hard work in rehabilitation was in preparation for her return to work.

Katherine stated that returning to her management position was “a given and her salvation”. Katherine knew that she had residual deficits: she was unable to play piano; she experienced fatigue; and she had difficulty reading but these were not evident to persons at work. She states that this was both good and bad. She became “so tired to tears” by Thursday night that she knew she could not work on Fridays. The decision to work 4 days a week was a big risk because she did not know whether her superiors would approve the reduced schedule. Her doctor described her 4 day a week return to work as a miracle. She believes she was turned down for partial long term disability because she had been labeled as non-compliant in rehabilitation. She decided not to fight the decision, conserve her energy, and take the day off without pay. Katherine also became much more protective of her energy, limiting outside involvements, and resting in the evenings.

As Katherine’s workload increased, she sought to demonstrate that she needed help not because of the stroke but because of the large service demand. Her immediate superior was non-supportive but the president understood this and provided support in several ways, including hiring a coordinator to help out. With this support, Katherine reconsidered and postponed retirement. Still she is weary and, planning to retire in 4 months, is concerned that
she leave the program in good hands. She looks forward to more time for play, travel, and being open to short-term work opportunities. Katherine feels that her pattern of career decision-making, a combination of happenstance and being open to opportunities, has not changed.

**Elisabeth, 40, Age at Brain Injury 36**

Elisabeth had attended a very academic high school in Germany and it had been her expectation that she would attend university. At age 17, the move with her family to a small Canadian town interrupted this plan. She felt adrift. After high school she worked in a sandwich shop owned by her parents. At age 20 she attended the local hairdressing school and opened her own salon at age 23. She worked hard, 6 to 7 days a week, to build up a good clientele but the salon swallowed up her 20s. At age 30 she followed her boyfriend to a larger community and continued to work as a hairdresser. At age 34, she began to think she might like to do something else. Finally at age 36, not sure of her future direction, she took an evening course at a local community college.

At the time of injury, Elisabeth was attending the last class of this course; she had excused herself and had gone to the washroom because she had a very bad headache. While she was in the washroom, an aneurysm in her left temporal lobe, later identified as grade 4 subarachnoid, ruptured. Another student, sent by the teacher to look in on her, found Elisabeth unconscious on the bathroom floor. Elisabeth credits her survival to the rupture in a public location and to prompt surgery and medical assistance.

The surgeon informed Elisabeth’s parents that few survived the surgery; if she did survive she would have significant impairment. As a rehabilitation inpatient, Elisabeth soon realized that she was making a more rapid recovery than the other patients. After 8 weeks,
she went home. She was not yet well but was told that there was nothing else that the medical profession could do for her.

Because her aneurysm ruptured while Elisabeth was attending a class, all the medical documents identified her as a student. Soon she began thinking of herself as a student. Six months after her injury, with the scars from surgery still visible on her head, she approached Employment Insurance for funding to return to school. She was advised to wait at least one year before contemplating studies and that she might not be able to recover sufficiently to study. Undeterred by their discouragement and with her mother’s support, Elisabeth enrolled in a distance education psychology course. The solitude of distance study suited her and gave her something to do.

When Elisabeth completed the course with an A grade, the employment counsellor became supportive and funded the social services diploma. Currently Elisabeth is simultaneously completing the last semester of a social services diploma and beginning the third year of the Bachelor of Social Work (BSW). She is determined to fund her BSW studies with student loans or part-time work and, because she does not have her own children, she wishes to work full-time as a social worker in an area where she will have contact with children. She has not told others that she is considering continuing on to a Masters of Social Work (MSW).

Elisabeth believes the reason for her survival and almost total recovery is to help others in need. Through her injury, she became aware of the scope of social work, the importance of helping others, and the survivor’s need for someone in their court. Her mother’s support was crucial but she had many others in her court including her boyfriend, father, and friends. She found significant role models, both positive and negative, in her
rehabilitation. One speech therapist in particular helped her believe that she had the ability to return to school while one unhelpful social worker provided her with a model of what not to do. The experience of being nurtured during her recovery has engendered her desire to nurture others.

Elisabeth describes her brain injury as a total blessing which gave her motivation and a second chance in life. It is the best thing that has happened to her: waking her up from a passive approach in which she drifted through life and giving her a purpose in life. She does have some residual impairment, namely memory and fatigue, and is more talkative since the injury. She is currently being investigated for seizure disorder. Yet she feels that she is unbelievably fortunate in both her recovery and in having a sense of what is important in life. She now views hairdressing as very superficial and is clear that her purpose is to help make a difference in people’s lives. She feels very strongly that this is her obligation; she has received so much from the system and she must give back to others because people deserve care and nurturing.

Sophie, 33, Age at Brain Injury 24

Presently, Sophie is 7 1/2 months pregnant with her first child. In 1996, she sustained a severe traumatic brain injury and physical impairment. She was heading downhill, riding home from a mountain bike ride, when she hit a large, unmarked trench in the road and landed on her head. She credits her brand new helmet with saving her life. She has no memory of the 3 weeks before and the month after the accident. She spent 3 weeks in a coma and 5 months in a rehabilitation unit. Sophie lived with her parents for the next 2 years as she went through outpatient rehabilitation. The injury left her with right side paralysis and
destroyed her speech. She was unable to talk for 6 months, was initially in a wheelchair, and was unable to eat and breathe on her own.

Sophie still does her own daily physiotherapy exercises at home and, as a coping strategy, factors her fatigue in all decisions, including career decisions. She still has weakness and balance difficulties and has replaced former sports activities with swimming, hiking, and walking. She still has some right side paralysis that is invisible to non-professionals. She has learned to print with her left hand but, due to the effort, spelling is affected. Cognitively, she has difficulty with multitasking. She has regained her speech but still remains concerned with the clarity of her speech.

At the time of her injury, Sophie was working as a part-time server at a pub, a model, and a victim services assistant. She planned to start a BSW program in a few months and then a Law Degree. Although she had been with Victim Services for only 2 weeks, the employer held her job for her until she was able to return. She describes this as a gift which gave her the confidence to push through her rehabilitation and challenges and to make a good recovery.

During an intense 5 year litigation process Sophie was assessed by many professionals who concluded that due to her cognitive impairment, she would not ever be able to return to school. Sophie perceived these conclusions as “shutting down her possibilities” and was determined to prove them wrong. The injury was a turning point in Sophie’s career and her plans shifted to a more humanistic social work focus. She was no longer interested in the status and prestige of law and felt that she could not be content in a legal environment. She believed that she was alive for a reason and that she had a purpose in life. On behalf of people with brain injury, she wanted to set an example and show the
experts that there are many possibilities after brain injury; that there is life after brain injury; and that generalized predictions that do not take into account the uniqueness of persons with brain injury are wrong.

Two years after the injury, Sophie started a BSW at a post-secondary institution close to her support system. She moved onto campus and completely immersed herself in school. As a “self-determined” person, she made very limited use of campus disability services. Sophie met her husband in her third year and, after graduating with a BSW, they moved to another province to complete an intense one year MSW. Again, Sophie’s strategy was to completely immerse herself in school; she was not involved in any external activities, including housework and cooking, which were done by her husband.

Sophie and her husband moved back to BC and took whatever employment opportunities came their way. It became very clear to Sophie that her purpose and passion were now to offer adjustment counselling for persons who had sustained a brain injury. Although she did not know what a case manager did, she took a position, in the direction of her passion and purpose, as case manager with a brain injury nonprofit. The position, however, did not offer the desired opportunity for counselling and the case management was stressful because it strained her multitasking skills. Nonetheless, Sophie made connections with her clients that confirmed her purpose and passion. Due to her own brain injury experience, Sophie offered an experiential empathy that made a unique and significant contribution to adjustment counselling.

Sophie left the brain injury nonprofit and opened a private practice offering adjustment counselling for persons with brain injuries. She had been open a few months when she became scared. The counselling was very demanding; running a practice involved
many tasks in addition to counselling and the income was not secure. Whereas initially she had planned to combine private practice and mothering, she no longer thought she could do so. She wanted to return to a secure position after maternity leave and have the ease of being an employee. She took a part-time social work position which would provide a good balance with parenting, her priority, and would later provide an opportunity to move into a rehabilitation department. The pay, benefits, and working conditions were good, and the position offered the opportunity to continue counselling while developing a broader expertise in disability counselling. Additionally, Sophie obtained some distance from brain injury work, which sometimes felt too close to home.

Sophie is currently about to start a one year maternity leave and plans to return part-time to this position while her children are young. Since her pregnancy, she is less career-oriented and feels that there will be time, when her children are older, to resume her chosen career in brain injury. Although brain injury remains her passion, she sees her future in terms of the broader field of disability adjustment counselling.

**The Themes**

Six themes emerged from the participant’s accounts of their career decision-making as being common to all or to the majority of the participants. The participants described their experiences as interactive and continuous with some themes having greater salience than others at different points in the participants’ experiences. Therefore, the themes are not completely discrete nor is there an absolute order of themes. Additionally, the participants were either more articulate or evocative in describing the experiences salient to specific themes. Therefore, not all participants are equally represented in each theme write up and
there may be some overlap in the thematic descriptions or a participant’s vignette may illustrate more than one theme. A descriptive summary of the themes illustrating elements of each theme as endorsed by the participants is presented in Table 2.

The six themes and five sub-themes that emerged in this phenomenological investigation are as follows:

1. Continued centrality of career
   (a) The intensified meaning of a paid work career, and
   (b) The influence of rehabilitation in career decision-making
2. Continued centrality of the relational in career
3. Sense of life purpose and altered life perspective
   (a) Increased agency in career decision-making
4. Sense of continuity and change in identity
5. Sense of increased vulnerability in interactions
   (a) Sense of being devalued, and
   (b) Sense of equality
6. Sense of insecurity and emotionality
Table 2: Descriptive Summary of the Themes

<table>
<thead>
<tr>
<th>Elements of Themes</th>
<th>Sa</th>
<th>L</th>
<th>Ra</th>
<th>J</th>
<th>Ry</th>
<th>K</th>
<th>E</th>
<th>So</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Continued centrality of career</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>a) the intensified meaning of a paid work career</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Economic function</td>
<td>* * * * * * *</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Equality and balance in relationships/Independence</td>
<td>* *</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Fulfillment / Development/Salvation</td>
<td>* * * * * * *</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Sense of pride in self</td>
<td>* * * * * * *</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Sense of desperation to return to pre-injury plans</td>
<td>* *</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Return to normality</td>
<td>* *</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>b) the influence of rehabilitation in career decision-making</td>
<td>* * * * *</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Sense of determination to prove self</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Influence of nurturing and non nurturing staff</td>
<td>* *</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Continued centrality of the relational in career</td>
<td>* * * * * * *</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• simultaneous experience of mother and paid work careers</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• accentuated significance in paid work career</td>
<td>* * * * * * *</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. Sense of life purpose and altered life perspective</td>
<td>* * * * *</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• altered life perspective</td>
<td>* * * * * * *</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• life purpose</td>
<td>* * *</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• benefits or gifts from injury</td>
<td>* * *</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>a) increased agency in career decision-making</td>
<td>* * *</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. Sense of continuity and change in identity</td>
<td>* * * * * * *</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• sense of loss and continuity of identity</td>
<td>* * *</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. Sense of increased vulnerability in interactions</td>
<td>* * * * *</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>a) sense of being devalued</td>
<td>* * * * * * *</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>b) sense of equality</td>
<td>* * *</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6. Sense of insecurity and emotionality</td>
<td>* * *</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• financial insecurity</td>
<td>* * * * * * *</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• insecurity, not certain, unsure,</td>
<td>* * * * * * *</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• lack of confidence</td>
<td>* *</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• sense of risk (possible loss)</td>
<td>* * *</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• comparison to pre-injury self</td>
<td>* *</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• fear</td>
<td>* *</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• anxiety</td>
<td></td>
<td>* *</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• depression</td>
<td>*</td>
<td></td>
<td>* *</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• coping: withdrawal</td>
<td>*</td>
<td></td>
<td>*</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• coping: small steps/tentative decisions</td>
<td>* *</td>
<td></td>
<td>*</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

1 Symbol denotes participant endorsement of themes.
2 Symbol denotes participant endorsement of elements of themes.
Theme 1: Continued Centrality of Career

This theme consists of two interrelated sub-themes: (a) the intensified meaning of a paid work career; and (b) the critical influence of rehabilitation in career decision-making. The eight women described paid employment as a central aspect of their lives from which they derived self-esteem and identity and which underscored the importance of the women’s function as economic providers for themselves and their families. Three participants described the intensified meaning of a paid work career as a strong sense of desperation to return to their pre-injury plans while four participants described an increased sense of determination to return to work or studies. Six women described rehabilitation as a critical influence for career decision-making and as interconnected with the experience of career decision-making.

The intensified meaning of a paid work career: While all participants emphasized the economic function of paid work and each single woman emphasized her work role as her only means of support and security, two women, in particular, described a desperate determination to continue working due to economic need. Sarah experienced the impact of being her sole support as the need to continue working at all costs: “I was pushing myself and even my own supervisors were telling me, ‘Go check it out.’ But I wouldn’t, because who’s going to earn your bucks. There’s nobody going to pay the rent... [until] I literally physically could not work.”

The increased salience of the economic function of a paid work career was not limited to the single women. Rylan, for example, experienced an inner panic and fear about her family’s increased financial need following her brain injury. She returned to work before she
was physically ready, covering up her inner panic and fear, and stayed even when she knew she was in danger of being fired. Rylan described this experience:

It would have been a lot easier for me to quit before I got fired. But I felt so panicked about the whole money thing. I felt so desperate.... I had foot surgery and I went back to work with my stitches still in because I was so afraid to take more time off. Even though nobody actually said that to me. I already sensed the disappointment in me for the time off I was taking. And so afraid of not looking at the big picture. It felt immediate at that moment. So I would say all those jobs I stayed in, actually I knew I wasn’t doing a good job. I knew I wasn’t welcome where I was.... I knew right away that they knew right away.

But paid work had an increased personal meaning and value beyond a practical economic function which seven women variously described as equality, salvation, fulfillment, and independence. The mothers in the group, attending to the needs of their families, also described a sense of having waited to undertake a paid work career outside the home. For Jane and Rylan, in particular, this sense of having waited contributed to a strong sense of loss and of desperation to return to pre-injury work plans. Jane waited until her youngest son was 10 years of age before deciding to retrain for a career outside the home. She sustained a traumatic brain injury the weekend before she was to start a court stenographer training program. She described herself as desperate to get back the career and education opportunity she had lost out on: “I have lost out on being a court reporter and having that as a profession and an income. And I want to be a woman working in the world. And I want ... freedom to be my own person, not just be Mom ... keep...developing myself with a career.”

Rylan also waited until her youngest son was 10 years old before taking up work outside the home. She had been working outside the home for one month when she sustained a traumatic brain injury. For Rylan, a career outside the home fulfills the desire for a grown
up and more professional self and for “feeling equal”. A paid work career outside the home signifies personal and financial equality and balance in relationships and family. Rylan had wanted “to go out to work in something else. I just saw myself growing up. I guess I saw myself being more professional.” While Rylan successfully returned to her home-based hairstyling work, she is still searching for a paid work career outside the home in which she will be successful. Thus, she still retains the sense that she has not grown up and does not yet have a desired sense of equality.

Katherine waited until her youngest son was 5 years old before training for a paid work career outside the home. She saw the person she did not want to become in her stay-at-home mother-in-law:

My mother-in-law was going through a dreadful menopause and I seemed to be the target of her hostilities. So it was a good lesson for me that I wanted to make sure that when my time came that I would ... other interests and other activities rather than focusing just on my children and my grandchildren.

For Katherine, work outside the home provides salvation for herself and for her family and protection from obsessing in the home and from becoming the woman she does not want to be. Work provides good health and sanity and fulfills the need to be something more. With autonomy at work, Katherine finds her place in her work and makes this place her own. She describes the continued personal meaning of her paid work career: “I was very dead keen to get back to work. I mean I felt that was going to be my salvation and...to get back here, was really important to me.”

Similar to Katherine and Rylan, Sarah also described the meaning of a paid work career as imparting security beyond a financial security. For Sarah, whose lifelong “fear of trusting others” created the need not to be dependent on others, paid work provided a fierce sense of independence. Rylan describes good career decisions as offering “easy transitions”
and “falling within a comfort zone”. Although disrupted post-injury, a sense of comfort remains an integral desired aspect of a paid work career for Rylan.

The work ethic the women bring to their paid work career remains unchanged, however, and offers an increased sense of pride in self. Sarah describes a strong work ethic, instilled in early childhood, and a sense of herself as a good worker which continues post-injury: “one other volunteer and me [were] supposed to sort out a lot of the sponsorship [for] income tax receipts...they let the other volunteer go and kept me because I was so detailed. ...I also ended up...getting them ... very caught up.” Ramona, continuing to take pride in doing a “bang-up job,” states: “I’m really good at what I do here and I’m doing a really bang up job for this guy and that feels really good.” Katherine continues to “hold herself to high standards” and “to be the best that she can be.” Rylan derives great pride and pleasure in her clients’ satisfaction. Sophie, Jane, and Elisabeth immerse themselves in their studies and experience increased self confidence and pleasure with each success.

Two women further described the intensified meaning of paid work as a drive for normality. Rylan describes the emotional context of an early return to work:

After my accident to go back to work, that was pretty difficult. Because here we were in a lot worse position financially, this job was on hold for me and it felt like so many pressures on myself to just get everything back to the way it was, because I just didn’t want to think about how things were, the financial pressures. It was a difficult time for my whole family. I didn’t really realize that impact at that time but you know even my kids, everyone was told that I probably wouldn’t make it... I just wanted my life to be back to normal so I worked pretty hard at getting back into how everything was but unfortunately everything wasn’t how it was.

Similarly, Jane described her determination to prepare academically for a paid work career as “I had this drive to be normalized.... I said, ‘No I am going to do this. ... I am going to get mainstreamed.”
Four women described an increased sense of self-determination in their return to work or studies necessitated by the need to prove their abilities for themselves and to others after brain injury. The women described rehabilitation professionals as important others to whom they most often needed to prove themselves. The two aspects of an increased sense of self-determination are described within the next sub theme and within the Sense of Increased Vulnerability in Interactions theme.

The influence of rehabilitation in career decision-making: Six women further described the experience of rehabilitation itself as central to a continuous career decision-making process. Katherine, viewing rehabilitation as preparation for her return to work as a manager, experienced much anger at the emphasis on unrelated physical activities in the rehabilitation setting. She was concerned about dressing for work but “the occupational therapist wanted me to peel vegetables. You know just junk stuff.” When rehabilitation professionals told her that she could not return to her management position, she refused to accept their pronouncements and told them that she would return to her position with or without their support:

She started going on about how of course I would never get back to 100%. They always told me that I would never get back to a 100%. And I needed to settle and I better settle soon and then I was probably seeing the most improvement that I would see in that six months….And I didn’t care what they said … and I knew myself and I was ready to see. And if it had all fallen apart, I don’t know what I would have done then. I guess they would have been proven right but in fact no. I mean but you have got to ask the most that we can of ourselves. I mean we can’t settle for second best. I am not prepared to do that, never have been.

Elisabeth, discouraged from pursuing academic studies by an employment counsellor because of her brain injury, was determined to prove that she was academically able. Without support, she immersed herself in academic studies starting with one course. Similarly,
despite contrary advice from professionals and predictions that she would not be able to care for herself, Sophie continued to hold on to her pre-injury career plans to pursue a university degree. She was spurred in part by her determination to prove the professionals wrong:

I knew that it was a goal that I would not let go of.... My prognosis was pretty bleak. I had a lot of people and professionals and experts telling me that “Sophie, be realistic. You can’t really even, can’t think about going back to school. You have a lot of cognitive impairment and it’s just going to be too much and you shouldn’t do that... you might not walk, let alone you know go back to school and become, do what you want to do.” So that was a bit, that was almost fuel adding fuel to my passion. It was almost like, “No. No. Wait a minute here! You don’t quite know me. You don’t understand this is something that I am going to do. Like my mind is set.” ... I think I even wanted to prove myself even more after I was told again and again, my parents were told as well, not to expect too much out of me and I would not be able to come back to school let alone do my Masters. So that is the nice part of the story.

Elisabeth actively made career decisions as she interacted with and observed the professionals and practicum students who cared for her and others in the rehabilitation setting. Elisabeth first began to view herself as a student while in rehabilitation:

And so because this [the ruptured aneurysm] happened at the school, all my medical records refer to me as a student, and in my mind when I recovered, because everybody within the medical profession focused on the fact that I was a student, in my mind already it made me look at myself somewhat differently. I had to start it but it just was because it happened there and the school kept coming up in all my files.

She observed, “And I was so impressed with how knowledgeable the staff were ... whereas I was so much older but I had not had the maturity at those ages to do these things and I was just really impressed with that.” The professionals and practicum students, serving as negative and positive role models, contributed to Elisabeth’s desire and belief that she could also become a professional and that she would return to school to become a social worker:

I began to think that maybe I would go back to school. But at that point it was really kind of a pipe dream because nobody had any idea whether I would recover well enough to go to school. And I didn’t really see it either but I kind
of clung on to the fact that it might be something that now I would do.

Jane, particularly angry at being treated “like an ICBC number” and unhappy with her occupational therapist, determined to train for a client-centered helping profession. She describes one such experience in rehabilitation which fuelled her determination to support others in rehabilitation:

This happened with OT and it was in my home and it was in my space too. This is where she said to me..., “No, Jane, you don’t do spaghetti by boiling the water first. Okay,” and I went, “What, what, I am one of 10 kids. I cooked for 12 people, from the age of 14 on, with my mother. I know what I am doing here.” And she would say, “No this is what you do first before you boil the water.” And I would just “rrrr” [growl]. They would just say, “Jane is rebellious.” And I said, “I already know this. Don’t tell me that I don’t know what I already know.”

Lucy took charge of her own rehabilitation and fashioned it to support her career direction in the arts as writer and musician. She describes the connection between rehabilitation and a paid work career:

I started writing online but I treated it as though it were a journal.... so writing things down became another outlet, became a way of processing, it became a record because I would think these things and then forget them and so it became this great way of recording my thoughts and ideas. It became a way of dealing with what had happened to me.... And it gave me hope, gave me hope that maybe, maybe this could be a career.... so it all happened around the same time but the decision to do it was a career decision. It was thinking “I’m going to write a book and that’s how I’m going to support myself.”

For six participants, the experience of being nurtured, of receiving help, and of being helpless in rehabilitation gave rise to an increased sense of compassion and the desire to nurture or help others in need. Rylan speaks of an increased desire to nurture people who are perceived as underdogs in society. Sarah declares that through her experience of dependence and limitation, she developed a sense of compassion and respect for herself and others, whereas previous to brain injury she judged herself and others harshly:
It’s taught me a little bit about the human condition. In that way, I who sat on the judgment throne of God and used to sometimes look at people like who are on welfare... and who... rip off the system .... It’s made me have a much more compassionate view that, let’s not be so quick to judge.

Elisabeth describes the relevance of the negative and positive support she received during rehabilitation as models for how to help and not help others. She felt disempowered when the social worker’s actions suggested that Elisabeth was not worthy of support:

Because ... she didn’t see me as deserving of temporary disability, it just made me feel very well disempowered, just very even down more. I was already dealing with all of the physical stuff but then having someone tell you that ... it stood out so much in contrast to the other two [social workers] that I had had who were really just amazing, just in their sensitivity and in their, just how they approached me that I knew that I felt the effects of having somebody that thinks, “She [Elisabeth] can do something.” Even the speech pathologist who thought I could do this versus somebody saying, “Well, there is just nothing here for you.” Just you know the difference in their attitude how it affected my attitude.... She [social worker] sort of represents the model of how I hope not to be treating other people.

This experience underscored for Elisabeth the importance of having someone in your court and the significance of nurturing others:

I feel more nurturing towards others.... Last year, my godfather who is in his 70s had a fairly severe stroke. And this is the first time in his life that he’s been sick and I see that with him too. I think until it happens to you and you receive that nurturing and non judgmental...

For Jane, the experience of “being victimized” and not being heard by rehabilitation providers intensified her drive to help others. Jane describes the client-centered approach as a gift which she can give to others:

The gift is this whole helping the person with client-centered needs, based on where they are, who they are, what they need, only what they need.... This is the gift. Let them give me what they need not I’m going to be there as this professional person saying, “Here this is what you need now. Here is what I am going to do for you today.” even if I have let them talk. I want them to tell me what they need.
Sophie states that her own brain injury facilitated an experiential empathy and a deeper relationship in the counselling relationship with clients who have a brain injury. She also views experiential empathy as an important contribution and gift she can give to others.

In summary, these eight women endorsed the continued centrality of career post-injury. All participants emphasized the economic function of a paid work career as well as intensified personal meanings such as sense of pride, freedom, salvation, security, equality, or normality. Three women described a sense of desperation to return to work and pre-injury plans. Six women described the experience of rehabilitation as a central influence in career decision-making giving rise to determination, defiance, uncertainty, and increased empathy. Often, interactions with rehabilitation professionals, perceived as negative or positive role models, had a direct impact on the participants’ career decisions. For four of the women, a strong sense of self-determination flowed from negative interactions in which rehabilitation professionals insisted on lowered career expectations. Notably, the experience of being helpless and being nurtured had a tremendous impact not only on sense of compassion and empathy but also on career decisions to apply new understanding from the experience in a helping profession.

**Theme 2: Continued Centrality of the Relational in Career**

This theme highlights the continued centrality of interpersonal domains in the women’s experience of career decision-making and the salience of familial domains especially when children are young. While all participants endorsed the continued importance of relatedness in their lives; after brain injury, seven women in particular experienced an accentuated significance of relatedness in multiple career contexts.
The five mothers in the group experienced their careers as mothers and paid workers simultaneously such that, especially when children were young, either might be more salient in any given moment. Career decision-making which allowed the mothers to attend to whichever was more salient in a given moment, described as home and work balance, was experienced as intentional, value driven, and occurring within a familial context. Through strategies, such as flexibility of work schedule, proximity to the home, and decreased work demand, mothers ensured a continued ability to simultaneously mother while engaged in paid work. Rylan’s experience, as a young child in daycare and home alone, fuelled her desire to be a “real Mother” to her three children; to maintain a good home for them; and to always be there for them. Similarly, Jane, a single mother, chose to work as a temp in order to spend “multi time” with her first child. Later, when her second child was diagnosed with significant special needs and Jane’s advocacy and care for her son was “a career unto itself,” she increased proximity and flexibility by operating a home-based secretarial business.

Katherine, a university graduate, wanting to balance home and work when her children were young, trained for a less demanding technical career. She experienced pride in her mastery of both realms: “I was still sort of that master woman though. I was still baking the buns and still ironing 15 shirts on Saturday night…. I still had to do it all but I prided myself on being able to do everything….It worked out well.” She further emphasizes proximity in making a good decision: “Of course being fairly close to home, I could drop them off on the way to work and pick them up at lunch time and get them home and give them lunch.” Similarly, Rylan described a good decision as one where she “could continue working and still be at home with my kids.”

The simultaneous experience of mother and paid work careers and emphasis on home
and work balance did not differ after brain injury. Ramona, who at age 40 made a decision to become a full time mother to her 12 year old stepson, a child with special needs, values her current work situation as it “gives me a lot more freedom to also focus in my home life.” Sophie, pregnant with her first child at 33, emphasizes “finding a balance between family and work and career.” She values her paid work career but “not at the expense of my family too much. I am pretty clear in what would work best for our family.” At the time of her marriage break up, Rylan did not have the money to support her children and left the home without them; so a paid work career “became really important.” Rylan said “I lost my confidence in my mothering” but she realizes in retrospect “that my relationship with my kids has always been pretty strong.” Though she “was desperate to have support” for her son because she was “burning out,” Jane continued her career as an advocate for her son. She experiences a loss as this career comes to an end: “I don’t know what I will do when he is not [living with me]. He has been accepted into residential services placement...so I won’t have that role anymore as advocate for him.” Katherine, planning contract work after retirement from her management position, looks forward to time with her grandchildren.

Mothers experienced an internal shifting of priorities and an intuitive sense of the right time as they made career decisions. Sophie experienced “totally shifting of priorities when I found out that I was pregnant” with “career (paid work) kind of on the back burner for now.” She has increasingly experienced a greater salience of her mother career: “And I would almost say that family is absolutely first,” and knows “in my heart” that “now is the time for mothering.” She further describes mothering as a career choice in its own right:

I just want to be there and I don’t want to be passing our kids off to daycares. I just want to be a mom. I just want that to be my full time job. I want that to be my career for the next how many years. Those are just crucial years in the beginning and even when the kids are going to school.
Ramona envisions that she might retrain when her stepsons no longer need her care; but for the time being she views mothering as her most important career. Katherine described the family context of “a time for me” when she entered a Masters program:

the kids were growing up. ...I could leave them. I don’t mean leave them but they were fine with my husband. They were at school and at work. And it seemed like a time for me. And my husband agreed that it was a time for me.

Rylan described the “right time” to work outside the home as the time when her children were the “right ages” and her third child “didn’t get cheated out of the things that the other two did.” Similar to Katherine, she emphasized the family context and continuity of care for her children. Rylan said, “We always had a hot breakfast and that was my time to socialize with the kids before they went off to school and my husband did the dinners and that was his time.” Rylan illustrates the familial context of career decision-making:

I felt that it would be really hard to have had everything a certain way and then bang have it just complete opposite. So before this job was offered, in thinking about what I would like to do and how I would like to do it, that also involved everybody else in the decision because my deciding to make a change would also mean that everyone else would have to participate in that change and take some responsibilities for the changes.

Significantly, the simultaneous experience of “mother” and “paid worker” careers was not limited to the mothers in the group. Elisabeth’s realization that she would not have children was experienced as a desire to integrate contact with children in her paid work:

I am going to try to apply for work within the school district. I am doing a practicum right now working with children...decided to go into the school district because I don’t have children and I thought I wanted to connect with that population before I got too out of touch with them.

Though less intense, Sarah’s new desire for some connection with children may also be viewed as a related experience. She said: “I’ve never liked kids but now I’m getting more tolerant. I even sometime thought ...teaching something ... like crafts.”
Seven women emphasized the increased importance of the relational context in their paid work career. Ramona highlighted the accentuated significance of the relational after brain injury when she asserted that "Family, family and friends, that's the first thing, people matter. That's the bottom line. People matter." Ramona illustrates the strength of her convictions, before brain injury, about the importance of the relational in the workplace:

knowing full well he was so sick without, giving him the option of, saying "please ... go on long term disability" and that turned me off so I couldn't work there anymore. I just lost total respect for the place. It just blew me away, just absolutely blew me away. So I'm very much that way.... I will not stay working for people I have no respect for.

She notes a heightened relational sense after brain injury, "I always had that attachment. I always did, more so now," and finds a deepened meaning in her work as a legal assistant by helping and nurturing clients. She further explains "that's where I get my most fulfilment."

Looking forward to possible retraining, she states "career wise ... if I was going to do anything, I think I'd probably want to go back and do something that has a human attachment." Jane explains that it is through brain injury that she has learned to make time for the people she loves, including taking care of herself. She describes her realization of the connection of self care to mothering, "I thought you are doing that. You are mothering yourself here too. You are mothering him (her son) and you are mothering yourself and so I did a lot of that."

Elisabeth connects her contention that people are "deserving" to a heightening of socialist attitudes, developed as a child in Germany. She describes her decision to enter the field of social work, "It's just the attitude and you believe that people are deserving and need the help or they don't .... I fall into the group that believes." Similarly, this accentuation of the relational across multiple career contexts and a sense of fulfillment derived in the
relational context are also evident in Sophie’s experience. Sophie described herself as “a people person” who was always “very excited about developing relationships” before injury and “always knew that would be included” in her career. Whereas she had considered a career in law before injury, in choosing social work after brain injury and later in counselling persons with brain injury, she intentionally elected to intensify the relational in her paid work career. She describes her desired depth of relationship as missing in her current social work position: “I am so used to being able to relate to people on such a deep level that I am finding that is missing now, that depth and that true ...experiential empathy.” After brain injury, Lucy also has a desire to make a difference in her writing career:

It made sense to me that I would have a job, have a career where I could say something that might be inspirational to others....I thought that it was more useful...than working for a corporation, making money and being self-important. But rather maybe not making much money but making a difference.

Three women further described the connection between the relational in a work context and their mental health. Ramona places a greater emphasis on the relationship with her major contractor than she does on remuneration: “He makes me so happy. Isn’t that corny, I mean he makes me happy. That’s a dumb thing to say but I’m so happy working with him. He’s just, it’s fun. He gives me challenges...we work well together, we’re friends.” Sarah, also emphasizes the importance of a supportive relationship with “one wonderful boss” who was “good to me” to her attitude in the workplace and to the quality of her work. Rylan “loves the interactions, the friendships” and “making a difference in somebody’s life.” She describes the connection between the relational in a work context and maintenance of her mental health:

I am a very social person so to stick me somewhere just doing one thing at a time; I know the frustration comes with that too...that whole depression thing
that comes into play when all of a sudden [I'm] not feeling really active....
Active for me is that interaction with people.

In summary, before and after brain injury, the 5 mothers in this group experienced their careers as mothers and paid workers simultaneously with either more salient at any given moment. The 5 women, describing home and work balance as a means for attending to their shifting priorities, employed strategies such as flexibility of work schedule, proximity of workplace, and decreased work demands to achieve the desired balance. The women described an intentional and value driven experience of career decision-making to attain work and home balance. The women further described an internal shifting of career priorities and an intuitive sense of the right time to enact a changing salience of mother or paid worker careers. Additionally, two women who were not mothers expressed a new desire for contact with children within a paid work career.

After brain injury, seven women experienced an accentuated significance of the relational in multiple career contexts. Furthermore, four women experienced a heightened fulfillment and meaning in paid work careers involving a deeper human connection. Three women emphasized the significance of the relational in the workplace context to positive mental health. Notably, two women emphasized that a good relationship with an immediate supervisor contributed to good mental health.

**Theme 3: Sense of Life Purpose and Altered Life Perspective**

This theme highlights the participants’ meaning making and benefit finding following brain injury. Seven women understood their recovery from brain injury as a miracle or a second chance at life with a concomitant transformation in perspective or purpose. Furthermore, seven women described their brain injury as a near death experience. The women variously described this transformation as a changed perspective; as a clear sense of
life purpose; as a sense of true appreciation for life; or as a secure knowledge of what is truly
important in life. These women further endorsed a connection between their altered
perspective or life purpose and their experience of career decision-making; seven women
described a direct connection between injury or recovery from injury, and increased agency
in their career decision-making.

Three women described their changed perspective as an all encompassing view of life
that affected all life decisions. Katherine said of stroke, “it is not a decision, but it is a mind-
boggling event that changed my perspective on almost anything.” Similarly, Sophie
experienced “a different perspective” which involves “a different world’s view.” An altered
perspective on life caused Elisabeth to re-evaluate how she wanted to live her life: “it gave
me a whole different perspective on my own life in terms that I had just kind of drifted and
not really... [done] the things that I would have imagined I would be doing” and not really
things that were important “if looked back at my life.” She describes her decision to become
a contributor in life: “It is almost as though you can sit life out or join the process and
contribute to it. And I don’t think I was contributing to it before.” This altered perspective
underscored a sense of agency fuelled by a “motivation change and the sense of urgency that
it’s life going by.... I want to do something with it [life] and if I am going to do it then I have
to do it now.” Following injury, Elisabeth feels “an obligation to do something more with my
life.” This conviction is predicated on two interconnected observations during medical
treatment and rehabilitation: 1) a remarkable recovery as “it just became apparent really
quickly that for very few people the recovery is as good as mine was” and, 2) a confirmation
of self worth as “others felt the need to save me and perform the surgery, which few recover
from.” She further describes this obligation and responsibility to contribute to life:
All of that made me feel like, obligated to do something positive with it rather than just drifting again. Because then why should the system have to spend, I don’t know how much it cost to put somebody through brain surgery but in terms of the money and the effort and manpower that was put into getting me back to where I am at now.

Jane also states that “I really want to do something with my life.” For Jane, unexpected recovery after coming “that close with the accident to losing my life” is a “very meaningful” experience which confers a sense of purpose; the recognition of life purpose and related career decision-making to enter the field of rehabilitation practitioner takes on a spiritual dimension:

I am here for a reason…. The whole recognizing, and getting for me, it is like a spiritual thing. There is a meaning here, there is a purpose in my life and I am in this time and place for this. Take it in, grab it, go with it, have it right, hold it and know what it is and be with it… I think that is a big thing which I was kind of outside of myself seeing myself in that space. “You are here for a reason”.

Similarly, Sophie connects “just feeling a real sense of purpose” to being alive after her injury:

I had a very strong sense of purpose. I was sort of put on this earth to do something, and obviously I lived for some odd reason. Like I, just, I thought I am meant to be here for something; just that real sense of knowing there is something else that is planned for me and it wasn’t my time yet to leave.

Furthermore, a sense and recognition of purpose imparts “a pretty clear focus on where I needed to do my best work” that served as a turning point in her career decision-making:

it was just really appreciating people’s individual experiences, and recognizing the importance of my family relationships, and just wanting to do work, and a real sense of purpose, feeling after my injury. It was this is where I need to do my best work; was this is working with people that have had brain injury and disabilities in a counselling kind of capacity. Yeah that was really the turning point for me, was just my injury and my re-direction after that....And so I just had a real different perspective.

Given her altered perspective, Sophie is “glad” that she did not pursue law, her pre-injury
choice, because it would not have been “a gratifying road” in her life. Rather, her “struggle,” on behalf of persons who have a brain injury, has been to prove to lawyers and rehabilitation professionals that “there is life after brain injury” so they will temper their assessments with an appreciation of the individual and not “shut down people’s possibilities”:

I really needed to just prove them wrong or show another possibility or another perspective. Like this [brain injury] doesn’t necessarily mean that I can’t do these things. ...I took it on a not so much as a person, yes at the beginning, this became a little more global for me at the end...it had a larger meaning for me at the end of this struggle and wishes. Sort of how could anyone, sort of place such expectations and judgments and shut down people’s possibilities when you just never know really who someone is and what someone is capable of. In spite of all the odds, there’s just, there is exceptions to every rule.

For Sophie, the field of brain injury “is really where my passion lies” and where “I feel I can have lots to contribute to that or give back.”

While all participants expressed a desire, following injury, to help others in need, two women did not specifically connect this desire to a sense of purpose. Sarah, for example, describes “a dream” to become a motivational speaker who assists persons in need. Following a good recovery, Ramona also experiences a desire to help others:

I’d like to do some volunteer work maybe to start off with because there’s so many people out there who have ...had, I mean I’m so lucky, I’m so lucky because I am still really all there ...there’s so many people out there that are really, really struggling...I’ve sort of thought maybe I should get into doing a little bit of counselling.

In keeping with a sense of purpose and desire to help others, all participants expressed a motivation to participate in this research in order to help other women who sustained brain injuries.

Six women described the experience of brain injury as a source of fulfillment and contentment from which they derive a sense of true appreciation for life and knowledge of
what is truly important in life. A more active and congruent experience of decision-making is a direct function of this knowledge. Elisabeth experiences brain injury as a total blessing that is responsible for increased agency and happiness in her life:

It was a total blessing and I would describe it as that. It was probably the single best event if I was to pick one. Now if the outcome hadn’t been the same then I would obviously feel very different about it. But because of the way things happened it is like it woke me up. Yeah, like I had really been half asleep all through.... The one thing I can say is that I am a lot happier as a person since I am making more active decisions and I think because I had that experience.

Sophie expresses gratitude for the “gifts” that have enriched her life after brain injury and that contributed to her happiness:

I am here today; all of these things have transpired in my life that wouldn’t have normally had this not happened. So I just think it was really really kind of meant to be and just making the best of it but it hasn’t been difficult to do that because ...there’s just a lot of gifts in my life that I wouldn’t trade for the world. And I think I never would want to compromise any of that again. Yeah I am kind of glad that happened. I mean even though I have some physical impairments still now and still challenges and stuff I just wouldn’t trade any of it and I know it sounds like a cliche.

She further enumerates the many “gifts” among which is a sense of being content in herself and an appreciation of what is important in life:

I think it is due to my accident I have met my husband...the richness of just my family and the relationships with my family. We have always been very close but there is another level of our bond now which is just quite unbelievable...being really really content with who I am as a person and... feeling a real sense of purpose. I could not be happier... if you ask someone “what do you think of Sophie?” I am often described as very positive, happy. There aren’t a lot of days that I feel really low. It takes a lot to really get me down. I just appreciate life so much and just really appreciate what is really important... that is a gift not taking things for granted. That has been one of the biggest gifts for me, ...having just a different perspective. Really when you think about it it’s hard not to. Of course that would happen. You can’t really go through something that significant and life changing without really growing and being a different person. That is certainly how it has happened for me.
Similarly, Ramona finds fulfillment after brain injury:

anybody who’s taken a walk on the other side will come back and say, ...what really matters in life, it’s really true, you’ve got to have fun and you’ve got to feel, definitely you have to feel fulfilled. I feel fulfilled sure right now.

Whereas previous to brain injury, Ramona sought recognition from others in the workplace, after brain injury she is motivated by finding enjoyment in her work:

I can challenge myself. I don’t have to prove anything to anybody. I would pick something where I would just say... “this is going to be great because I’m going to really enjoy this and it’s going to just be very wonderful.”

After injury, Ramona understands a paid work career as secondary to life. Jane expresses appreciation for her recovery in this way, “I wake up every day and I say ‘Thank you for this day’ because I know that where I was at is nowhere where I am now.” Jane further credits her experience of brain injury with the new understanding she brings to her relationship with her son and daughter. Jane illustrates her daughter’s perspective on this change:

I would never want you to be hit on the head again but you are best Mom in the world almost because of that ... since that happened you are so patient, you are so understanding, you want to hear where I am at.

In line with a more internal definition, after injury, of what is important in their lives, six women place a decreased importance on money or status in their career decision-making. Ramona stresses this change in her decisions, “It’s not about the money with me at all. It really isn’t…. It’s not about that for me at all anymore.” Elisabeth also downplays the importance of financial remuneration to her career decisions:

In my mind it’s not important. I know now that I can live on a lot less money than I ever thought I could and be just fine.... I can be fairly happy on a relatively small amount of money. And so I don’t think financially is a big reason for me to take or not to take a job.

For Lucy, this decreased emphasis on money represents a significant and unexpected change
in her career decision-making: “And I just found that a bit ironic that I made so many career choices based on money and that changed for me. That’s really changed for me.” Sophie also downplays status and prestige in her decisions:

It was more to do with status and prestige... And those things had no meaning for me whatsoever after my injury... I can’t believe I thought I could do work, I could be a lawyer and lawyers do wonderful work but ... status and prestige attached to that, that didn’t matter to me at all anymore. I just wanted to be really humanistic and social minded.

Lucy directly connects excitement at newly found sense of purpose, to inspire others and make a difference, with a decreased importance of remuneration and status in work:

I was really enthusiastic too. I was very excited about it. I really felt that it was more in line ...life in terms of “what’s my purpose?” ...It made sense to me that I would have a job, have a career where I could say something that might be inspirational to others... that made more sense to me. I liked the idea. I thought that it was more useful....than just going and working for a corporation, making money and being self-important. But rather maybe not making much money but making a difference.

While Rylan is satisfied with her life and with her home-based part-time hairdressing business, she does not earn sufficiently to support herself. Regarding career decision-making, she maintains that “if money wasn’t an issue it would be a lot easier.” In this case, she considers “how much I really enjoy elderly people.... I love the interactions, the friendships, making a difference in somebody’s life.”

Increased agency in career decision-making: Seven women describe a direct connection between a secure sense, following injury, of what is truly important in life and an increased sense of agency in career and life decision-making. Related to an intuitive knowledge of what is important in life is an equally intuitive understanding of what is superficial. Following injury, Elisabeth views hairdressing as a profession “that is so superficial that it would not satisfy me in that way alone” and as “a step backwards.”
Elisabeth describes a sense of agency in career decision-making as an important change in her life. She states that “going back to school [to study social work] was the first really active decision” she has made and squarely places the locus of her new agency on “it really actually was the aneurysm” and on “the realization of how quickly things can change in life.”

Ramona describes the connection between experience of brain injury and a sense of what matters and doesn’t matter in this way: “When you’ve had something happen in your life where the rug has been completely pulled from out beneath you so much stuff seems inconsequential.” As a result of this knowledge and a sense of limited time, she experiences an increased agency and ease in her career decisions: “I just don’t believe that there’s any time to waste… I think in a lot of ways I’m just more in control of my life now. Bottom line, life’s too short.” She further describes a connection between a sense of security in her self and ease in her global decision-making:

everything happened for a reason because a lot of things really did turn out right. I’m secure in myself now. Oh god I used to suffer anxiety. I used to question everything I did. It was like “Is this right?” “Is this wrong?” It’s just..... Who cares! Life is too short for god’s sake! ...I mean, I’m not out trying to decide whether or not I’m going to rob a bank. I’m just “Am I going to do this job?” or “Am I going to move here?” “Am I going to go out with this guy?” “Am I going to take this course?” or whatever. Life is too short to just sit there and ponder. Just do it!

Similarly, Jane experiences an increased ease in decision-making described as “I feel safer. I feel like I trust myself more.” Related to this ease is an increased agency in global decision-making that extends to a sense of freedom and pleasure in “building” her identity. She describes the connection between brain injury and an increased agency:

The freedom to build myself and be who I am in my identity...that is a wonderful thing to have. People can have that. They don’t have to have brain injury or trauma to get that. But it took that kind of brain injury and trauma to
get me to it. It was not forced, not forced, but in the beginning it was forced because of the emotions that were with me in the beginning, the emotions, the frustrations, the fear....It sort of became liberating as time went by and then I started to love it.

Katherine also connects an increased agency in career decision-making to a strong sense of identity. Of her career decisions following an anticipated retirement from her management position, she states, “But I am not planning to be... something I am not.”

For six women, an increased regard and appreciation for their own needs across life contexts is reflected in increased agency in career decisions. Before brain surgery Sarah espoused an unquestioning work ethic which compelled her to disregard her own needs and preference; this pattern is changed after brain injury. Whereas before brain injury she did work that she despised, she now states “I cannot do that to myself.” She describes an increased agency when she states “Sorry, but it’s out of the question. I can’t do work just for the sake of work.” But she still retains a sense of herself as “a very hard worker” and of her current career decisions, she warns others to “Get outta the road cause I’m coming through.”

Sophie explains the relation between a changed perspective, described as a sense of appreciation, and a more reflective career decision-making:

I was a real go getter before.... my edges have softened... I am a lot more laid back as a person than I was as a person. Before I was just so goal orientated I would accomplish something and I would be “Okay, what’s next?” Which is fine but it’s just not who I am now. I do stop and I do appreciate. I am just sort of in the moment, to say this is all good. I don’t need to do anything more right now. I can just appreciate where I am at and that is kind of a new perspective.

Following unsuccessful application for a long term disability on a one day per week basis, Katherine engages in agentic career decision-making related to strong work ethic and injury. While her doctor “thought it was a miracle that I had come back 4 days a week” her superior “thought I would start taking Fridays off as sick days.” Of her decision to decrease her
workload without pay, she states, "I felt quite comfortable with myself. If I am not taking pay then I am quite able to take the day off." Lucy described increased agency in future career decisions in this way:

It’s going to have to be something that I want to do, that’s going to support me... emotionally. I don’t think my jobs prior to this decision did that. I think they supported me financially. I think they supported me intellectually but I don’t think they were three dimensional, multi-dimensional. I don’t think that they took into account "What does Lucy really want to do?"

Jane underscores this increased agency when she asks in the decision-making context, "What will this do for me?" in the long term.

In summary, seven women understood their brain injury and their recovery from brain injury as a miracle or a second chance at life with a concomitant understanding of what is meaningful expressed as a sense of life purpose, altered perspective, sense of appreciation for life, or knowledge of what is truly important in life. Seven women endorsed increased agency in career decision-making as determination to pursue that which matters. These women sought to implement more internally driven values such as fulfillment, meaning and contribution to life in their career decisions. Furthermore, the realization that life is short spurred decision-making congruent with that which the women viewed as important in their lives. The seven women endorsed an experience of career decision-making that was more congruent, secure, and active across multiple career contexts. Finally, six women emphasized the benefits obtained through their experience of brain injury and endorsed a less materialistic perspective in career decision-making.

**Theme 4: Sense of Continuity and Change in Identity**

This theme encapsulates the women’s simultaneous experience of continuity and change in identity. While this experience is more salient for the four women who sustained a
traumatic brain injury, the four women who sustained an acquired brain injury also endorsed aspects of this experience. Aspects of identity, such as accentuation of the relational and intensified meaning of work, have been described in two previous themes: Continued Centrality of Career and Continued Centrality of the Relational in Career. Changed aspects of identity have previously been described in the Sense of Life Purpose and Altered Life Perspective Theme. The focus of this theme will be on the participants’ explicit descriptions of their experiences of identity continuity or change and consequent relevance to career decision-making.

The four women who sustained a traumatic brain injury related the experience of identity loss to the loss of pre-injury career including employment, education, or volunteer activities. Lucy especially experienced an acute sense of loss of identity crafted over many years: “identity is so linked to what we do out in the world, for employment.... It took me all of those years to create the identity that I had and that was wiped out in that accident.” In addition, Sophie’s experience of loss extended to self-presentation: “my identity was shattered as who I was before and how I presented myself.” Jane clearly located her experience to a loss of adult identity: “I regressed and I went back to my childhood and I went back to being a girl.” Lucy described the experience of loss as an active but painful process of letting go that is made more difficult by ongoing comparisons to pre-injury identity:

I’ve let go of the idea that I’m going to be returning to work in the same capacity and in the same place I was when I left. ...it took a long time for me to really let go of that because I was so attached to the persona of who I was.... I still measure myself by who I used to be.... I don’t know when I’m going to drop this idea that who I was is who I’m supposed to be. I don’t know if that ever happens.

Interconnected with the experience of loss is the protracted experience of
"rebuilding" or "reinventing" a sense of identity. Often the recognition that previous identity no longer works precedes a deliberate development of the post-injury identity. Lucy “acted as if ...I was still that person but I didn’t understand why it wasn’t working....It didn’t make any sense to me.” Rylan similarly describes this difficult experience as a simultaneous learning process: “still trying to be that person that has not been working for me; so trying to learn how not to be that person has been the most difficult.” She further experiences a conflict within herself: “the outside represents something that is so different from the inside and that is my own conflict and something that is really hard for other people to understand.” For Lucy, comfort with aspects of the “reinvented” identity precede “letting go a piece” of the pre-injury identity and happens “a little at a time.” Jane rebuilt her identity over the course of 4 years with the help of therapist: “I went from being a person who lost her identity to a person who basically established a new identity.”

Although Jane and Lucy initially experience anxiety and fear, they also perceive this process of establishing a new identity as an opportunity to develop an identity more congruent with their real self. Jane, for example, comes to appreciate the freedom inherent in this opportunity:

The freedom to build myself and be who I am in my identity....that is a wonderful thing to have .... It was not forced, not forced, but in the beginning it was forced because of the emotions that were with me in the beginning, the emotions, the frustrations, the fear. I had heightened fear and anxiety.

Jane also experiences great successes in rebuilding her person especially as she started to like her new person. She envisions with excitement that “there is no end in creating who we are. And I am developing...and it will go on forever.” Likewise, Lucy emphasizes that it is not “all doom and gloom” and that “where I am now [is] great and I get to explore... I think that’s great.” For Lucy, post-injury self-presentation is more real and accepting: “I have this
vulnerability about myself that I would never have allowed myself to have before. I just wouldn’t put myself in that position. So I’m more real.” Furthermore, she experiences the new identity as a more complete expression of self:

[brain injury has] also given me access to my creative self again. It’s taken away this persona that I became really attached to but it’s now allowing me to see part of myself that hasn’t really surfaced in over twenty years... and it’s a much calmer, friendlier, non-violent place...my interests have changed...or they’ve just reverted back to where they started before the money thing entered in the picture.

Other women also endorsed a continuity of identity as differences in post-injury identity were experienced as a heightening or accentuation of their pre-injury personality. Sophie experienced this continuity as an exacerbation of personality traits:

any kind of personality trait that I had before my injury was exacerbated completely....Say I was really happy or something, I might be elated now or just my emotions were very extreme and very heightened....if I knew I was going to do something or if I had a goal in mind ...then that would be more extreme, like I need to accomplish that even more so than before. I would be more passionate about it or heightened the personality characteristics. Even being an organized list person, very goal orientated, well that was so heightened. Now it still is....I do fall into that pattern a lot, just extreme... I think that this is part of my personality of who I am and who I was before.

Similarly, Rylan experiences many differences as accentuated aspects of her personality:

a lot of the things that I see that are different they are just heightened. It’s not like they weren’t there before but they are getting too much play time.... I think a lot of things that I feel right now are the same things that I have always felt. Criticisms, I have never liked being criticized. I like predictability. I like to do things well. I like flexibility a lot. So I think the patterns even now are the same they were....They are much more important now than they were.

Consequently, she finds it more difficult now to “go outside of those places that I feel more comfortable” in career decision-making and especially in a paid work career. Lucy also experiences continuity of her intellectual self, “a thirst to know,” which she perceives as an
ongoing “theme in my life” that “sure enough it’s still there.”

Significantly, this continuity is also experienced in career decision-making as a consistency with the self. Sophie highlights this consistency between pre-injury identity and career decision-making:

And after injury, I ... was consistent and social work was consistent with who I have always been before. Like I have always been people orientated and more interested in people relationships, dynamics, and how it worked. And sociology was something when I was in my early schooling I was... always interested in people and how they worked and what made them tick.

Jane stresses that her career decision to enter a helping profession is more consistent with her lifelong “passion to help people” than pre-injury career decisions. Lucy also describes the experience of career decision-making as an enhanced connection to pre-injury creative identity:

So the career choices are based on creative endeavors but there’s still a component of intellectual interests... it has the potential to be more well rounded than ever before. So this is quite a gift... that’s really quite a gift. ... there wasn’t really any room for creativity in there [previous employment]. I’ve always been an artist you know. And here I am back to square one and maybe I won’t have to compromise this time.

The meaning for Lucy is that she will not have to abandon any part of herself. Furthermore, a return to her creative self is “just another wish granted” in her life.

Three other women similarly articulated a heightened creativity after brain injury as significant to career decision-making. For example, Jane makes time for and immerses herself in creative hobbies such as painting and crafts. Sarah, who now describes herself as “so creative,” developed a passion for creative work such as refinishing antique furniture and decorating in the Victorian period. She describes her desire for creativity: “I constantly want to do... crafts if I could. I want to learn how to re-upholster the antique stuff. ...I can design.” While Rylan made a decision to be a hairstylist due to the creativity inherent in the work, she
now experiences an enhanced need for visual creativity in her life. She is drawn to home
design and has successfully completed a recent redesign project for a customer. Similar to
Sarah and Jane, Rylan experiences much pleasure and success in creative home decoration on
a budget. She says, “having to be resourceful I like that. So I love going to second hand
stores and recreating things. I like that kind of stuff.” She further describes this enjoyment as
a complete absorption, a “getting lost in” the creative process.

To summarize, the sense of simultaneous continuity and change in identity was most
salient for the four women who sustained a traumatic brain injury. These women described
an experience of identity loss related to loss of pre-injury career or an altered self-
presentation and a protracted process of developing a post-injury identity that was initially
accompanied by anxiety and fear. Importantly, as two of the women began to believe or
enjoy aspects of their new identity, they began to perceive the development of the post-injury
identity as a rewarding opportunity to develop an identity more congruent with their real self.
Four women simultaneously understood heightened expressions of pre-injury personality as
changes and continuity in identity. The ensuing experience of career decision-making was
described as more consistent with and inclusive of aspects of identity. Additionally, four
women endorsed an enhanced creativity as an important aspect of their post-injury identity to
be integrated in career decision-making.

**Theme 5: Sense of Increased Vulnerability in Interactions**

This theme elucidates the sense of increased vulnerability in interaction with others as
an integral aspect of the experience of career decision-making for the eight participants. This
theme consists of two inversely related sub-themes: (a) sense of being devalued; and (b)
sense of equality.
Sense of being devalued: Although the sense of being devalued was a common experience in interaction with others, the eight participants endorsed varying degrees of feeling diminished across settings and differing responses to being devalued by others. Generally, the sense of being devalued by others was most salient in settings where others were in a position of authority such as in interaction with professionals in rehabilitation settings and in interaction with superiors in the workplace. The eight participants variously expressed the sense of being devalued as being discounted; being disempowered; being disenfranchised; not being understood; being treated like a child; being labeled; and being given decreased expectations. As well, four women experienced an internal sense of being devalued in self-comparison to pre-injury self or in self-comparison to others culminating in increased sensitivity to others’ judgments. Additionally, invisible disability operated as double edged sword resulting in others diminishing the participants’ experiences of loss. Significantly, for four women, the sense of being devalued triggered an anger which provided an impetus to regain self-determination.

For six women the sense of being devalued occurred within an imposed, impersonal process in litigation, rehabilitation, and employment contexts. The women were most offended by objectification at the hand of professionals presumably in a supportive capacity. The women experienced assessments as degrading situations due to the imposition of lowered expectations; anger was, therefore, a common reaction to such situations. For example, Sophie describes her perception, in a litigation context, of assessment and professional opinions as “shutting down her possibilities”:

I understand that part of ...the assessments and the professionals’ opinions are really to be realistic, not to give false hopes... But at least there has got to be some room there for people to say, “You know what prove me wrong.” There are exceptions to rules. There are people that have done it against all the odds.
That was never offered.... The stats only tell us so much. How do you factor in individual uniqueness, and individual people... there are no brain injuries alike. There are no two people alike. So how you can just sort of have a standardized sort of way you are going to turn out?

Sophie identifies her outrage at an impersonal judgment as the source of her resolve to prove them wrong:

How dare you place those judgments on me when you don’t even know who I am! Yeah, the stats show all this and yes the prognosis isn’t great. But you don’t know me as individual and the strengths that I do have and the gifts that I bring. So that just got me going even more so.

Sarah similarly expressed anger at perceived degradation during assessment feedback. She expressed her refusal to accept lowered expectations to the neuropsychologist as:

“I could care less if you’re a professional.”

The experience of being degraded extends beyond imposition of lowered expectations to include violations of self-determination and dignity during an assessment process. For example, Katherine was not given advance warning that the implicit purpose of testing was to illustrate perceptual deficits with potential repercussions such as removal of driving privileges. Expecting confidentiality, Katherine expressed her concerns to the agency psychologist only to learn that patients did not have confidentiality within the agency. She continues to experience anger at these significantly “unprofessional” violations which left her “hot under the collar”. Elisabeth recounts also being offended by feeding and bathing programs that require the patient to swallow and to bathe in front of an occupational therapist. Likewise, Jane describes her experience of being objectified by rehabilitation professionals as “one of the sour things that forms in my side from the rehab days.”

She further describes this experience:
I had handfuls of people who were professionals in my rehabilitation but they weren't really on my side. They just liked to fill out the forms and send them to ICBC...on weekly and monthly schedules. I felt like I was a number.

Significantly, “shutting down possibilities” was not an uncommon occurrence in the women’s interactions with professionals related to career decision-making. Three women, in particular, described these interactions as an imposed process; their refusal to comply with lowered career expectations placed them in positions of proving themselves without support. For Katherine, being labeled noncompliant was a cost of self-determination during her unhelpful experience with the rehabilitation specialist. When Katherine refused to accept that she would not ever be able to multitask and consequently could not ever return to her management position, she was asked to sign a waiver that she would not hold the agency responsible. Katherine’s expression of noncompliance highlights her sense of self-determination: “No, I am not into this process. I am going to get back to work and it will either be with your approval or without your approval.” Katherine further points to her high standards as the source of her motivation: “you have got to ask most that we can of ourselves...we can’t settle for second best. I am not prepared to do that, never have been.” Similarly, Sophie points to a “push to excel” as a source of motivation to prove herself and for “just not buying into all the other viewpoints of experts saying I couldn’t”:

I just always really reacted to people who were trying to shut down my possibilities, that would not sort of let me go, “Okay, you know you are right. I might as well as give up. What is the point?” In fact it just made me want to prove myself even more.

Elisabeth also describes the experience of being actively discouraged and told that “at the very least they wanted me to wait a year” when she informed the employment counsellor of her intention to return to school. She, nonetheless, decided to return without support although she could see that “people were very doubtful because I still had no hair and a scar
showing.” She explains her motivation to achieve in spite of disability:

The motivation ...came from almost having lost the ability ... I wouldn’t say I have a disability but I am certainly still affected by it especially some days more than others. ...the motivation is there to just overcome that or to be able to despite [disability], if I can’t completely overcome it then to do something in spite of it.

For Elisabeth, determination to return to school without support left her with absolutely no choice but to receive social assistance. Although, Elisabeth and others perceived that she “was deserving of it because this [brain injury] was beyond my control, she experienced “stigma” and “degradation” when she applied for social assistance. When Elisabeth demonstrated her ability by earning excellent grades during the one year waiting period, the employment counsellor acknowledged her success and approved funding for retraining. Though, Elisabeth appreciates “the severity of the surgery that I had and the injury that I had,” she says: “I always feel ...like I am milking that a bit [funding] because I know a lot of other people that are far more affected by their experience than I am and should be more deserving of more help.”

Critical to the women’s stories is their determination to reach their potential despite the reduced expectations devoid of hope or encouragement that were offered by professionals. Additionally, two women, perceiving lowered expectations from friends and family, asserted self-determination by not sharing their career decisions with others. Elisabeth, for example, made the decision to transfer into the Bachelor of Social Work program, “In my mind, without telling other people about it because they thought I was crazy that I wanted to go back to school in the first place as quickly as I did.” Lucy similarly does not tell her friends in the “writing community” that she is writing a book in order to avoid negative judgment and discouragement. An important point in three women’s stories was the
absence of acknowledgment of accomplishment from professionals who had urged lowered expectations. Sophie, for example, remarks that she has not received any acknowledgment which underscores her point that professionals are not attending to the individual person.

Two of the four women who returned to academic studies described decisions to not use postsecondary disability services in order to maintain a sense of independence, self-direction, or normalcy. Sophie states, “Those things were available but I just decided not to do that… I was always very kind of self directed, self motivated person that thought you know I am doing this.” Elisabeth similarly states the importance of not using services for students with disabilities: “But I never did take the extra time and that was not … comparing it to what other people might do but it’s almost a race with myself… I feel like I am a step closer to the normal ability that I might have had before that.”

Workplace interactions with employers or coworkers, who enacted negative assumptions about the participant’s competence and work ethic, also contributed to a sense of being devalued with concomitant negative effects on mental health. When, a year and a half after her surgeries, Ramona returned to her workplace on a half-time basis, she felt pressured to work the long hours she had worked in the past and felt guilty each day she walked in the door because she was not staying as late as the firm wanted. She further experienced a lack of empathy, lack of care for her as a person, and lack of understanding for her situation. Ramona was “so terribly unhappy” and “disturbed” by this workplace treatment:

a few of the lawyers … treated me like I was stupid … like I was not all there…. They would give me an instruction and they’d look at me and ask me to repeat what they had just told me…. basically treating me almost like I was 5 years old. So I really felt uncomfortable with it and it was really hard on me.

When Ramona realized that “this firm is not helping me, they’re hindering me, they’re really being hard on me,” she made a decision to leave the firm. She explains: “I just knew I could
not be in a firm that didn’t appreciate me.... I thought I deserve better than that.” Katherine also felt devalued and a lack of appreciation when her immediate supervisor, assuming that a workload issue was due to stroke, ignored Katherine’s request for additional personnel. Feeling quite depressed and unsupported, Katherine had made plans to retire early. However, she was able to prove to the president that the workload issue was not due to her stroke and, therefore, received additional personnel. She says, “That support made all the difference to me and that is why I decided to … continue working.”

Significantly, self-comparison in the workplace to a pre-injured self exacerbated the sense of being devalued. Before injury, Lucy experienced significant appreciation in the workplace: “there wasn’t one day where someone didn’t say to me, ‘I’m so happy you’re here’ and viewed herself as “quite an attractive employee… and then I got hit by a car.” After injury, when her employer terminated her employment without warning, she experienced a sense of not being wanted and of being disenfranchised:

My employer calls me and says you have to come in and sign some documents. So I come in and they make me hand in my ID. That really rattled me because that was the first indication to me that … they don’t want me…. my job was posted, my phone was disconnected. I was disenfranchised. That’s how I felt and I was just cut away from the whole scene.

In self-comparison to her pre-injury self, Rylan experiences an internal sense of being devalued which increases her sensitivity to the employer’s judgments. Rylan’s example illustrates the ensuing downward impact of an employer’s negative judgments on a preexisting sense of “feeling bad” that she cannot then shake off easily. In returning to work for a previous employer, Rylan forewarned her employer “about difficulties that could come up and especially specialist appointments.” As a punctual and timely person, Rylan says, “I already feel bad [about leaving work for medical appointments] because I don’t think that I
would have been the kind of person that would have been understanding of that ... before this accident.” The employer’s negative judgment, expressed as displeasure when Rylan takes time off for specialist appointments, compounds Rylan’s sense that she is no longer a valuable employee and she feels “like a failure.”

Sarah similarly describes an internal process of being diminished and an increased sensitivity when she highlights her limitations in self-comparison to others in the classroom. She further explains the relevance of an anticipated lack of support to her experience of depression: “I get very easily disappointed in that because I know my own limitations and with that [comes] the incredible sensitivity. Then I always think, well who’s going to take the time. Who’s going to take the time?” This expectation that others will not be patient and supportive brings her to a “morbid thinking” and “to the lowest” point. Jane likewise related a heightened awareness of her distractibility in comparison to other students and perceived negative judgment to an internal sense of being devalued. She said: “I started to feel really stigmatized because I would jump around so much.”

A final point made by three of the women is that, because of invisible disability, their hard won recovery is not always valued or believed by others; rather others minimized the women’s experience of loss or injury. Sophie described devaluing as a common response at workshops when she shares her experience of injury and recovery: “almost devaluing my experience, thinking you are lying, or this possibly couldn’t have happened to you, it was so far fetched.” Katherine describes the response to invisible disability in her workplace as a good thing and a bad thing:

by the time I got back here I had worked really hard....on my rehabilitation....I was thin but I looked really well and I think people thought, “oh well it could not have been, really been that serious.” Because that is a good thing and a bad thing. I did make a good recovery and everybody said,
“Oh well, you couldn’t have been, you couldn’t have been that bad. You look so fine and you are moving fine and all that.” But I knew that I had residual deficits.

The following incident illustrates Elisabeth’s experience of being disempowered when a social worker discounts her injury:

But she from the beginning said “No. No. There was just no way that I was going to get temporary disability.” .... And then [after argument with doctor] she approached me and told me that okay I should apply for it and make it sound like I had my worst possible day. ...because she didn’t believe me ..., didn’t see me as deserving of temporary disability, it just made me feel very well disempowered, just very even down more. I was already dealing with all of the physical stuff but then having someone tell you that ...

For Elisabeth, this social worker “represents the model of how I hope not to be treating other people.”

In summary, the sense of being devalued was a common experience in career decision-making for the eight women. The sense of being devalued was most salient in interactions with professionals in rehabilitation settings who imposed lowered career expectations or with superiors in the workplace who judged the participants negatively. Four women described the experience of anger and a determination to prove themselves when professionals urged them to accept reduced career expectations. These women attributed their motivation to the desire to reach their potential in paid work careers. Four women, who experienced an increased sensitivity to others’ judgments, described a precipitating internal sense of being devalued during self-comparison to pre-injury self or others. Finally, three women reported that others devalued their experience of injury and recovery because of their invisible disability.

Sense of equality: Conversely, respect and a positive support from others provided six women with a sense of equality in career decision-making. Furthermore, the women directly
related a sense of being valued to positive mental health. Significantly, a critical ingredient in positive support was the demonstration of belief in the women’s capacity to achieve a desired career goal. Elisabeth articulated the differing effects of receiving support in rehabilitation from professionals who believed in her versus receiving support from professionals who did not believe in her:

it stood out so much in contrast to the other two [social workers] that I had had who were really just amazing, in their sensitivity, how they approached me...I knew that I felt the effects of having somebody that thinks she [Elisabeth] can do something...even the speech pathologist who thought I could do this versus somebody saying well there is just nothing here for you. Just the difference in their attitude how it affected my attitude...I think in a way it made me feel more that I wanted to go into this field because I had had these other two really positive experiences.

Elisabeth further describes a key positive support experience in her return to school decision:

On my very last day, the speech pathologist gave me homework. ...she read the article to me. I had to take notes and prepare a presentation about the article for her the next day and I took this very seriously. I practiced my speech to my mother and several other patients and I gave her the speech the next day. And she was impressed but more I was impressed...that I actually remembered this...And so then I decided yeah to go back and I started taking classes.

Sophie similarly emphasizes the facilitative impact of encouragement from “just people believing in me” on her journey to becoming a social worker:

I really had so much support behind me which was so instrumental in going forward....I really attribute my recovery and a large part of how well it has gone for me to my family and friends who’ve rallied around me and supported me and believing in me through all the ups and downs.... I think if it weren’t for my family and the people around me who I loved and cared for, I don’t know where I’d be. I really feel sad because at the Brain Injury Society...I saw a big link between the [lack of] family support and how they [persons with brain injuries] turned out. So I know that’s really important.

As a specific example, although Sophie had not intended to start the Masters of Social Work immediately following completion of Bachelors of Social Work, she felt “comfortable” about
doing so with her husband’s encouragement and decided “I am going to just go with his support.”

Katherine perceived her physical rehabilitation efforts, in preparation for her return to work, as a joint venture with her husband:

My husband and I had worked really hard on my rehabilitation. The walking, didn’t matter what the weather was ... we would go to the beach and we would walk ... an hour every day, every single day, rain or shine ... and the gradual thing of being able to start to swing my arm, take my arm out of my pocket, being able to put on a glove. I mean all those little milestones became huge.

Elisabeth likewise describes recovery as a joint venture with her mother,

My mom moved into a bed and breakfast right around the corner from [hospital] and she was there all the time. If it hadn’t been for that, my recovery wouldn’t have gone as well as it did. Just the fact that someone is stimulating me by talking to me, that made me think, that helped a lot. I am just really grateful for... I just feel..., really lucky in everything, in the family I have had, the opportunities I have had. I feel I had a best case scenario.

Furthermore, Elisabeth states that her mother, who lived with Elisabeth in the first 6 months, was the only person who initially believed in Elisabeth’s capacity to complete a university course immediately after surgery.

Lucy also emphasizes patience as an important aspect of a loving support:

My friends are patient with me and they’re supportive and loving. They’ve had to adjust to me as well and so now they don’t try to hurry up a conversation with me. They don’t try to finish off my sentences for me. They just let me get there, whereas before I think they thought they were helping me or they were impatient. So they’re allowing me to find my way.

Jane’s description of the effect of a postsecondary support program further illustrates that a positive support, which incorporates belief in the individual, confers a sense of hope:

It was a wonderful thing to take. I found that it was great for support....I loved being in the place of back in time when I succeeded. It gave me a lot of hope in recognizing my potential to succeed again in a different way.
Jane also receives a positive support from instructors who accommodate her needs with sensitivity and especially from a fellow student who offers a close friendship and an “overall blueprint of the finished format” for assignments.

Ramona emphasizes that the actions of her long term disability manager, who “was really, really helpful with me,” enabled Ramona’s search for a healthy work situation. Realizing that Ramona might be suffering from post traumatic stress disorder, the manager obtained funding for therapy. Ramona especially appreciated the manager’s confirmation that the first return to work environment was putting too much pressure on Ramona: “She looked at my work environment [and] took a walk through the office. Then we went for coffee and she said, ‘I can tell right away this is not for you…. this isn’t working for you. They’re putting you under too much pressure’.”

Ramona equates the respect and support of a good boss to the ability to work well together and to her current happiness in the workplace. A current boss, “a wonderful man” who understands the concept of brain injury, demonstrates a high regard for Ramona. For example, if Ramona is not having a good day, he’ll say “don’t bother coming in today.” Furthermore, through his actions, he demonstrates a belief in Ramona’s capacity to succeed as a legal assistant. Ramona emphasizes that he has mentored her and guided her with a patient sensitivity:

When I told him what had happened he [said]... “We’re going to slowly get you back up and running.”...he took me from point A, knowing that I was really not completely with it yet, and just slowly, slowly, slowly retrained me. He took me... 10 or 15 hours a week ...and he just slowly sort of guided me. And he’s completely got me back up and running by slowly giving me a little bit more responsibility and now I’m to the level where I’m full on with him.

She says of their working relationship, “he makes me happy... I’m so happy working with him. It’s fun, he gives me challenges, we just work well together, we’re friends.”
As a contractor, Ramona has the flexibility to “to work for people that I really want to work for,” to select lawyers with “great attitude towards their practice,” and to select environments with “no pressure.” She further highlights respect from employers and being appreciated in the workplace as the source of her workplace happiness: “I work for three of the six [lawyers], they all treat me with a huge amount of respect, they think the world of me… they love me here.”

Sarah similarly stresses “one good boss” as an important factor in her future paid work career decisions. A former “wonderful” boss serves as the model of a good boss. Though he was aware that she needed more time to catch on, he “was never condescending” when he helped her. Further, respect from this former good boss and his expressions of appreciation such as “you have an outstanding moral work ethic” enabled a feeling of being equal. While Sarah “used to take [condescension] an awful lot” before injury, she now maintains “I know that I’m an absolute equal, an absolute equal, and I will not take that.” Rather, her current view is that she and her boss serve each other so that “if my boss is good to me, I’ll make sure that everything falls into place.” Katherine described validation from the president as reason for continuing in her position. Rylan also identifies the clients’ trust in her ability as an important aspect of a successful unpaid home decorating work trial: “What worked really well was that I connected really easy with this couple. They were just so giving me every decision; they weren’t offended by anything so it was easy to work with them and make changes…in their house.”

To summarize, six participants described the experience of positive support in interactions with others which conferred a sense of equality in career decision-making. A critical ingredient of positive support was the demonstration of belief in the participants’
capacity to succeed in self-determined career decisions. Elisabeth’s description, “having someone in your court,” encapsulates the women’s articulation of positive support as a significant factor in a good recovery from brain injury. Four women expressed a perception of good recovery as a joint venture with family and friends. Three women described positive support in the workplace as the demonstration of belief in the participant through respect, understanding, and patience. Notably, the presence or absence of belief in the participant and presence or absence of hope are key distinctions between positive support related to sense of equality and negative support related to sense of being devalued.

**Theme 6: Sense of Insecurity and Emotionality**

This theme highlights the women’s sense of insecurity and emotionality in career decision-making as related to their awareness of changed cognitive or physical capacity and to the need for accommodation of changed cognitive or physical capacity. The eight women variously expressed the sense of insecurity as uncertainty, not feeling comfortable, insecurity, self doubt, mistrust, taking a risk or a loss of confidence. For six women, the sense of insecurity also included the experience of financial insecurity. Concomitant with a sense of insecurity, seven women experienced emotions of depression, anxiety, apprehension, or fear. Six women further described strategies for coping with a sense of insecurity that included withdrawal; presenting as normal; tentative decisions; decisions made slowly or with considerable thought; plunging into an anxiety provoking activity; reframing difficult tasks as skills to be learned; taking baby steps; and engaging in volunteer or unpaid work positions. Importantly, four women noted that their sense of insecurity varied in degree, within individual settings, according to the perceived degree of success. Furthermore as these women experienced small successes, a sense of insecurity gave way to the sense of
confidence in individual settings.

For the eight women, an integral aspect of the sense of insecurity was self-comparison to pre-injury cognitive abilities or physical abilities. Lucy illustrates how self-comparison to her pre-injury self, described as an “overachiever my whole life” whose career decisions were “based on challenge,” contributes to the sense of insecurity in the learning process:

I really struggle with grasping new things. I struggle with grasping things I used to know...I’ve already had experience with trying to learn things and feeling the frustration of that. So I have to develop patience with myself. I’ve never had to before. The whole learning process has changed for me. I didn’t really even think about it before. I just did it, I just threw myself into a situation and learned and I’m doing that again. I’m throwing myself into a situation and maybe the outcome will be the same but the process is different. It’s going to be repetition. I’m not going to be doing things perfectly. It’s an acceptance that I’m going to make a lot of mistakes... I have insecurities around it. I don’t have spontaneity around it like I used to. I don’t like not being able to learn the way I used to... but I think it’s probably good for me. It’s a big adjustment.

Whereas before injury Lucy “was surviving and thriving” in a competitive environment, she knows she “couldn’t survive there right now.” Furthermore due to some difficulty in expressing herself, her former ease in social networks has changed to sense of “struggle” in social conversation. As her communication has improved, she doesn’t “feel quite so embarrassed and so afraid” with strangers and puts herself “out there a little bit more.”

Elisabeth similarly describes withdrawal from people early in her recovery “because I still didn’t feel like myself” and felt the need “to appear normal” to others. It “seemed too tiring and complicated to be around people.” This withdrawal was a key factor in her decision to begin academic studies with a university distance course. Sophie, noting that her “confidence level was shattered” also describes an early withdrawal due to concern about how “I presented myself. I was just so uncomfortable and nervous to speak to anyone on the
phone, to answer the phone, to write because I couldn’t.” Jane however describes an ongoing experience of panic and feeling like a “fish out of water” in the classroom due to residual communication difficulties:

And communication is so important .... it’s the social cues... how to feel comfortable with I have to say so I don’t sit there...I don’t feel comfortable with that emotionally or physically...I feel a bit like a fish out of water ....there has been the odd student or two who have been sitting in the classroom before class when everybody is doing their thing and they want to talk to me. I will feel a bit panicked. I feel like “What do they want? I am going to get zapped here. Am I going to get drained?”

Similarly Sarah shares that she was “very nervous around other people” when she returned to her workplace after brain surgery. Slowly over time this discomfort became a more pervasive withdrawal: “There was five adjectives that used to describe me, friendly, outgoing, vivacious, bubbly and social...Now I had become a recluse, very isolated, very reclusive....it’s become a problem and it causes a lot of loneliness. Yes, I don’t trust anybody.” Sarah connects self-imposed reclusion to the uncertainty that she feels much of the time: “it’s like having to work double time because the one thing I get from brain surgery...is that feeling ... of unsure because I distract and I have trouble making decisions.”

Furthermore, Sarah relates a sense of pervasive insecurity to a slowed cognitive ability; unable to keep up in busy workplaces, she has been laid off and has also experienced an emotional collapse. She anticipates that the “fair bit of mental support” she requires to offset uncertainty and a downward emotional spiral will not be available to her:

I need to have a person or two...that are very supportive of me because something happens to me. This is definitely from the brain surgery. ....I’m doing a job and ...I’m doing well and then something happens and that ... where I start going down...emotionally. I start getting very teary. I become very reclusive...I need quite a bit of support and don’t think it doesn’t scare me, because it does. I think ... “Who wants to hire me? Who wants to hire somebody like that?” I’m very tough on myself ...I think “What are you good for?”
Sarah relates awareness of her “own limitations” to emotions of being “scared” and “easily disappointed” in her post-injury experience of career decision-making. For example, while Sarah is “loving school” and would like to continue with academic studies, she is also “scared” to pursue further academic studies because she is “having trouble keeping up.” Additionally, because she has not had any one job for more than two years post-injury, Sarah harbors the “hidden thought” that she will be a low income person: “that scares me because then I think ‘Am I ever going to be able to be solid in any work? ...Am I not dependable?’ It brings up that fear in me.” She further points to government policies that force people to get back working at low paying jobs and that offer only one chance for retraining as significant contributors to her fear.

Whereas Sarah highlights the connection between an awareness of cognitive changes and a sense of being scared, Jane highlights the significance of a residual anxiety from the trauma of almost losing her life and of loss of control of her life as a “bigger factor for me lots of the time than [cognitive] brain injury symptoms.” Jane illustrates how anxiety blocks her academic performance and the ensuing frustration and sadness:

I still have a performance anxiety where I get blocks ...no matter what I have studied, I can get half of the answer and the other half is totally blocked out...If on every [one] of those 30 questions you can only answer half, you are only going to get half marks so then barely just pass....it really bugs me a lot because I block out....I would sit there and cry, but ...physiologically I don’t cry...but I have the emotions with it.

Jane further illustrates the connection between the experience of anxiety and feeling unsafe to a lack of self confidence when the instructor calls on her in the classroom:

I will go ohh [sound of anxiety] and I will think “Okay get focused. Just get focused on where you are at because if you don’t, you are going to just lie and say I didn’t do my homework when you did. You know you can answer this. ...is it lack of self confidence [that] is going on here?”
Jane copes with the experience of generally feeling unsafe by “just plunging in there” and engaging in reframing self-talk: “I have to tell myself that you are safe….everything is fine…it’s not really about safety but it is maybe …a skill.” Jane explains that reframing career goals as skills to be learned facilitates movement towards her goals: “I will likely go after it… to me that is bait. I will look around for where can I learn this.”

Similar to Sarah, Jane also emphasizes the contribution of government policies to an increased experience of anxiety. Significantly, the greater emphasis on self-employment in the changing workplace and lack of job stability engendered a lack of confidence and anxiety that contributed to her decision to change fields of study:

at the time the government was changing over from NDP to Liberal ...I started to feel panicked that [due to] the Liberal [policies] ...I would have to learn how to become an education assistant as a private business. ...that the education money was being cut back to that extent....I really felt just like jumping out of that....I stopped school. I didn’t quit. I finished the semester.

Jane perceives the social aspect of communication in her future workplace as “anxiety provoking” and emphasizes that she does not have the opportunity to practice communication skills in her academic program:

what it takes to get comfortable with doing something is practicing it and practicing and practicing and then it becomes a skill...I don’t know where I am going to get that from because [in the] academic arena there is not really opportunity for that.

She thinks that her “decisions will be different,” if she can “get more comfortable with expressing myself” and “separate from anxiety.” Jane manages a sense of insecurity by making tentative decisions with an eye on readiness: “I will try it on for size. I will see how I do and if I like it, I’ll stay there. If not, I am going back. I am not going too fast, when I am ready.” Jane describes a “void” in future career decisions: “I don’t know where I will begin but I think I will.” Furthermore she is aware that “I will likely need some kind of support...
but I am used to having resources...as I grow I shed... resources and I get new ones and
[I'm] happy to do that.”

Similar to Jane and Sarah, Rylan described a sense of apprehension and of fear in her
return to sales work after brain injury: “going over it in my head beforehand. ‘What do I do
when I get there? What did I do? ...What do I go to first?’ ... It was pretty scary.”

Whereas pre-injury Rylan had not “ever experienced anything that I couldn’t do
before,” post-injury, following a number of unsuccessful work attempts over a six year
period, she experiences a “fear of jobs.” Rylan describes unsuccessful attempts to downplay
cognitive difficulties with a normal presentation in her return to sales work: “I was really
good at my presentation of being just fine but then when it came to the functioning part
...there were lots of things...that I didn’t remember ... eventually I was fired which I figured
would happen.” As a parent volunteer, she similarly unsuccessfully tried to present as
normal on the high school accreditation team:

I learned really quickly how to; there would be a buzz word and that was just
enough to be part of it but not really get what was going on, carry my binders
in and out, never look at them because it just didn’t mean anything to me any
longer, working on budgets it just didn’t mean a lot.... all of those things
[volunteering at schools] just sort of disappeared... I wasn’t invited in

Through a recent assessment, she has learned that, due to good social and verbal skills she
can “easily convince people that I am capable whereas I am not.” Due to this good social
presentation coupled with a personality tendency to “push myself even past where I should push myself,” Rylan fears that she will find herself in work situations where she is not
successful and will “feel like a failure.” She describes the impact on her emotional well
being:

that whole up and down thing that happens because I get involved in
something and feel like I am on top of the world. All right this feels so good. I
am back at it and then realize that I haven’t been back at it because somebody is unhappy or I did something that I wasn’t supposed to do but I didn’t realize.

She wishes that her emotions in the workplace, which are “either way up here or ...way down there...could hover around the middle...but this doesn’t seem to happen.” She feels unsettled when she is feeling really good because she knows “it is probably not going to last, something is going to come.” This apprehension is compounded by the knowledge that she misses the ‘warning signs” that should alert her to work performance issues. When Rylan considers future career decisions, she experiences considerable fear:

> when I think about other things to go into, I am pretty emotional about it because I am afraid of those things... I have gone along thinking everything is going just great and then all of a sudden somebody says something to you and instant tears or things that happened that you are not even expecting or don’t even realize are going to happen and even my own reactions not just the anger it is the emotional stuff too.

Remuneration significantly increases her sense of fear because “they have the right to expect all these things and right away I feel like I am not going to live up to the expectations.” Additionally as “a very nurturing person,” she experiences fear not only because she anticipates that she will hurt others in the workplace with uncontrolled defensive anger but also fears “feeling a thousand times the pain that I see that person feel.” Connecting defensive anger to a loss of confidence, she states: “I lost my confidence in my mothering as well...it’s just very recently actually that my kids can say something to me as all our kids say and I don’t take it so defensively.”

Hairdressing in the home is a “perfect” career for Rylan, but post-injury, due to limited physical stamina and pain, she cannot increase hairdressing hours to increase her income. Rylan expresses a sense of insecurity about the possibility of planning for all that she must consider in career decisions which she manages by giving her future decisions “a lot of
thought.” Foremost she wishes to avoid the “feeling of failure” and the desire to do
“whatever I can do to give myself as many successes as possible ...in future careers.”

However, for three of the women the sense of insecurity and experience of fear were not limited to situations of poor work performance. Sophie similarly identified the sense of insecurity and experience of fear as key in her decision to close down her successful private counselling practice after a few months. While she began the practice confident that in offering counselling for people with brain injuries she would “create a niche that is very unique,” she soon “got a little bit scared” and found all the details “overwhelming.” Sophie said, “I was doing well with getting the clients that I did but I just thought oh boy, I can’t.” She found the work that went into each session “so demanding” and “exhausting” that she became concerned that she would be too “tired.” Additionally she experienced financial insecurity and questioned whether she was ready to be in charge of everything in the business:

How I am going to actually really make a living, a really secure living when I have got so many plans to have a family and create a life with my husband? Do I really want to have this all being in charge of just absolutely everything there is in my own business? And I thought I am not ready yet to take it all on.... I got a little bit worried ...I just don’t want to rely on myself to make a living on my own ... This is not exactly what I thought it would be.... it’s a bit too much for me to take on right now.

While generally successful and confident in her post-injury positions, Sophie experienced a high level of stress and the sense of being overwhelmed in a recent management position that “wasn’t a good fit.” Although she did a good job, working in an area of weakness came with a high emotional cost:

I do a good job of whatever I take on but it was not without a lot of distress and dislike....the last couple [years] in particular recognized what I can and can’t do, my strengths in terms of what I can’t do. And multi tasking and case management work is not my strength at all.
In describing herself as a “not very courageous person,” Elisabeth highlights the courage inherent in taking risks in career decision-making. Pre-injury, the impetus of career decision-making was the avoidance of risk by “playing it safe” and “not making a decision she might regret.” Post-injury, she minimizes the sense of being intimidated and the experience of fear by taking “baby steps”:

When I entered university, it all freaked me out from the library, to do research, to ...Microsoft Word. I just saw all these obstacles and now that I am in the system, you realize that you are moved along. You don’t even have to be so terribly active moving yourself. You just get moved ... I am very happy that I am at such a small university.... We have so much attention ... you really feel like people know you... I think I am much happier here than I would have been, if I had at 19 gone to UBC. I don’t think I would have been happy. It would have been way too intimidating for me way, too scary, way too big. This is baby steps. That is me.

Furthermore, Elisabeth describes how a cycle of small successes gave her a sense of confidence and the motivation to take the next step:

I got an A- for psych 101 and that was within six months of brain surgery that I finished my that course. So I felt really good... having had the success is what kept me going... I don’t know ... how motivated I would have been if I didn’t see success.... it just went around and around between the motivation and the success and that in turn motivated me.

For example, although she experienced a sense of anxiety in her first practicum, she “learned from the first one that I can relax.” Although the second practicum was “overwhelming regardless,” she is “just able to relax a lot more and not feel as anxious about it all.” Although “it is so hard to anticipate in this economy,” Elisabeth nonetheless describes a sense of being “really open” to the broad range of future career possibilities in the field of social work.

Post-injury, Katherine “became much more protective” of her time. She describes this protection of her energy:
I cut back my hours to just ordinary working hours so that I would come in at 8:30 and I would leave at 4:30.... I don’t go to committee meetings or anything in the evening anymore. I used to be quite involved in church work ...but I don’t do that anymore. I sort of need the evenings to unwind.

Despite a reduction in working hours and evening commitments, Katherine describes a deep exhaustion: “on Thursday nights I would almost be in tears. I was so tired. So I just knew that I couldn’t work Fridays.” Although confident and successful in her return to work, Katherine nonetheless experienced a sense of risk in choosing to accommodate for fatigue:

It was a big decision to decide that I would only work four days a week. That was a major decision but ...I knew myself well enough and I felt I could take the risk. I didn’t know whether the [employer] would accept that but they were very willing to accommodate.

When her request for part-time long term disability was denied, she thought, “I could either put all my energy into fighting that or ...take Fridays without pay. So that is what I have done ever since.” Katherine emphasizes that overall her experience of career decision-making has not changed. She continues to “jump at opportunities as they come along” and she will have “my ear on opportunities in the future.”

Ramona also experiences a sense of insecurity related to cognitive changes and to part-time hours required to accommodate fatigue. She says:

I used to be someone that was right on the money; if I ever wanted a job anywhere I could just walk across the street. I had a reputation in this town for being very good at what I did, very very well organized, huge multi-tasker, and I just can’t do that anymore.

Consequently, the decision to leave her pre-injury position to become an independent contractor represented a significant financial risk:

I was giving up full time work and contracting...I didn’t have financial support. I did have long term disability paying me for the portion of time that I wasn’t working but I can [contract with lawyer] and not... be working next week for him, that’s contract work, a huge risk and...if I would have stayed at
the firm that I was working at I would still have long term disability because they can’t deny you once they’ve accepted you.

Additionally, she describes the initial disclosure, to a major contractor, that she had a reduced capacity for multi-tasking as a significant risk. While Ramona has experienced good success as an independent contractor, she is still “trying to figure out a way that I could actually work in a firm, get coverage, get all the benefits, have a great job there without having to work full time.”

While Ramona feels confident in her current work positions, she does not know her capacity for new endeavours. For example, her decision to live with her current partner and mother his son: “was really a tough decision to make because I didn’t know if I could handle it.” As she “slowly helped” her partner take care of his son over a year and a half period, she developed confidence in her ability and made the decision to move in together as a family. However, she still experienced a sense of uncertainty that she had done “right thing” given her own limitations. Although the experience has been a struggle, she was successful and is happy that things have worked out well.

While Ramona would like to try other things, she identifies two issues that contribute to a lack of confidence in future career decision-making and perceived readiness to “go to the next level.” She emphasizes that “I don’t really know if I have capacity for it [new learning]” and that “I am not going to put myself into a high pressure position.” Similar to Jane, she highlights the contribution of residual post traumatic stress to a sense of insecurity in future career decision-making.

In summary, the eight participants endorsed a sense of insecurity, related to changes in cognitive or physical abilities and the need for accommodations, in career decision-making. The sense of insecurity was not invariant, however; for each woman the degree of
insecurity varied according to the social context and perceived ability to succeed in individual settings. Significant to a sense of insecurity was the women’s inability to predict their performance in new settings. The women variously described the sense of insecurity as insecurity, being unsure, sense of risk, lack of confidence, or discomfort. Seven women endorsed the experience of strong emotions such as fear, anxiety, or apprehension in career decision-making. Importantly, three women, successful in their work, also endorsed a sense of insecurity. Two women indicated that the experience of success in a workplace or in an academic setting decreased the sense of insecurity and increased their confidence in that specific setting. Two women indicated that repeated experiences of difficulty in the workplace created a pervasive experience of fear in career decision-making. Finally, the experience of two successful women illustrated that a request for accommodation or a disclosure contributes to a sense of risk in decision-making.
CHAPTER 5: DISCUSSION

The focus of this chapter is to review the findings of this study in relation to recent literature on brain injury, career theory, and career counselling. The chapter begins with a restatement of the purpose of the study followed by the theoretical implications of the findings. The chapter continues with a discussion of implications for counselling practice followed by a review of the limitations of the study. The chapter concludes with suggestions for future research to further increase understanding of the experience of career decision-making for women who sustain an acquired brain injury.

Restatement of the Purpose of the Study

The purpose of this study was to illuminate, remaining as faithful as possible to the women's own words, the lived experience and meaning of career decision-making for women with ABI. This study used a phenomenological approach to answer the question, "What is the personal experience and meaning of career decision-making for women who have sustained a brain injury in mid-career?" Data from in-depth open-ended interviews were analyzed (Colaizzi, 1978) to explicate the career decision-making experiences of eight women and to identify common themes in their experiences.

Theoretical Implications

This discussion of theoretical implications relates the findings of this study to those reviewed in the areas of brain injury and of career. I present this material by first reviewing general implications of the findings followed by a more specific review of implications for each of the six common themes which emerged in this study.
Through explicit attention to diversity, this study investigated the experience of career decision-making for a group which has been previously ignored in the mainstream of psychology (Tate & Pledger, 2003), vocational psychology (Betz, 2001) and career development and counselling (Flores et al., 2003; Whiston & Brecheisen, 2002). The results of the present study extend our understanding of the experience of career decision-making from the decider’s perspective and experience (Phillips, 1997; Richardson, 1993) by beginning to illuminate how one group of women with ABI experienced career decision-making. The results revealed the experience of career decision-making to be a highly complex ongoing experience imbued with emotion and subjective meaning for each of the eight participants; acquired brain injury and rehabilitation experiences were intrinsically related to post-injury career decision-making. The findings further revealed that social interactions and the societal context significantly influenced the experience of career decision-making, giving rise to positive or negative emotions that facilitated or obstructed career decision-making.

The findings of this study fully support contentions in the career and vocational psychology literatures that the application of traditional theories and quantitative methods, espousing a narrow conceptualization of environment (Collin, 1997), overlooking contextual and individual complexity (Savickas, 2001), and ignoring constraints in individual lives (Blustein, 2001; Fouad, 2001), are limited within the life context of women with brain injuries. Importantly, traditional theories would not have revealed the social and societal factors that influenced the women’s career decisions (Psatha, as cited in Patton & McMahon, 1999) nor have focused attention on the emotionally charged and uncertain context of the decision-making experience (Gelatt, 1989; Kriekshok, 2001; Krumboltz, 1992; Phillips,
1997). Additionally, study findings supported Herr's (1999) assertions that an emphasis on subjective perspective, lacking in traditional theories, is necessary to understand how aspects of the social context interact with individual behaviour. In this study, an understanding of the women's subjective meanings and actions within their social contexts was critical to an individually situated understanding of the women's experience of career decision-making.

The findings of this study concur with concerns in the rehabilitation of persons with traumatic brain injury identified by the National Institute of Health (1998). Women in this study described their brain injury as a lifelong condition, contributing to uncertainty of functioning in new environments and emotionality in career decision-making. The women further provided concrete and emotionally charged examples of an influential rehabilitation setting which afforded limited opportunity for autonomous career decision-making. For two participants, efforts to assert autonomy in career decision-making came at the cost of being labeled noncompliant. One participant, who was not told that she had suffered a stroke, did not make a fully informed decision when, expecting to return to full time work, she terminated long term disability benefits. Finally, the women's stories of career decision-making suggested few enablement approaches; rather the women depicted work contexts mainly dependent on intraindividual efforts. It may be argued that limited opportunity for career decision-making, lack of ongoing support for a life-long condition, and limited use of enablement approaches represent contextual and environmental barriers (Fassinger, 2000) which obstruct career decision-making for women with brain injury.

Similar to the findings of Pössl et al. (2001), all the women in this study made modifications to their pre-injury work, including changes to type of work, change of employer, and reduction in work hours. Notably, all participants in this study engaged in
work or study hours that were considered part-time in their respective fields. Related to the inaccurate predictions of objective cognitive measures noted by Pössl et al., five study participants with poor prognosis were successfully engaged in work or studies contrary to the expectations of rehabilitation professionals and objective assessments. Furthermore, the women described a long process of neuropsychological recovery extending beyond the commonly expected six to 18 month period (Millis et al., 2001). In the brain injury literature, the recent acknowledgment of persons whose recovery exceeds expectations (Pössl et al., 2001) or whose neuropsychological recovery continues beyond the circumscribed period (Millis et al., 2001) is tempered by suggestions that unanticipated recovery is limited to a small group. It is possible that five participants in this study comprised a select group. However, taking a positive psychology perspective (Elliott, 2002) one might also argue that the brain injury literature has not sufficiently attended to persons whose recovery exceeds expectations and, therefore, current knowledge may underestimate the numbers of persons who make a good recovery. Elliott further asserts that applied psychologists, viewing positive results with skepticism, generally interpret positive results from a pathological perspective. Wright (as cited by Elliott, 2002) called attention to this fundamental negative bias in rehabilitation almost twenty years ago. This negative bias creates an imbalance in clinical practice and brain injury research which limits the understanding and facilitation of positive change and growth in brain injury. Ultimately, this negative bias represents a fourth significant sociopolitical barrier to career decision-making for women with ABI.

The elevated risk to mental health in ABI within the context of additional stressors such as occur in the non supportive workplace (Rush et al., 2006) imparts urgency to the women’s experiences of emotional distress in career decision-making. Although the women
in this study described experiences consistent with symptoms of depression, anxiety, or post-traumatic stress disorder, only two women had received therapy for mental health. It may be argued that limited access to psychotherapy (Folzer, 2001) represents a fifth environmental barrier to career decision-making.

**Theoretical Implications of Individual Themes**

This exploratory study of the career decision-making experiences of women with ABI revealed six descriptive themes within intrapersonal, interpersonal, and societal domains. These themes provide important insights into the experience of career decision-making and about the significance of subjective meaning to the career decision-making process. Individual themes augment the findings from published qualitative studies in the area of brain injury and of disability and career.

**Continued centrality of career**

Two interrelated sub-themes: a) the intensified meaning of a paid work career; and b) the influence of rehabilitation in career decision-making comprise this theme. Participants emphasized the economic function of work as well as intensified personal meanings such as sense of pride, freedom, security, equality, or normality. Six women described rehabilitation as a central influence in career decision-making giving rise to determination, defiance, uncertainty, and increased empathy. Determination occurred in the context of proving post-injury abilities to self and others.

Similar to participants in the Levack et al. (2004) and the Oppermann (2004) studies, the women in this study confirmed a return to work as an important goal and a source of personal fulfillment, self-worth, and satisfaction. The experiences of three study participants, in particular, resonated with the findings of Power and Hershenson (2003) that for participants with well developed work ethic, the loss of work led to a loss of value as a
person, loss of self-confidence, and loss of self-esteem. Previous qualitative studies, however, do not convey the strong emotions which accompany return to work decisions. Rylan and Sarah, for example, directly implicated a sense of desperation as integral to paid work career decisions. Furthermore, the findings of this study contradict the brain injury literature which generally presumes that denial of post-injury limitations is responsible for unsuccessful return to work decisions (e.g., Stambrook et al., 1990) and for decisions contrary to rehabilitation recommendations (Armstrong, 1991). Katherine, for example, distinctly relates her return to work decisions to the personal salvation inherent in work. Rather the women in this study clearly indicated that emotion and subjective meaning importantly drive career decisions. The present study furthers our understanding of emotions, such as desperation and determination, and of the subjective meaning of career in career decision-making.

In this study, determination to return to a paid work career represented efforts to regain a sense of normality, independence, freedom, equality and of self-determination. These findings resonate with findings from the Conyers et al. (1998) investigation of the career development of female college graduates with physical or sensory disability who were employed. Conyers et al. found that work played a central role in the lives of the participants contributing a sense of identity and of purpose, and reducing the self-perception of being “disabled” and the sense of dependency frequently associated with disability. Framed within the context of identity, subjective meanings of the paid work career in this study (normality, independence, freedom, equality, and self-determination) may be understood as contributing to an identity that is not “disabled” or dependent. For Elisabeth and Sophie, not making use of services for students with disabilities provided a sense of normality and self-
determination. Rylan's attempts to keep functional changes hidden in the workplace may be understood as an effort to maintain former identity (Nochi, 1998). That the participants in this study, all of whom were involved in work or studies, did not refer to themselves as a person with a disability supports a connection between identity and the subjective meanings of work or study.

Focusing on poor outcomes for women in vocational rehabilitation, Noonan et al. (2004) suggest that low expectations based on disability interact with restrictive gender roles to lead to nonwork roles for women. One previous study discussed rehabilitation personnel as major influences to the support or obstruction of career development (Power & Hershenson, 2003). The experiences reported by the women in this study confirm a bias towards low expectations for women with brain injury. Additionally, operating within the sociopolitical environment of the rehabilitation setting (Swain et al., 2003), rehabilitation personnel's low expectations represented societal barriers to career decision-making. The findings of this study extend the critical influence of rehabilitation to additional dimensions of the rehabilitation experience. These include the influence of professionals as positive and negative role models; the determination to reach one's potential despite low expectations; and the significance of being nurtured to an increased empathy, expressed as a desire to enter helping professions. Underscoring the significance of career decision-making in their lives, the participants described career decision-making as an ongoing experience during rehabilitation.

Continued centrality of the relational in career: This theme highlighted the continued significance of the relational in the women's careers and the salience of familial domains especially when children were young. Before and after brain injury, the five mothers in the
study experienced their careers as paid workers and mothers simultaneously with either more salient at any given moment. Additionally, seven women described an accentuated significance of the relational in career after brain injury.

This theme resonates with the conclusions of previous research in women’s career development (Hackett, 1997; Phillips & Imhoff, 1997) that women’s personal and career lives as inextricably linked, and that interpersonal and familial domains are uniquely central to the identity development of women. This theme further resonates with conceptualizations of women’s identity development (Kroger, 2000; Sorell & Montgomery, 2001) as a lifelong process of construction and transformation greatly saturated with intimacy issues. Consistent with previous research on women’s career development (Fitzgerald & Harmon, 2001; Gutek, 2001), mothers in this study, viewing mothering as an important career, reported home and work balance as a significant influence in career decisions.

This study makes a unique contribution to extant literature on the significance of the relational in women’s career development by illuminating the accentuated significance of relational in career following brain injury. Although others have reported fulfillment in service to others after serious illness and brain injury (Biderman et al., 2006; Frank, 2003), the increased significance of the relational in career has not previously been explicitly reported in the career or brain injury literatures.

Sense of life purpose and altered life perspective: This theme highlighted the participants’ meaning making and benefit finding following recovery which seven women described as a miracle or a second chance at life. Seven women variously described a sense of purpose, altered perspective on life, sense of appreciation for life, or a firm knowledge of what was truly important in life. The sub-theme of increased agency in career decision-
making reflected a determination to pursue that which truly mattered and the implementation of espoused values in career decisions. Six women, endorsing a less materialistic perspective in career decision-making, emphasized the benefits obtained through the experience of brain injury and recovery.

Focused primarily on acute stages and patient populations (Olkin & Pledger, 2003), the quantitative literature on brain injury (Kreuter et al., 1998; Kalpakjian et al., 2004; McGrath & Linley, 2006) has only recently begun to investigate positive psychological change and to acknowledge the meaningful capacity to experience positive emotions following brain injury. These authors, suggesting that internal factors and time since injury are important to positive growth, have not captured the subjective meanings of positive psychological changes. The findings of this study confirm that women with brain injury can experience psychological growth and can lead a satisfying life following brain injury. In beginning to illuminate the subjective meanings of the women’s positive psychological perspectives, this study advances knowledge in the brain injury literature about positive change and the long term course of women with ABI. Importantly, this knowledge will contribute to the delineation of positive change process and inform therapeutic approaches that nurture hope for positive change.

Benefit finding, the identification of positive benefits, has been well documented following medical adversity (Affleck & Tennen, 1996). The results of this study cohere with the common themes which cut across medical problems including strengthening of relationships with family and friends; valued changes to life priorities and goals; and the perception of positive personality changes such as empathy, tolerance, courage, and patience. Similar to studies which relate benefit finding to less depression and more positive well being
(Helgeson et al., 2006; Affleck & Tennen, 1996), the women who endorsed benefits in this study self-identified as having a good life. Consistent with the finding that positive psychological growth in brain injury does not preclude moderate levels of distress (McGrath & Linley, 2006), these participants nonetheless experienced distress, anxiety, and uncertainty in specific career contexts.

In a qualitative inquiry, Taylor (1983) found that 50% of 78 women with breast cancer viewed cancer as a catalyst for restructuring lives along more meaningful lines. Cancer had caused the participants to reappraise their lives, providing them with a new attitude toward life, and to reorder priorities with high priority for relationships and lowered priorities for mundane concerns. From these findings, Taylor developed the theory of cognitive adaptation. The sense of purpose and altered perspective theme coheres with one of three themes from the theory of cognitive adaptations: a search for meaning following an adverse event. Six women described this meaning as sense of life purpose, an identification of what was meaningful in life, and an alignment of career decision-making with these values. For example, Sophie believed that she survived to do something; Elisabeth understood brain injury as a ‘total blessing’ which woke her to an obligation to do something positive with her life; Jane described the moment she found her meaning in life; and Sarah gained the sense of being an equal.

Focusing on positive meaning and benefit finding in brain injury, the findings of this study cohere with the results of four recent qualitative studies which have also identified positive meaning in brain injury. Similar to the participants in the Levack et al. study (2004), the women in this study endorsed the achievement of a positive and ongoing journey through life over money or status. Similar to 20 of 40 participants in Thompson’s study (1991) on
meaning after stroke, participants in this study reported an increased appreciation for life and a reevaluation of priorities. Similar to 6 of 10 participants, in Nochi’s (2000) study in which the narrative of “the grown self” presented TBI as a momentum for growth and the development of positive characteristics, the participants in this study understood the experience of brain injury as integral to the development of positive characteristics such as increased empathy, greater compassion for others, increased patience and understanding with children, and a softening of edges. Similar to 2 of 6 participants in Howes et al.’s study (2005), participants in this study reevaluated their values post-injury and appreciated life more. Similar to 26 of 59 individuals in Chamberlain’s study (2006), in which the narrative of “the recovering self” stressed a change of values, the participants in the present study described changes in values, to a more internal definition of what was important. Participants in this study, however, stressed that post-injury values represented a return or accentuation of pre-injury values rather than an actual change in core values. Rather, the women in this study, expressed brain injury and recovery as the catalyst for a deeper exploration of core values and a determination to align career decision-making and their lives with espoused values.

The findings of this study extend our understanding of career decision-making as inextricably interconnected with heightened values and meaning for the women with brain injury. Three women offered a deeply held certainty that their purpose in living was to help others in need. This aspect of survivorship in serious illness, an unquestioned sense of purpose in life, is described by Frank (2003) as conferring upon individuals an “unquestioned conviction of the need to help people” (p.255). These individuals simultaneously drift into lives of service and have a moral calling to offer hope and reciprocity others. The findings of
this study, extending the moral calling of survivorship to women with brain injury, augment our understanding of ways in which the women’s experience of career decision-making is far removed from the fully rational model espoused by traditional career models and the deficit-focused approaches in rehabilitation. Rather, these findings exhort us to more fully integrate subjective meaning and intuition (Gelatt, 1989) in career decision-making models used with this population.

It is important to note that, as with quantitative studies investigating psychological growth (Kreuter et al., 1998; Kalpakjian et al., 2004; McGrath & Linley, 2006) and qualitative studies investigating meaning in medical adversity and brain injury (Affleck & Tennen, 1996; Howes et al., 2005; Nochi, 2000; Taylor, 1983; Thompson, 1991), not all participants in this study found benefits in brain injury or endorsed positive psychological growth. One participant in particular, who was engaged in a job search at the time of the interview, reported significant distress and a strong yearning for a return to life without brain injury. However, when compared to previous studies, a greater percentage of participants in this study endorsed positive benefits and meaning from brain injury. The participant composition of this study suggests a tentative explanation for this difference. A greater time since injury has been related to positive psychological growth in brain injury (Kreuter et al., 1998; Kalpakjian et al., 2004; Howes et al., 2005; McGrath & Linley) and to benefit finding generally (Helgeson et al., 2006). Additionally, women have been found to engage in more benefit finding (Helgeson et al., 2006). Unlike studies which included participants soon after brain injury (Chamberlain, 2006; Howes et al., 2005; McGrath & Linley; Thompson, 1991) or which included male and female participants (Kreuter et al., 1998; Kalpakjian et al., 2004; Nochi), the participant composition of this study was restricted to females whose time since
injury ranged from 3-10 years. It is possible that the greater percentage of participants in this study who endorsed benefit finding and meaning in brain injury are due to purposive sampling criteria of greater time since injury and female gender.

**Sense of continuity and change in identity:** This theme, more salient for the four women who sustained TBI, encapsulated the women’s simultaneous experience of continuity and change in identity. These four women described the experience of loss of identity or altered self-presentation and an active protracted process of rebuilding post-injury identity more congruent with an ongoing sense of the real self. Career decision-making post-injury was described as more consistent with identity than was the case pre-injury.

Kroger (2000) suggested that identity development following loss involves not only readjustment to the loss and finding new life meanings but also retaining important identity elements thus establishing visible forms of continuity. While loss of identity or discontinuity of self has been well established in TBI (Inkmann, 2001; Lewington, 1997; Nochi, 1998; Paskiewicz, 1988; Stewart, 2002), few studies have addressed identity maintenance. Whereas Nochi’s participants achieved identity maintenance by distinguishing functional changes from the self and keeping functional changes hidden from others, the participants in this study emphasized retention or heightening of core values and personality. Similar to the 14 participants in the Secrest and Thomas study (1999) who described a paradoxical sense of continuity and discontinuity with the self after stroke, the eight participants in this study endorsed a sense of simultaneous continuity and change in identity. While participants in the Secrest and Thomas study related the sense of discontinuity to changes in physical body, the participants in this study related changes in identity to changes in work, self-presentation, and comparisons to pre-injury cognitive and processing abilities. These differences may
again reflect differences in study composition; 7 of 14 participants in the Secrest and Thomas study were less than 2 years post-injury, were older with a median age of 67 years, and seemed to have more significant physical impairment.

Whereas Chamberlain's study (2006) suggested that meaning, defined as a change in values, was significant in the development of a new identity, the participants in this study emphasized a reconnection with core values as significant to the sense of continuity with the pre-injury self. Four participants in particular experienced identity maintenance through the integration of meaning, an expression of core values, in career decision-making. This study extends our understanding of the significance of the women’s value-based career decision-making in brain injury to the establishment of visible forms of continuity with the self (Kroger, 2000).

**Sense of increased vulnerability in interactions:** This theme consists of two inversely related sub-themes: a) sense of being devalued; and b) sense of equality. The sense of being devalued was most salient in interactions with professionals in rehabilitation settings who imposed low career expectations or with superiors in the workplace who judged participants negatively. Four women reacted to devaluation in rehabilitation with anger and a firm determination to prove themselves. Four women described an internal sense of devaluation in self-comparison to self or others which increased their sensitivity to others’ judgments. Others’ misunderstanding of brain injury, particularly the aspect of invisible disability, contributed to devaluation. Conversely, respect and support from others provided six women with a sense of equality in career decision-making which the women directly related to positive mental health. Significantly, belief in the participant’s ability to succeed, an offering of hope, distinguished positive support from negative support.
An earlier theme discussed the influence of rehabilitation as a barrier, within the sociopolitical environment, to participants’ autonomous career decision-making. This theme emphasizes attitudinal factors and focuses on the obstructive or facilitative effects of social interactions, with significant persons, to the participants’ career decision-making. This theme illustrates the influence of significant persons to the fluctuation of participation and performance in career and in career decision-making; this fluctuation has been identified as the enablement/disablement phenomenon (US Dept of Education, as cited in Pledger, 2003). This theme also illustrates how one aspect of the social model of disability (Government of Canada, 2004), career-related interactions in the social environment, serves to restrict or enable performance.

Support for the findings of this theme, the effects of positive or negative interpersonal support on functioning, is found in the results of recent qualitative studies in the areas of brain injury and work, and of disability and career. While Power and Hershenson (2003) found that family and treatment personnel operated as major influences for the support or the obstruction of career development for persons with TBI, their report did not provide any further details about the nature of this influence. Conyers et al. (1998) and Noonan et al. (2004) identified social support as a critical factor in the development of the women’s self as a worker with a disability. Conyers et al. found that the positive expectations of others were especially potent during times of self doubt leading to a renewed focus and commitment to educational and career goals. Similar to the findings in this theme, Conyers et al. found that the manner in which participants responded to low expectations, such as a challenge for proving people wrong, served as a mediating factor which influenced career development more than the negative feedback itself. Similarly, four participants in this study found
motivation in their anger and in a determination to prove the self capable and to prove others wrong. Noonan et al. found that tangible support and emotional support, such as inspiration, encouragement, and modeling of success, were critical to the survival and success of highly achieving women. One participant in the Noonan et al. study indicated that having persons in her life who believed that she could live a full life with disability was critical to her success. In the present study, belief in the person's capacity emerged as a critical ingredient in the facilitative and positive mental health effects of positive support.

Recent qualitative studies in the brain injury literature, providing a fuller explication of the hindering effects of negative interactions, offer indirect support for the findings of devaluation in this theme. Some participants in the Secrest and Thomas study (1999) experienced disability through a rupture of connection in interaction with others particularly within the context of unhelpful help. Connection for these participants meant reciprocity and being understood by the other. Participants in the present study reported the experience of negative interactions in which they were not treated as equal persons in the following ways: being discounted, being disempowered, not being understood, being labeled, and being treated like a child. Importantly, four participants, describing an increased sensitivity to negative interactions, experienced diminished mental health and hope. Participants in the O'Callaghan et al. study (2006), an inquiry of the awareness of deficit for patients in rehabilitation setting, described stigma and the invisibility of brain injury leading to incorrect expectations from others, as obstacles to self-awareness. Related to findings in the Secrest and Thomas and the O’Callaghan et al. studies, the findings of this study suggest that the effect of interactions which are characterized by lack of understanding and by stigma, in which the person with brain injury is not accepted as a person first (Braithwaite, 1990), may
erect obstacles when the person is vulnerable. Unlike the O'Callaghan et al. study which characterizes interaction with rehabilitation personnel as fully supportive, the participants in the present study, experiencing significant positive and negative interactions with rehabilitation personnel, indicate that the presumption of a facilitative support is not always defensible.

Finally, investigations of the quality of life in brain injury have found that the availability of emotional support, especially in a partner relationship, is the element of support most associated with good quality of life (Kreuter et al., 1998; Steadman-Pare et al., 2001) and that general mental health is a primary predictor of perceived quality of life (Steadman-Pare et al., 2001). The sense of equality sub-theme identifies emotional support, comprising belief, respect for the integrity of the person, and a patient understanding, as integral to performance and the amelioration of mental health. One might argue that a positive emotional support imparts hope to the individual which reduces vulnerability to devaluing interactions. A tentative support for the facilitative role of positive emotions, such as hope, in brain injury comes from biopsychology and positive psychology. Davidson (as cited in Groopman, 2004), an expert in the biology of positive emotions, speculated that positive emotions play a role in turning off negative emotions. He hypothesized that “there are circuits from the prefrontal cortex, associated with positive emotions that are inhibitory to the regions of the amygdala” (p.199), a key part of the pathway that mediates fear. Frederickson and Joiner (as cited in Duckworth et al., 2005) hypothesized the existence of an upward spiraling effect of positive emotions in helping individuals to find positive meaning in stressful or negative situations, which in turn increased positive emotions. The women's accounts of the effects of positive emotional support seem to cohere with these hypotheses.
For example, Sophie found the courage to pursue a Masters degree with her husband’s support; Ramona is full on as a legal assistant with the support of her employer; and Katherine with her husband at her side, regained the use of her arm. The findings of this study potentially augment our understanding of the specific ways in which a positive emotional support operates as a facilitative factor in career decision-making for the women with brain injury.

Sense of insecurity and emotionality: This theme highlights a sense of insecurity and emotionality in career decision-making as related to participants’ heightened awareness of changed cognitive or physical capacity and of consequent need for accommodation. This theme chronicles the participants’ struggles in post-injury career decision-making and the participants’ endeavours to cope with these struggles. These struggles encompassed experiences of financial insecurity; of being easily overwhelmed; of being more easily fatigued; of struggling with new learning and multitasking; and of failing in areas of previous competence. Importantly, while degree of insecurity varied in accordance with perceived failure in post-injury experiences, all women, including women with successful work experiences, endorsed a sense of insecurity. Women who experienced successes reported lessened insecurity and an increasing self-confidence within specific settings. Strategies for coping with a sense of insecurity and concomitant emotions included withdrawal; presenting as normal; making tentative or considered decisions; reframing difficult tasks as skills to be learned; taking baby steps; engaging in volunteer work or unpaid work positions.

Extrapolating from the finding of varying self-perception of disability (Conyers et al., 1998), it may be argued that the sense of insecurity in career decision-making is related to varying self-perception of disability in actual and possible career environments. Participants
in the Conyers et al. study (1998) reported that self-perceptions of disability varied according to physical and social surroundings, such that having disability was central to self-concept in some situations but not in others. Among the factors that mediated a sense of self in relation to disability and work were the expectations of others. Conyers et al. reported the importance of skill development in requesting accommodations and described delayed entry into the workplace as a consequence of difficulties in requesting accommodations. Specific to the present study, career decision-making focused awareness on post-injury changes and the potential need for accommodation. One may suggest that uncertainty about the expectations and actions of others in the career environment may further increase self-perception of disability and sense of insecurity. Notably absent from the Conyers et al. study, however, is the emotional context of varying self-perception of disability in the workplace. Participants in the present study explicitly related a continuum of negative emotions, ranging from uncertainty to apprehension, to the need for accommodation and self-perception of disability in career environments.

Potential problems associated with the uncertainty of the new economy; including increased stress, increased anxiety, greater isolation, increased depression, unemployment and underemployment (Axelrod, 1999; Dorrel 2000; Sonnenberg, 1997; Sullivan, 1999), may be seen to correspond to and exacerbate potential problems of depression, anxiety, social isolation, and unemployment reported in the brain injury literature (Morton & Wehman, 1995; NIH, 1998; Wehman et al., 2005; Williams & Evans, 2003). Herr (1997) contended that persons with disabilities, often facing social stigma and restricted choices, are more vulnerable to the psychological consequences of the changing workplace. The findings in this study that participants’ increased self-perception of disability and negative emotions
increased with devaluing and uncertain career decision-making contexts supports Herr's contention of a greater vulnerability.

Previously discussed, enablement approaches, such as tangible and attitudinal accommodations, are rarely used in brain injury rehabilitation (NIH, 1998); thus, few participants in this study requested accommodations. Furthermore, participants in this study pointed to the contribution of government policies (e.g. programs that offer one chance at retraining; funding changes whereby employees become private contractors; forcing people to work at very low paying jobs; lack of supports for persons who make return to work or training decisions contrary to program directives); of workplace practices (e.g. non availability of good part-time work; lack of accommodations); and of insurer practices (e.g. denial of long term disability for part-time work) to increased insecurity and emotionality in career decision-making. These policies and practices ignore the fact that objective measures of brain injury are not predictive of outcome (Pössl et al., 2001); disregard the emotional and physical costs of full-time work for persons with brain injury (Levack et al., 2004); and ignore the fact that success and self-awareness in brain injury are gained through real life work experiences over time (Wehman et al., 2005). For the participants in this study, these policies and practices represented significant sociopolitical and societal barriers to career decision-making.

The growing awareness of linkages between positive or negative career experiences and mental health (Murphy and Athanasou, 1999; Herr, 1999) are especially relevant to the findings of this study. Borgen and Amundson (1984) demonstrated that mental health outcomes in unemployment could be precipitated by factors in the environment or within individuals. The findings of this study suggest that factors in the environment and within the
individual interact and are inextricably related. Participants in this study directly related past history of failure experiences to the intensity of negative emotions experienced in career decision-making. Furthermore, participants directly implicated intrapersonal changes in cognitive and physical ability in interaction with others to the consequent sense of uncertainty. Rylan, who experiences a significant "fear of jobs," knows intuitively that she needs to give herself "as many successes as possible in future careers." Significantly, she fears failure and not being able to live up to others' expectations. Sarah, relating awareness of cognitive limitations to being "scared," harbors the "hidden thought" that she will be a low income person because she will be unable to find a supportive person in the workplace. Jane explains that if she can "separate from anxiety" about her communication with others, her career "decisions will be different." The findings of this study augment understanding of the intensity of emotions (anxiety, depression, insecurity, uncertainty, and apprehension) experienced in the current career decision-making context by women with ABI. More generally, this study offers an important contribution to an understanding of the role of emotions in career decisions and augments understanding about the interaction of person and environment in career decision-making.

To summarize, the findings in this study make an important contribution to the understanding of career decision-making from the subjective perspectives of eight women with ABI. Participant descriptions of experience demonstrate that the post-injury career decision-making experience is infused with subjective meaning and emotion; that acquired brain injury and rehabilitation experiences are intrinsically related to post-injury career decision-making; and that post-injury career decision-making is aligned with espoused values and is often more congruent with identity than pre-injury career decision-making.
Paradoxically, this increased agency in career decision-making occurs within a context of greater struggle and increased barriers to career decision-making in the form of restrictive government policies, and negative support in work and rehabilitation contexts. Importantly, this study augments understanding of the significant ways in which positive support, characterized by belief in the person, facilitates career decision-making for the women with ABI. Additionally, this study extends knowledge of influences to career decision-making by explicating the critical influence of the rehabilitation experience. Finally, the findings of this study have potentially augmented our knowledge of interactions between the individual and the broader environment in the career decision-making experiences of women with brain injury. The implications of the findings of this study for recent career theory and practice are presented in the next section.

Implications for Counselling

A most significant implication of this study is that an understanding of the women’s subjective meanings, emotions, struggles, and interactions within their social and societal contexts is critical to a situated understanding of the women’s experience of career decision-making. The lack of research from a subjective perspective has concealed the intensity of emotions and suffering experienced by women with ABI in career decision-making. This paucity of information regarding career decision-making for women with ABI represents a significant barrier for the provision of empathic and enabling career counselling. In its most general application, the results of this study will inform counsellors of important aspects in the career decision-making of women with ABI. For example, themes and sub-themes identified in this study begin to delineate factors to be considered in a counselling assessment procedure. Information from study results will not only assist the counsellor to tailor career
counselling interventions to the specific needs of the female client with ABI but may also assist the counsellor to challenge her own biases. One important bias, identified by participants as a frequent barrier, regards low expectations for the career potential of women with ABI. Indeed this barrier is so pervasive that Wehman et al. (2005) conclude that “there needs to be significantly more efforts aimed at training rehabilitation counselors, special education teachers, transition specialists, case managers, and psychologists on the work capacity and potential of persons with TBI” (p. 125). This sentiment was more poignantly expressed by a participant who stated that she wanted professionals to know that “there is life after brain injury.”

As previously stated, an incontrovertible implication of study results is that traditional career theories do not explain career decision-making for women with ABI. Consequently, the simple matching of career decision and measured interests and abilities (e.g. strengths and weaknesses in neuropsychological assessments), deemed inappropriate in career counselling practice generally (Krumboltz, 1998; Peavy, 1996), is especially indefensible in practice with women with ABI. Traditional theories do not suggest enablement approaches nor focus therapeutic attention on the emotionally charged and uncertain context of the decision-making experience (Gelatt, 1989; Kriekshok, 2001; Krumboltz, 1992; Phillips, 1997). Importantly, practice based on traditional theory fails to address critical aspects in the landscape of career decision-making: inextricable connection with subjective meaning and alignment with values; feelings of uncertainty and strong emotions; isolation due to withdrawal or exclusion; frequent experience of being devalued in social interactions; experience and expectation of personal struggle during times of personal or workplace
change, self-perception of disability in interaction with the environment; risk to mental health; and the presence of environmental barriers.

The value of the contributions of this study to career counselling practice rests on its illumination of the complexity of the context and the significant uncertainty with which women with ABI make career decisions. Findings that women with ABI engage in ongoing career decision-making; experience emotional consequences, such as depression and anxiety, (Levack et al., 2004; Oppermann, 2004; Power & Hershenson, 2003); and experience difficulties with workplace changes and personal changes (Pössl et al., 2001) mandate a therapeutic life-span approach to career counselling. Based on the results of this study, I join the authors of the aforementioned studies in concluding that there is no question of the need for access to counselling in the long term. Indeed, I would argue that the lack of counselling based processes in vocational rehabilitation and career decision-making represents a significant contextual barrier to the career development of women with ABI. I agree with career theorists and researchers (Amundson, 1995; Borgen, 1997; Collin, 1997; Krumboltz, 1998; Richardson, 2000) who assert that career decision-making occurs within the life context and is not productively addressed in isolation. I conclude, in agreement with Borgen (2002), that vocational guidance must be embedded in counselling based processes and that these processes must be available earlier in the help seeking process. I further concur with Miller’s (1993) assertion that cognitive, behavioral and emotional issues are not readily separable in real life. The following recommendations emerge from this study: (1) that career decision-making be viewed as an ongoing process; (2) that career counselling be conceptualized as life planning and offered within the framework of a personal counselling process; (3) that career counselling be adapted to meet the individual needs of women with
ABI; and (4) that career counselling be made available at multiple points over the long term, such as times of personal or vocational change; (5) that all aspects of career counselling be offered within a cooperative process; (6) that all rehabilitation professionals who offer aspects of career support to women with brain injuries receive training in basic counselling skills and training about the potential of women with ABI; and (7) that career counselling for women with ABI be enlarged to include the identification and deployment of positive individual qualities which may facilitate the attainment of self-determined career goals. These recommendations also challenge the career counsellor to adopt an expanded role in order to effect change at the societal system level. For example, the career counsellor may advocate for the development of government and insurance policies aimed at ameliorating barriers, such as lack of access to counselling during times of workplace change or personal stress. Specific suggestions for counselling based processes will next be discussed in relation to recent career theories and models of career decision-making and career counselling.

Herr (1997) conceptualized career counselling interventions as existing on a continuum of intervention foci, with different career problems requiring different emphases. More specifically related to counselling for persons with brain injury, Miller (1993), maintaining that no clear line demarcates cognitive rehabilitation from psychotherapy, recommended a multimodal approach to therapy. The findings of this study, similar to the Wehman et al. study (2005), highlighted the need for career counselling as the participants encountered difficulties in real life work and study settings. The implications of emotional and practical struggles in participant accounts cohere with Miller’s and Herr’s conceptualizations and point to the career counsellor’s responsibility, in cooperation with the client, for selecting the specific foci of intervention and the approach to be used in
counselling. A career counsellor would necessarily adopt different approaches in supporting Rylan with her significant "fear of jobs" and the downward spiral of her emotions when she "feels like a failure;" in supporting Ramona with her uncertainty about her ability to learn new things; and in supporting Sophie as she experiences the personal costs of doing a good job. While I would argue that the career counsellor must integrate enablement approaches (NIH, 1998) with attention to therapeutic issues, a discussion of enablement approaches is beyond the scope of this study. Therefore, the subsequent discussion of the implications of this study is intended to assist career counsellors to select career counselling interventions appropriate to the foci of intervention in relation to career theories and models of career counselling and career decision-making.

The findings of this study, highlighting the complexity of career decision-making experience, suggests that, on the whole, recent career theories and models of career counselling, influenced by constructivist philosophy and espousing an enlarged focus in career counselling, are appropriate to career counselling practice for women with ABI. The features of a constructivist framework most pertinent to career counselling for women with ABI are a focus on meaning making and life design (Peavy, 1996), and a conception of an active individual as part of a social and societal system involved in lifelong career development (Patton & McMahon, 1999). The subsequent review of the Systems Theory Framework of Career Development (STF: Patton & McMahon, 1999), Contextualist Action Theory (Young et al., 2002), Peavy's Constructivist Career Counselling Model (1996), and Cochran's Career Project (1992) does not suggest the application of one single model in career counselling women with ABI. The judicious application of career counselling theories
and models rests with the career counsellor who must be well versed in counselling, career, and brain injury and focus intervention foci to the career concerns of the client with ABI.

This study revealed that recursiveness in the interaction between person and environment significantly impacts career decision-making for this group; thus the simple application of ecological models (e.g., Szymanski & Hershenson, 1998) is insufficient in career counselling practice. While the STF (Patton & McMahon, 1999) acknowledges the recursiveness of the interaction between person and environment and the restrictions imposed by the sociopolitical environment, the STF conceptualizes disability as an intraindividual influence and does not explicitly attend to the substantial roles of subjective meaning and emotions in career decision-making revealed in this study. These limitations, precluding the simple application of the STF to career counselling for women with ABI, suggest rather the utility of the STF as a metatheoretical framework for identifying influences (McMahon, 2005) within a collaborative career counselling process. Patton and McMahon (as cited in McMahon, 2005) conceived the STF as a map to guide career counsellors as they facilitate clients’ career narratives. Participant accounts suggest that comprehensive attention to individual, social, and societal systems and to the recursiveness of these influences are necessary for appropriate career counselling.

Career theorists (Brown, 1996; Chen, 2002; Patton & McMahon, 1999) have identified the application to career counselling as a general strength of Contextualist Action Theory (Young et al., 2002). Most significant for the career counselling of women with ABI is an explicit attention to the role of emotion in regulating and guiding action. For example, the application of Contextualist Action Theory directs the career counsellor’s attention to the role of anger, the determination to prove oneself, and the fear this study identified in the
career decision-making of women with ABI thereby enlarging the therapeutic focus of career
counselling. Importantly, through the concept of joint action, career counsellor attention is
directed to the social context of career decision-making including the influence of
interactions with counsellors, rehabilitation personnel, supervisors and significant others.
Most significantly, Contextualist Action Theory acknowledges that not all parties may have
an equal role in co-construction of joint actions, thereby permitting the examination of the
respective roles of counsellors and other rehabilitation personnel who provide various aspects
of post-injury career counselling. However, unlike the STF (Patton & McMahon, 1999),
Contextualist Action Theory does not explicitly identify influences in the societal context;
does not attend to past and future influences to career decision-making; and does not
explicitly acknowledge the differential opportunity structure and discrimination as real
influences existing in the environment. These omissions represent significant limitations for
career counselling of women with ABI. For example, Contextualist Action Theory may not
direct career counsellor attention to the low vocational expectations for women with ABI and
the limited use of enablement approaches, which, in this study, emerged as real barriers to
career decision-making for women with ABI.

Significant strengths of the application of Peavy’s (1996) constructivist career
counselling model and Cochran’s Career Project (1992) for counselling women with ABI are
a view of career counselling as a cooperative process which encompasses life planning, a
holistic perspective of the individual, a significant focus on subjective meaning, a view of the
client as the expert in her own life, and the use of narrative in counselling. The focus on
narrative and meaning converges with recommendations, in the brain injury literature, for
therapy aimed at restoring meaning and purpose and expanding possibilities in life (Miller,
1993; Nochi, 2000; Prigatano, 2005). Narrative facilitates self-construction in the counselling process (Bujold, 2004) and emphasizes meaning as the central subject of career. Cochran’s Career Project (1992), in which a personal theme integrates the individual’s life story, is especially relevant to the meaning-making of women with brain injury. Meaning-making in response to loss has been related to adjustment and positive psychological growth in adverse medical events (Helgeson et al., 2006; Taylor, 1983; Taylor et al., 2000) and in brain injury specifically (Howes et al., 2005; McGrath & Linley, 2006; Thompson, 1991). Similarly, the women in the present study expressed meaning as a sense of purpose or an altered perspective which they related to a good life after brain injury and which importantly guided career decision-making. Through the use of narrative, the counsellor can assist women with ABI to see their future as a continuation of their life story; to create their own identity (Spain & Bedard, as cited in Bujold, 2004); to create career narratives that are meaningful and fulfilling; to clarify the meanings of decisions, and to become agents within the context of their own lives (Cochran, 1997).

However, the goal of co-construction in Peavy’s and Cochran’s career counselling approaches is problematic in career counselling for women with ABI. Without an explicit goal of client self-determination and acknowledgement of counselling as a social process, there is the danger that the career counsellor’s attention will not be directed to the inherent power differential between counsellor and client. Additionally, although Peavy’s and Cochran’s narrative approaches to career counselling incorporate context by addressing the meaning of events, participant accounts suggest the need for a more explicit consideration of the social and societal context such as suggested by the STF (Patton & McMahon, 1999). Furthermore, narrative approaches in career counselling may be appropriate for some but not
all women with ABI. Two participants, who did not endorse a sense of purpose following brain injury, may not be ready to find meaning in career decision-making. The concept of a life theme resonated with the stories of three participants which suggests that Cochran’s Career Project may well be the ideal approach to career counselling for these women. The implications of study findings are that the career counsellor must exercise caution, good judgment, and serve as a facilitator for the reconstruction of meaning only when the client is so ready (Miller, 1993).

Implications related to career decision-making models emerge directly from the participants’ descriptions of the coping strategies that enabled them to diminish the sense of risk inherent in implementing career decisions. The women described coping strategies such as taking small steps, making tentative decisions, making well-considered decisions, reframing difficult tasks as skills to be learned, and engaging in trials such as volunteer and unpaid work positions. As suggested by Krumboltz (1992), Herr (1993b), and in Planned Happenstance Theory (Mitchell et al., 1999), an important role for the career counsellor is to teach women with brain injury the skills, resources, and personal flexibility that would enable them to seize opportunities and to create satisfying lives for themselves. For example, Jane’s emphasis that lack of opportunity to practice communication skills operates as a barrier to career decisions after graduation may be productively addressed in career counselling which directs attention to skill development. The incorporation of positive uncertainty (Gelatt, 1989), encouragement of tentative commitments, and trials of alternative experiences (Krumboltz, 1992) in career counselling provides women with ABI the opportunity to refine self-awareness, and to develop new skills and new strategies for implementation in real life settings. Significantly, career decision-making models which
promote the wisdom of provisional commitments (Gelatt, 1989, 1995; Krumboltz, 1992) recasts the career decision-making strategies of women with brain injury into a more positive, universal frame with the potential to diminish negative emotions and support a more positive mental health.

Finally and most important, the finding of the experience of vulnerability in interaction with rehabilitation and career personnel has a most critical implication for the therapeutic relationship as a process in career counselling. Specifically related to brain injury, Prigatano (2005) and Miller (1993) have identified the therapeutic relationship as an important ingredient of therapy. The sub-theme of a sense of equality provides a window into the essential ingredients of a positive emotional support: the demonstration of respect for the integrity of the person, patient understanding, and belief in the potential of the person. This sub-theme suggests that these ingredients are critical to the establishment of a supportive therapeutic relationship in career counselling. This recommendation echoes Parker’s (as cited in McMahon, 2005) contention that the role of the career counsellor has shifted from being a matcher to being a nurturer. This role has been previously expressed by Amundson (1998) who highlighted the role of the career counsellor in nurturing and affirming a person’s positive self-concept, self-knowledge, and self-belief and the necessity of respecting the uniqueness of the whole person in creating a mattering climate. To the four building blocks (Carl Roger’s genuineness, unconditional positive regard, empathic understanding, and counsellor flexibility) suggested by Amundson for the therapeutic relationship in career counselling, I would like to add a fifth ingredient, an attitude of hope as integral to belief in the person’s potential.
Study participants have described the imparting of hope, as an important source of personal validation, which is notably absent in devaluing experiences with rehabilitation personnel and in career services. Indeed, participant accounts described instances in which helping professionals attempted to eradicate hope with respect to self-determined career decision-making and career goals. Elliot and Kurylo (as cited in Elliott, 2002) have documented this process in a case study describing how professionals used psychological test data to argue against a patient’s personal goals, and which the patient later pursued successfully with the support of her family. Focusing on deficit and on the reduction of negative symptoms, the fields of rehabilitation, medicine, and clinical psychology have not explicitly nurtured positive emotions such as hope in the course of treatment (Elliott, 2002; Groopman, 2004; Seligman et al., 2000). Unfortunately, recent models of career decision-making and career counselling, reviewed in this study, are also silent on the subject of hope within a therapeutic relationship.

A focus on deficit and disregard of hope contrasts with the unequivocal therapeutic understanding that the arousal of hope and positive expectancies is a significant common factor across therapies (Arkowitz, 1997). For example, Grencavage and Norcross (as cited in Arkowitz, 1997) identified therapist positive expectations, therapist cultivation of hope, and client characteristics of hope, faith and positive expectations as commonalities across the common factors literature. Specific to brain injury rehabilitation, the instillation of a realistic sense of hope has been described as an important component in therapy which helps to overcome hopeless and helpless feelings (Prigatano, 1986) and which may assist to minimize devaluation (Chamberlain, 2006). McGrath and Linley (2006) have suggested that the delineation of the process of positive growth following brain injury may foster therapeutic
approaches focused on hope. Frank’s (2003) finding, that long-term survivors have a moral calling to offer hope and reciprocity of self and other, confirms the significance of hope as a source of validation in nurturing relationships with persons who have survived illness.

A positive psychology approach (e.g., Duckworth et al., 2005; Dunn & Dougherty, 2005; Elliott, 2002; Seligman et al., 2000; Snyder, Lehman, Kluck, & Monsson, 2006) highlights the strengths of the individual in overcoming obstacles and builds on positive emotions, positive qualities and meaning. I believe that a greater focus on positive individual attributes and potentials are important components of hope in career counselling for women with ABI. Hope theory (Snyder et al., 2006), emphasizes that individuals who are high in hopeful thought are more likely to attain the goals they set for themselves and that hope, as a goal directed motivational process, can be taught. Briefly, the hope theory process for nurturing hope involves assisting the client to make stretch (challenging and achievable) goals; planning main and alternate pathways to reach goals, and supporting agency or motivation to reach goals. Strategies, important for career counselling women with ABI, emphasize client selection of valued goals, visualization of novel means to attain goals, creativity in finding alternate routes toward goals, the use of positive self-talk, and recognition of progress towards goals and subgoals. However, based on the findings of this study, I would also emphasize that positive psychology, like other approaches to career counselling, must be offered within an affirmative and supportive relationship (Amundson, 1988) and must instill hope through both content and process.

Limitations of the Study

Phenomenology, an exploratory method that seeks to illuminate the lived experience of a phenomenon from the subjective perspective of persons who experienced that
phenomenon, was thought best suited to the initial investigation of the experience of career
decision-making for women with ABI, a phenomena about which we know very little. Four
limitations to this study, concerning phenomenological methodology and the nature of the
sample, warrant consideration.

First, limitations inherent to the phenomenological method suggest caution in
applying the information from this study to other groups of women who have sustained brain
injury. The focus of phenomenological research is an understanding of persons' experiences
rather than the generation of explanatory laws (Giorgi, as cited in Osborne, 1990). The
results of phenomenology are therefore not intended to generalize to other groups or to
identify correlational or causal relationships between phenomena. While we cannot
generalize from these findings, this study has contributed a preliminary understanding of the
lived experience of career decision-making for a small group of women with ABI. The
themes derived in this study may well resonate with the career decision-making experiences
of other women with ABI. Findings from this study may serve to expand the counsellor's
knowledge of the potential range of career decision-making experiences for women with
ABI. The counsellor is cautioned, however, that other similarly placed women may not share
the experiences described by the women in this study.

A second inherent limitation is the use of retrospective accounts which are the most
frequent data source for phenomenological studies (Osborne, 1990). Participant self-reports
of career-decision-making experiences, which formed the data for this study, were likely
altered by the passage of time. However, since phenomenology is interested in the meaning
or sense that persons make of their experiences rather than factual information, data sources
for phenomenology are evidently retrospective and retrospective accounts are well suited for
the phenomenological investigation (Osborne, 1994; van Manen, 1990). It is quite possible that participants in this study did not report aspects of the career decision-making experience because these were not salient at the time of interview or that the women selectively presented certain aspects of their experience. For example, one participant, who described an unanticipated good recovery, professed that she wanted others to know that “there was life after brain injury.” It is quite possible that, due to her intention, positive aspects of her experiences may have been more salient at the time of interview. Nonetheless, the participant accounts of career decision-making experiences obtained in this study suggest that the participants offered a richly detailed and meaningful description of their experiences such that common meanings of career decision-making inhere in the accounts.

A third limitation of the study concerns the selection and volunteer process through which a small homogenous group of Caucasian women were included in this study. First, professionals were asked to forward introductory letters and recruitment posters to women whom they knew to be articulate. Second, purposive sampling criteria, which limited participation to women who were involved in the community as a student or worker or volunteer, served to select primarily women who were in early middle age. Additionally, the majority of the participants in this study reported positive emotional support from partners and family; such support has been related to good quality of life (Kreuter et al., 1998; Steadman-Pare et al., 2001). Through selection criteria of articulateness and community involvement, and incidental inclusion of women with emotional support, the women included in this study may represent a very select group of women with brain injury who may be construed as doing well following brain injury. Thus, results of the present study cannot be applied to differently situated women with ABI such as women from visible minorities who
sustain an ABI; women with ABI and visible physical or sensory disabilities; women who sustain an ABI in early career; women who are not involved in the community; and women with ABI who do not have a source of positive emotional support. It is important to note, though, that participants, who self-reported as having a good life at the time of the interview, nonetheless reported emotional suffering and struggles which they experienced at earlier points in their career decision-making. Third, women who volunteered for the study may have done so for a variety of factors which may further differentiate participants from other women with ABI. For example, all participants reported that they had chosen to participate in order to help other women with ABI. It may be that women with ABI who do not profess altruistic motives are different from study participants in important ways. Finally, older or younger women, whose career decision-making experiences occurred in the context of a different generation, may have quite different experiences.

Finally, the participants in this study had sustained different types of brain injury. It may be argued that the individuals with traumatic brain injury have a very different recovery course from persons who acquire brain injury through stroke, ruptured aneurysm, and brain tumor and that therefore career decision-making experiences differ from those of other participants. While it was apparent that a sense of loss of identity was most pertinent to the experiences of the women with traumatic brain injury, such differences were not noted in the remainder of the themes identified in this study.

Implications for Future Research

This exploratory study has contributed a preliminary understanding of the lived experience of career decision-making for women with ABI, a topic which has previously been ignored in the brain injury and career literatures. Findings of this study point to the
significant need for vocational support within a counselling based process to promote mental health and to foster positive outcomes. The development of targeted career counselling approaches requires an in depth understanding of women’s career decision-making experiences which can only be attained through future research. Several recommendations are offered for future research which may serve to confirm and extend upon the findings of this study.

First, an unexpected finding in this study was the alignment of career decision-making with the sense of purpose and altered perspective in life. This finding was unexpected because the brain injury literature has only recently acknowledged positive meaning in brain injury (Howes et al., 2005; Kreuter et al., 1998; Kalpakjian et al., 2004; McGrath & Linley, 2006; Nochi, 2000; Thompson, 1991). Future research efforts may be devoted to the investigation of the career decision-making experience of a group of women who self-report a sense of purpose and to the delineation of the process by which individuals develop positive meaning or a sense of purpose in brain injury. It would be important to learn more about the subjective experience of this process; the factors which support the journey to positive meaning; and whether positive meaning could be supported and nurtured in counselling. Additionally, an explication of the process and of the experience may offer hope to other individuals who sustain a brain injury.

Second, responding to the criticism that women with brain injury have been ignored in the mainstream research, this study focused on the career decision-making experiences of a small, homogeneous group of Caucasian women. It would be important to know whether participant accounts share similarities with the broader population of individuals with ABI. It is quite possible that studies which comprise a more diverse group of participants with ABI
would generate divergent findings. Future research investigating the experience of career decision-making should therefore be conducted with larger groups of participants and with more diverse groups such as women from rural areas where there are few resources and few employment prospects; women who self-report as not doing well with career decision-making; and women from visible minorities and women with visible disability who may experience additional barriers and discrimination (Noonan et al., 2004). Men’s experience of career decision-making also warrants investigation. Alternatively, it may be productive to investigate the experience of more homogenous groupings with respect to the nature of injury to determine whether, for example, the experience of persons with traumatic brain injury are markedly different from that of persons with other forms of acquired brain injury.

Third, the findings of this study highlighted the rehabilitation experience as an important influence to the participants’ career decision-making. The influence of rehabilitation, not previously reported in the rehabilitation or career literatures, warrants further research because participant accounts suggested that devaluing experiences were common in interaction with rehabilitation personnel. Future research may seek to delineate the social and societal factors which contribute to enabling and devaluing career decision-making experiences in rehabilitation. An explicit purpose of this research would be to develop practices that promote the sense of equality and diminish devaluing experiences.

Fourth, there is little longitudinal research in brain injury; therefore little is known about the life course of individuals after brain injury. A longitudinal investigation of the long term career decision-making experience would provide an increased understanding of issues that may arise in the career decision-making journey. Rumrill et al. (1999) and Shahnasarian (2001) have proposed the development of life-span approaches to career decision-making for
persons with disabilities. Long-term vocational and counselling supports have also been recommended for persons with brain injury (Levack et al., 2004; Oppermann, 2004; Pössl et al., 2001; Power & Hershenson, 2003) but there is currently limited research information to guide the provision of long term supports. The results of longitudinal studies could serve to inform policy and program development for life-span approaches to career decision-making and for the provision of long term counselling supports.

Finally, the findings of this study suggested that rehabilitation professionals may not be fully informed about the potential of persons with brain injury. Perhaps a lack of knowledge and a focus on deficits in the literature and in practice contribute to limited information about potential and to low expectations. A productive focus for future research may be an examination of the career development of successful persons with brain injury. The Noonan et al. (2004) study, a grounded theory investigation of the career development of highly able women, may serve as a prototype for investigating the process of career development. Results of investigations about the career development of successful persons with brain injury would serve to inform rehabilitation professionals and counsellors about the potential of persons with brain injury and possibly diminish the attitudinal barriers which obstruct the career decision-making of persons with brain injury. The career intentions of one participant aptly substantiate the need for this research: “She [rehabilitation professional] represents the model of how I hope not to be treating other people [as helping professional].”

In closing, I turn to the words of one study participant who rightly exhorts all helping professionals to not lose sight of the individual before them:

How dare you place those judgments on me when you don’t even know who I am! Yeah, the stats show all this and yes the prognosis isn’t great. But you don’t know me as individual and the strengths that I do have and the gifts that I bring.
REFERENCES


Bauer, G. (2000). Roll call: Who’s missing from your workplace? Experts say absenteeism may have more to do with the health of an organization than with the health of its employees [Electronic version]. *Canadian Healthcare Manager, 7*(2), 12-17.


Dorrell, K. (2000). Breaking down the barriers: Non-physical disabilities like mental illness are the fastest growing category of disabilities today. Plan sponsors have an important role to play [Electronic version]. *Benefits Canada, 24*(12), 36-40.


Dear Colleague:

I am asking for your assistance in recruiting participants for my dissertation research. I am investigating how women with acquired brain injuries make career decisions in their lives. This research is part of my Ph.D. work in Counselling Psychology at the University of British Columbia (UBC) and will result in a doctoral dissertation that will be housed in the UBC library and available to the public upon request. My dissertation research is part of a larger study which investigates how people make career decisions in their lives. The need for this study is based on the observation that people may be taking into account very different factors when making career decisions in today’s rapidly changing world than people did in the past and on the career counselling literature which indicates the need for new models of career counselling more suited to our rapidly changing environment. Specifically, the experience of women with acquired brain injuries is unknown. Therefore, my focus on women with acquired brain injuries is intended to give the women a voice and to make their experience known in the research literature.

I am seeking adult volunteers who are willing to talk about their career decisions in an in-person interview that will be audio taped and transcribed. I will ask participants to describe career decisions they have made in the past, career decisions that they may be making now, and career decisions they anticipate having to make in the future. All identifying information will be kept confidential. Because my research is interview-based and phenomenological in nature, I am seeking participants who are verbal and who can reflect on and articulate their experience.

I am seeking female participants who are a minimum of 2 years post-injury; who live independently in the community i.e. not in a supported living arrangement; and who participate in the community as workers, volunteers, or post-secondary college or university students; and who were working at the time of injury. Participants should have demonstrated abilities to work in a non-supported employment setting, to participate in regular post-secondary studies, or to contribute to the community in a non-supported volunteer position.

Would you please forward the attached letter and poster to women with acquired brain injuries who meet the criteria as described above? I would be happy to answer any questions you or potential volunteers may have about this research. I may be reached at 1 or via e-mail at . Thank you for your support of my research,

1 Telephone numbers removed from documents to maintain privacy
Appendix B: Recruitment Poster

A Study Exploring

CAREER DECISIONS

The principal investigators and supervisors for this study on people’s experience of making career decisions are Dr. Bill Borgen, ___ ___ ____, and Dr. Norman Amundson, ___ ___ ____, Professors in Counselling Psychology at UBC.

WE’D LIKE TO HEAR YOUR STORY IF:

• You are a female adult, either employed or in a volunteer position,

   OR a college or university student

• You experienced a traumatic brain injury a minimum of two years ago and you were employed at the time of injury

• You have made or contemplated career decisions, whether or not these decisions involved a career change. Perhaps you have also contemplated or made a recent career change

• You are willing to talk about your experience of making career decisions and the issues you took into account in a confidential one to two hour interview.

If you would like to participate, or would like further information about this study, please contact MARIA, Ph. D. student, at _________.

245
Appendix C: Introductory Letter Participant

Dear Prospective Participant:

My name is Maria Laquinta and I am investigating how people make career decisions in their lives. This research is part of my Ph.D. work in Counselling Psychology at the University of British Columbia (UBC) and will result in a doctoral dissertation that will be housed in the UBC library and available to the public upon request. The need for this study is based on the observation that people may be taking into account very different factors when making career decisions in today's rapidly changing world than people did in the past.

I am seeking adult volunteers who are willing to talk about career decisions they have made in the past, career decisions that they may be making now, and career decisions they anticipate having to make in the future. Participants will be asked a series of questions in a face-to-face interview, for instance: Give me an example of a career decision that you are in the process of making now. What issues are you taking into account when making the decision? What factors are helping you to make this decision? What factors are hindering you in making this decision? There will also be some demographic questions to help with interpreting the data.

There will be two interviews, the first of which will last about one and a half hours, and the second that will last from a half hour to one hour. Both interviews will be audio taped. The tapes will later be transcribed and given a code number in order to ensure your anonymity. The tapes will be erased upon completion of the study. The information obtained will be kept confidential. Participants will not be identified by the use of names or initials.

The purpose of the first interview is to collect information about the factors you have taken into account when making past, present, and future career decisions, and to obtain the demographic data. The second interview is to have you review the way in which the information collected has been organized to ensure it properly reflects your experience. It is my sincere hope that this research will capture the factors people are taking into account when faced with making career decisions and that the information obtained through this study might shed light on new ways to assist other people who are making career decisions.

Your involvement in this study is voluntary and you may decide to participate or not participate, or you may withdraw from the study at any time without prejudice of any kind.

A professional colleague who has not shared with me the names and addresses of people receiving this letter is forwarding this letter to you in confidence. Only those individuals who contact me for more information or to indicate interest in participating
in this study will become known to me. Your professional colleague will not be provided with the names of individuals who participate in this study.

If you decide to participate in this study, or would like more information, please contact me at _____. If I am not available you are welcome to leave me a confidential voice-mail message and I will return your call as soon as possible. I can also be contacted via e-mail at _______. The Principal Investigator for this project is Dr. Bill Borgen. He can be reached at the University of British Columbia by calling (604) 822-5261.

Thank you in advance for your time and interest, and I look forward to working together with you.
Appendix D: Interview Guide

I. Orienting Statement

The purpose of this interview is to better understand how people experience and make career decisions in their lives. By career, we mean activities that you do over time including work and other life activities.

Please speak as freely as you wish about your experience of career decision-making. You are not obliged to discuss anything that makes you uncomfortable. As we proceed with the interview, I may ask you to respond or elaborate on issues that will help me in understanding your experiences.

The principal question that I would like to ask you is: What is your experience of making career decisions? In discussing your experience, I'd like you to talk about your career decisions and how you make career decisions in your life.

Please tell me your story of career decision-making.

II. Introduce Lifeline: This line may help us to talk about your career decisions. The line represents your career over your life: the past, the present, and the future. Please mark key decision points in your career on the line. You can use age or date to anchor the points in time. Decisions may include staying, changing, or some other decision.

Please tell me how you came to make these career decisions.

III. Additional Questions

2. Can you describe any issues that might have influenced a career decision to stay?

3. Can you describe any issues that might have influenced a career decision to change?

4. How has your career decision making evolved over time? (patterns)

5. What do you anticipate you will take into account in making future career decisions?

6. Is there anything that you might not have thought about before that occurred to you during this interview?
Appendix E: Participant Consent Form

CONSENT FORM

Towards a Preventive/Developmental Approach to Counselling:
Helping People Meet the Challenges of Change" (Phase 3)

Principal Investigator: Dr. William Borgen, Professor
University of British Columbia
Department of Educational & Counselling Psychology, and Special Education
(604) 822-5261

Co-Investigator: Maria Iaquinta, Ph.D. Student
University of British Columbia
Department of Educational & Counselling Psychology, and Special Education

This research is being conducted as one of the requirements for Maria Iaquinta for the Doctor of Philosophy (Ph.D.) degree in Counselling Psychology at the University of British Columbia. The results of this research will be included in a dissertation that will become a public document in the University library once it is completed. The results of this research may also be published in appropriate professional and academic journals. This study is funded through a grant from the Social Sciences and Humanities Research Council of Canada.

Purpose
The purpose of this research project is to interview individuals about the factors they take into account when making career decisions. Participants will be asked to provide specific examples of career decisions they have made in the past, they are currently making, and that they expect to make in the future, along with the issues taken into account when making these decisions. Individual demographic information will also be gathered to help with interpreting the data.

Procedures
This component of the study will require two interviews. The first one will be approximately one and a half to two hours long. It will consist of introducing the participant to the purpose of the study and obtaining signed consent. Participants will be asked to provide examples of specific career decisions they have made in the past, that they are currently making, and that they anticipate making in the future. They will also be asked to discuss the issues taken into account when making these decisions and the factors that helped or hindered their decisions. The final part of this first interview will be to collect demographic information about the individual to aid in analyzing the data.
The second interview will last 30 – 60 minutes and will consist of a review of the categories discovered by the researcher. Both interviews will be tape recorded, transcribed and given a code number to ensure confidentiality. Upon completion of the study these tapes will be erased. Your total time will be approximately three hours within a three to six month period.

Confidentiality
Any information identifying individuals participating in this study will be kept confidential. Only trained Research Assistants on the research team will have access to the data. Upon signing the informed consent you will be given a code number to ensure the maintenance of confidentiality. Participants will not be identified by the use of names or initials in any reports of the completed study. All research documents will be kept in a locked filing cabinet in a locked office at the University of British Columbia. Computer data files will be password protected.

Compensation
There will be no monetary compensation to participants.

Contact for Information About the Study
If you have any questions or would like more information about this study, you may contact Dr. William Borgen (Principal Investigator) at (604) 822-5261 or Maria Iaquinta (Co-investigator) at ________.

Contact for Concerns About the Rights of Research Subjects
If you have any concerns about your treatment or rights as a research subject, you may contact the Research Subject Information Line in the UBC Office of Research Services at (604) 822-8598.

Consent
Your participation in this study is entirely voluntary and you may refuse to participate or withdraw from the study at any time without prejudice of any kind.

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.

Participant Signature ___________________ Date __________

Printed Name of the Participant signing above

Thank you for your willingness to participate in this study.
Appendix F: Sample Interview Probes

- Tell me your story.
- How did you come to make that decision?
- Tell me more about what you were feeling.
- I'd like to hear some more about the issues that led to that decision.
- Tell me what is important to you about these (factors, responsibilities). How did they influence you?
- It sounds like these are the influences, feelings, meaning? Was there anything else that influenced, .... your decision at the time?
- What was it that kept you (stuck there) (in that position)?
- What has changed for you?
- What was missing for you?
- What drew you towards (away) from ....?
- Were there other decisions you made not related to ....?
- Tell me more about how .... (person) was involved in your decision?
- Tell me what the meaning of this issue is for you.
- Tell me how ..... influences your decisions.
- Please describe what is difficult about your career decisions.
Appendix G: Demographic Questions

Phase # | Participant # | Date:__________________________

1. Occupation

2. Number of years in this occupation

3. Occupation/job level

4. Length of time in current job

5. Length of service in this company

6. Industry in which the person works

7. Number of years in this industry

8. Age

9. Sex

10. Income level (household)

11. Country of birth

   ➢ If not Canada, (a) length of time in Canada; and (b) 1st language

12. Marital status

13. Family status/parental status

14. Education level
Appendix H: Letter Second Interview

Dear (Participant Name):

Thank you for participating in a follow-up interview for my doctoral dissertation which examines the experience and meaning of career decision-making for women who have sustained a traumatic or an acquired brain injury. My doctoral research is supervised by Dr. Amundson and Dr. Borgen, professors in Counselling Psychology at UBC and members of my doctoral research committee. As discussed in our telephone conversation of date (email communication of ____), I am asking for your feedback and review of the data that pertains to your individual research interview.

I have enclosed a form for participant selection of first name, a brief biographical profile, and a summary of themes and meanings from your first research interview on _____. The biographical profile and summary of themes and meanings are intended as a snapshot at the time of the first interview. As such, the biographical profile and summary of themes and meanings will not include any new information or events which have taken place after the date of the first interview.

As a reminder, I include here the principal research question that I asked you at the first research interview: What is your experience of making career decisions? In discussing your experience, I'd like you to talk about how you make decisions in your life and what that was like for you. Please tell me your story.

1. Completion of the Form for Participant Selection of First Name
Would you please select a first name which I may use in the write up of the research results? It is preferable that you select a name other than your own first name. Please indicate your choice on the form, sign and date the form. Please return to the researcher at the University of British Columbia in the enclosed self addressed stamped envelope.

2. Feedback on the Brief Biographical Profile
The write up of the study results will include a brief biographical profile of each research participant. The enclosed profile has been based on the first research interview and will be edited prior to publication. For example, specific place names will be removed. Would you please indicate whether the researcher has described where you were at the time of the first research interview? Can you see yourself in the profile? Has the researcher missed anything of importance to your career decision-making at the time of the interview? Is there anything you would like to add to or change in the profile?

3. Feedback on the Summary of Themes and Meanings
The brief summary of your individual themes and meanings are a snapshot of the data you provided in the first interview. Themes have been identified as present after injury, before injury or as present before and after injury. The individual themes and meanings will be edited and integrated with those of other participants prior to publication of the research. Would you please indicate whether the researcher has captured where you were at the time of the first interview? Can you see yourself in this summary of themes and meanings? Has the
researcher missed anything of importance to your career decision-making at the time of the first interview? Do you have anything to add to the themes and meanings?

If you have any questions or would like more information, please contact me at ____ or via e-mail at
Appendix I: Form for Participant Selection of a First Name

Participant Selection of a First Name
For Write-up of Study Results

The Experience and Meaning of Career Decision-Making for Women with Brain Injury

This is to confirm that as a participant in the doctoral dissertation research conducted by Maria Iaquinta (Department of Education and Counselling Psychology and Special Education, University of British Columbia); I choose to be identified by the name of _______________________________ (first name only) in the final write-up of Ms. Iaquinta’s study.

I understand that in the final write-up or in any other possible use of study results, I will be identified by the above name only.

Participant’s name ____________________________________________________________

Signature _________________________________________________________________

Date _________________________________________________________________