ACCOMPANYING CLIENTS RECOVERING FROM TRAUMATIC BRAIN INJURIES: AN EXISTENTIAL-ANALYTICAL APPROACH

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This paper explores an existential-analytical (EA) approach to accompaniment within the context of recovery following a traumatic brain injury (TBI). The paper begins with a selective review of the TBI literature. This is followed by the case presentation of a patient who was accompanied in 48 sessions over nearly 4 years. This case serves the focus for a discussion of EA accompaniment and highlights common issues that may emerge in the course of recovery. In contrast to much of the extant literature on psychotherapy with TBI clients, which highlights functional limitations and psychopathological dimensions, EA accompaniment focuses assisting the client in finding inner consent through a personal, phenomenological process. The accompaniment maps relatively well onto the EA structural model. TBI clients frequently face challenges in all four fundamental motivations and are challenged to find a felt 'yes' in relation to the facticity of their situation, to life itself, to themselves in their uniqueness, and to a meaningful future. The paper aims to demonstrate the possibility and necessity of an EA approach to accompaniment as a crucial and often omitted dimension of TBI recovery.

KEYWORDS: Traumatic Brain Injury, accompaniment, rehabilitation, case study

BEGLEITUNG VON KLIENTEN BEI DER ERHOLUNG VON SCHÄDEL-HIRN-TRAUMEN
Ein existenzanalytischer Ansatz

Dieser Artikel untersucht einen existenzanalytischen (EA) Ansatz für die Begleitung im Rahmen der Erholung nach einem Schädel-Hirn-Trauma (SHT). Die Arbeit beginnt mit einer selektiven Durchsicht der SHT Literatur. Dieser folgt eine Fallbeschreibung eines Patienten der in 48 Sitzungen beinahe 4 Jahre hindurch begleitet wurde. Der Fall dient der Fokussierung für eine Diskussion über existenzanalytische Begleitung und beleuchtet häufige Probleme welche im Laufe der Erholung auftreten können. Im Unterschied zu viel der bestehenden Literatur über Psychotherapie mit SHT Klienten, welche die Funktionseinschränkungen und psychopathologische Dimensionen beleuchten, richtet die existenzanalytische Begleitung ihre Aufmerksamkeit auf die Unterstützung des Klienten bei der Suche nach innerer Zustimmung durch einen personalen, phänomenologischen Prozess. Die Begleitung passt ziemlich gut mit dem Strukturmodells der Existenzanalyse zusammen. SHT Klienten stehen oft vor einer Herausforderung auf allen vier Grundmotivationen, und sie sind vor die Aufgabe gestellt ein gefühltes „Ja" in Bezug zur Faktizität ihrer Situation, zum Leben selbst, zu sich selbst in ihrer Einzigartigkeit, und zu einer sinnvollen Zukunft zu finden. Ziel der Arbeit ist es, die Möglichkeit und Notwendigkeit eines existenzanalytischen Ansatzes bei der Begleitung als eine dringend erforderliche und oft unterlassene Dimension der SHT Genesung zu veranschaulichen.

SCHLÜSSELWÖRTER: Schädel-Hirn-Trauma, Begleitung, Rehabilitation, Fallstudie

Accompanying patients with traumatic brain injuries (TBI) is at times a challenging and complex endeavour and one which psychotherapists may approach with hesitancy (Klonoff 2010). Part of the complexity of this work is due to the fact that TBI patients frequently present with numerous co-occurring conditions, such as orthopedic problems, persistent pain or psychiatric disorders (Horn, Siebert, Patel, & Zasler 2013). Patients with TBIs may also have cognitive challenges, including low psychological insight, problems with short-term memory, processing speed, multi-tasking, receptive and expressive language, attention, and difficulty in learning new tasks (Eslinger, Zappala, Chakara, & Barrett 2013).

The psychotherapeutic literature on working with TBI patients tends to focus on their functional limitations and psychiatric diagnoses (Coetzer 2010; Klonoff 2010; cf. Zasler, Katz, & Zafonte 2013). While there are undoubtedly many who require such psychotherapeutic assistance, others may benefit from a more personal and phenomenological approach to accompaniment. Psychotherapeutic work that orients itself according to diagnostic and functional deficits may overlook the personal and existential challenges that are frequently part of the life situations of such patients.

This article aims to highlight the importance of accompaniment TBI patients in their recovery. I begin with an overview for TBIs, their classification, signs and symptoms and common psychological consequences. This is followed by a case-based elaboration of my work with one TBI patient whom I accompanied for approximately 4 years. Accompaniment with this patient touched upon themes and processes associated with the four fundamental motivations (Längle 2003). My hope is that this article may serve the purpose of revealing the need and the possibilities for accompaniment.

Understanding TBIs

Most psychotherapists today are not medical practitioners and thus may only be peripherally familiar with the consequences of a TBI and its course of recovery. It is helpful to have a basic understanding of common definitions, epidemiological data and classification systems associated with TBIs. I will review key aspects of this literature in order to provide a context for the approach to accompaniment. The reader who is interested in further elaboration of the neurophysiological and neuropsychological sequelae of TBIs may wish to explore such texts as Zasler, Katz, & Zafonte's (2013) *Brain Injury Medicine (Demos Medical Publishing)*.

Definition, Epidemiology and Classification of TBIs

Coronado, McGuire, Faul, Sugerman, and Pearson (2012) cite a commonly accepted definition of TBI, which has been adopted by the US Center for Disease Control and Prevention (US CDCP) since 1995. A TBI is defined as an "injury to the head arising from blunt or penetrating trauma or from acceleration/deceleration forces resulting in one or more of the following: decreased level of consciousness, amnesia, objective neurologic or neuropsychological abnormality(s), skull fracture(s), diagnosed intracranial lesion(s), or head injury listed as a cause of death in the death certificate" (p. 84).

The US CDCP(2019) estimates that more than 50,000 people die from a TBI every year in the US. Falls account for the largest share of TBIs in the very young (0 to 4 years) and elderly (65+ years). Assaults and motor vehicle accidents account for a greater proportion of TBIs in teenagers and adults (15 to 64 years). Dewan, Rattani, Gupta, Baticulon, Hung, Punchak Agrawal, et al. (2018) conducted a systematic review of epidemiological studies related to TBI and estimated the yearly incidence rate worldwide to be approximately 69 million individuals.

Persons with a TBI are commonly assessed according to the Glasgow Coma Scale (GCS, O'Phelan 2011). The GCS is a behavioural rating scale that assists treatment providers in the classification of the severity of the TBI. The GCS gives a score from 0 to 15 according to three behavioural responses – eye opening, best verbal response, and best motor response. A *mild TBI* ("concussion") yields a higher score on the GCS (13-15). Patients in this category are awake, but may be confused for a time following their injury. They can communicate and follow commands. A *moderate TBI* includes a GCS score between 9 and 12. These patients are generally drowsy to obtunded but not comatose. They can open their eyes and localize painful stimuli. A *severe TBI* yields a GCS score of 3 to 8. These patients are comatose following their injury, do not follow commands and may exhibit decerebrate or decorticate posturing. They have significant structural and metabolic brain dysfunction and are at high risk of secondary brain injury and deterioration.

Although there may be a correlation between the severity of the TBI and its subsequent functional and emotional consequences, this is not always the case. A small but significant number of patients with a mild TBI may require months or even years of recovery and may experience ongoing functional impairments and emotional distress. Conversely, some patients with severe TBIs may experience significant functional impairments but report relatively mild psychological distress. The personality characteristics of the TBI survivor, as well as the attitude towards the injury and the quality of personal and structural support appear to have a significant impact on psychological adjustment post-injury (Coetzer 2003).

Signs and Symptoms of a TBI

While vast majority of mild TBIs resolve on their own or with minimal medical intervention within a few weeks or months, some patients report symptoms that persist months and years after the injury. Iverson, Lange, Gaetz and Zasler (2012) reviewed the literature on mild TBI recovery and reported that the majority of studies reported complication rates of approximately 5 to 10%. TBI symptoms may persist alongside symptoms of a psychiatric condition and may influence the course of recovery. Hinson and Ling (2012) group associated symptoms into physical, cognitive and emotional symptom clusters. Common *physical symptoms* of a mild TBI include headaches, nausea, dizziness, fatigue, blurred vision, sleep disturbances, as well as phonophobia and photophobia. Common *cognitive symptoms* include poor attention, memory disturbances, slow processing speed, problems with judgement and impulsivity, and reduced executive function. *Emotional symptoms* include depressive moods, anxiety, agitation, irritability, impulsivity and, at times, aggression.

Psychological Consequences of a TBI

Although not the focus of this article, it is beneficial for psychotherapists to know that patients who sustain a TBI may present with a variety of psychological disorders. A variety of factors contribute to the likelihood of a psychiatric disorder following a TBI, including psychiatric problems that were present prior to the injury. Diagnosis of a psychological condition following a TBI is complex and

multi-determined. In his review of the literature on TBI and psychiatric disorders, McAllister (2013) reported that the base rates for those who sustained TBIs most frequently included depression and substance use disorders. Post-injury, McAllister found that patients most commonly presented with depressive disorders (27% to 61%), anxiety disorders (35% to 48%), substance use disorders (21% to 28%) and post-traumatic stress disorder (14% to 19%). These psychiatric conditions are in addition to cognitive and functional limitations of neurocognitive disorders (American Psychiatric Association 2013; World Health Organization 2019).

Personal-Existential Accompaniment of TBI Patients

The focus of this article is on the EA accompaniment of TBI patients who are seeking assistance in which the focus is not on the treatment of a psychiatric disorder. Silvia Längle (2018) recently reviewed an EA understanding of accompaniment. In contrast to psychotherapy, which is an interpersonal process that involves understanding and emotional processes and aims at treatment of disorders, accompaniment involves the personal working-through of unavoidable and unchanging life situations. The focus of accompaniment is not on changing external situations, but rather on the inward change of the patient's attitudes through the facilitation of personal competencies. Längle has mapped the accompaniment-related competencies onto the EA structural model and described specific skills associated with each of the four fundamental motivations. These competencies will be explored more closely through the elaboration of a case study in the coming sections.

Although the accompaniment of TBI patients focuses on assisting them in adjustment, each TBI patient's recovery is dynamic and unique. Patients may benefit from accompaniment for some time and then experience increased distress and/or dysfunction that requires psychotherapeutic intervention. Additionally, although there are some parts of a TBI that are likely to remain stable over the course of recovery, patients may experience some changes in their neurological condition over time. The evidence in this regard (Iverson et al. 2012) seems to indicate that the majority of recovery from a TBI is likely to occur within the first two years post-injury, with the most substantial gains occurring within the first year. I would argue, nonetheless, that patients benefit from accompaniment and that our work benefits from a phenomenological openness to the individual needs of the person and the situation. Indeed, Längle (2018) admonishes us to remember that accompaniment is dynamic and may transition into psychotherapy. Given the unpredictable nature of TBI recovery, flexibility on behalf of the accompanier and psychotherapist is essential.

The Need for Accompaniment

This article focuses on the *accompaniment* of patients with TBIs. The main reason for this focus is that a significant number of patients with TBIs present personal-existential challenges that are frequently missed given the current focus on the treatment of psychiatric disorders and the more functional approaches to TBI rehabilitation (Coetzer 2003; cf. Coetzer 2010; Zasler, Katz, & Zafonte 2013). What is missed is precisely the area in which an existential-phenomenological approach excels – an emotionally-attuned accompaniment that facilitates the development of personal capacities and attitudes in response to a TBI. Although some of the psychiatric challenges associated with a TBI may map onto psychiatric classification systems, there are numerous personal challenges that are part of the adjustment to the injury.

The structural model of EA provides a helpful guide to identify the personal-existential challenges with TBI patients. In my experience, many patients struggle initially with accepting their limitations and losses after an injury (FM 1). Symptoms of anxiety are common during this phase of recovery as patients become increasingly aware of their limitations and begin to ask themselves whether they can be in light of this change in their reality. Once patients begin to find some ground within themselves to allow their limitations to be as they are, they frequently enter into a process of grieving (FM 2). They realize that they care deeply about the values that they have lost and that these losses require their tears. As patients take time to turn towards what has been lost, they begin to ask themselves questions about themselves (FM 3). Who am I now? What of 'me' persists and in what ways have I changed? Finally, as patients progress through their neuropsychological rehabilitation, they often begin to ask questions concerning the meaning and purpose (FM 4) of their lives. Patients want to know where they may still be fruitful in their lives. Patients with TBIs often have faced boundary situations (Jaspers 1971) and come face-to-face with the limits of their existence. Many of them have explored and realigned their personal values in light of these situations. And these values are now affirmed as they seek out activities in which they can live in manner that is congruent with themselves and what is existentially relevant.

What is Existential-Analytical Accompaniment?

In a recent special issue on accompaniment and counselling in this journal, Silvia Längle (2018) explored the question of what constitutes accompaniment in EA and how this process is differentiated from psychotherapy and counselling. She cited the following definition of accompaniment[1]: "Accompaniment is the accepting and supportive presence, which endures the individual and remains with him (or her) in the situation in an adequate manner. The attitude of the accompanier gives space, is compassionate and is characterized by a respect for the dignity of the person (Längle S 1996, 38, translation mine). Längle differentiates accompaniment from psychotherapy both with respect to its *aims* and *processes*. Psychotherapy is intended to facilitate the treatment of *psychological disorders* through means of understanding, finding connections, and the collaborative working-through of an emotional process under the guidance, leadership, support and confrontation of the therapist (cf. A. Längle 2001). Längle (2018) then highlights specific competencies associated with accompaniment and maps these competencies onto the structural model. I have incorporated aspects of the structure of this article into the case study below.

Case Study

In this article, I employ a case-based approach to provide an overview of accompaniment following a TBI. Although each person we encounter is unique and incomparable in their personhood, the following anonymized case exemplifies some common challenges that clients with TBIs present in the course of accompaniment. Patients with TBIs encounter many different medical treatment providers, who frequently focus on the extent to which the patient maps onto the nosologial systems of their particular discipline. But TBI patients, as all human beings, want to be encountered in their uniqueness, and EA accompaniment offers such a personal encounter through the accepting, compassionate, and personal presence of the therapist. Let me introduce you to Jennifer, a client whom I accompanied several years ago in 48 sessions over the course of nearly four years.

Jennifer[2] was a 68-year-old woman who was referred to me by her family doctor for depression following a TBI. Approximately one year prior to her referral, Jennifer was involved in a life-threatening motor vehicle accident. As Jennifer was riding her motorcycle on a rural road, she suddenly encountered a deer on the highway. She attempted to swerve, lost control of her motorcycle, and hit a tree. Jennifer sustained a severe TBI, which included a loss of consciousness and a 1-week coma following the accident. Jennifer went through several months of intensive rehabilitation to recover her functional and cognitive capacities. When she arrived for our work, Jennifer had regained many of her functions. She spoke normally, with the exception of some occasional word-finding problems. She was able to walk and engage in most physical activities with relative ease. Apart from persistent headaches, she was relatively pain-free. Outwardly Jennifer basically looked like she did prior to the accident.

In spite of the fact that she had made a very good physical recovery from this severe accident, Jennifer was struggling cognitively and emotionally. Her cognitive challenges were numerous. She had always prided herself in her intelligence, in her ability to solve problems, and now Jennifer was faced with many cognitive limitations, including slow cognitive processing, a poor short-term memory, and challenges with executive functioning. She required the help of family and friends to plan her daily activities. Most challenging for Jennifer were the problems with her short-term memory and attention. She would frequently begin an activity, then become distracted by a thought or a phone call, and forget to return to her initial activity. Jennifer's home was littered with unfinished projects. In addition to her cognitive challenges, Jennifer also faced more general physical limitations. Two of the most difficult of these limitations were low energy levels and fatigue. Her daily routine included a 2-hour nap in the afternoon, after which she would awake with enough energy to continue for the rest of the day. Most nights Jennifer would go to bed around 8 pm, and then sleep for 12 hours.

Emotionally, Jennifer also faced many challenges. Initially she felt confused about her situation. What had happened to her and what was this new reality that she was now facing? She often struggled to follow her doctors' explanations of her injury and of its consequences. As a result of this lack of understanding, Jennifer would frequently engage in activities that would exacerbate her symptoms; she would plan day-long trips with her partner or make decisions to visit her daughter for week-long visits. Not understanding her limitations and her inability to pace her levels of activity led to increased

[1] In the original German, the definition is as follows: *„Begleitung ist die annehmende, mittragende Anwesenheit, die den Menschen aushält und mit ihm in seiner Situation angemessen verweilen kann. Die Haltung des Begleiters ist raumgebend, anteilnehmend und von Respekt vor der Würde der Person geprägt."* (Längle S 1996, 38)

[2] To maintain the patient's confidentiality, the names and some identifying details of the case have been changed.

headaches, feelings of frustration and irritability about her limitations, and eventually depressive symptoms, such as low mood, anhedonia, and social withdrawal. Fundamentally, Jennifer wondered whether her life was worth living. How could life possibly be good when so much of what she valued – her intelligence, her physical strength, her memory – had been taken from her?

In order to highlight the accompaniment-based nature of this case, I will focus on the following questions that also informed S. Längle's (2018) approach to accompaniment-related competencies. These are: (1) What are the relevant personal-existential challenges of a given fundamental motivation and how are they expressed specifically in Jennifer's life? (2) What capacities were required at this stage of the accompaniment? And (3) finally, what were the personal and situational outcomes in light of our accompaniment work?

Relating to a Changed Reality: Being-Able to Be

The exploration concerning the requirements for a fulfilled existence begins with the basic ontic question: How can we *be* in a given situation? This capacity for being is the most fundamental human ability (Längle 2003). We are here, thrown into a given reality (Heidegger 1967), and we are not asked whether we like or want this reality. This is an existential situation, that is, a situation that is constitutive for human beings; we are born into a world without our consent, and we have really no say about this facticity of our existence. The question that we face is whether we can be in this situation, whether we can give a felt inner 'yes' to the conditions of our lives. For many TBI patients, the question initially takes a slightly modified shape; namely, can I be here in this situation in which both my capacities and my life circumstances have suddenly and radically changed?

How were the personal-existential challenges expressed in Jennifer's life?

The theme of understanding and accepting a radically-changed life situation and personal capacities was present as I accompanied Jennifer. Through her accident, Jennifer found herself in a situation that she neither expected, wanted, nor fully understood. One moment she was riding her motorcycle along a country road, and the next she found herself coming out of a coma in a hospital bed. She felt shocked, utterly confused, and only gradually began to understand what really had happened to her and the extent of her injuries.

The engagement with the reality of her situation was complicated by Jennifer's TBI in a variety of ways. Firstly, Jennifer had to contend with a radical change in her *capacities*. When Jennifer entered into psychotherapy, approximately 1 year post-accident, she had recovered many important functions. The challenge for her was that she did not know what she could and could not do. This awareness only gradually began to dawn on Jennifer. For the sake of brevity, I will highlight just one such example. One of Jennifer's cognitive challenges was her decreased capacity for orientation. She had previously been a competent adult who was able to navigate her way through a large metropolitan area in Canada without any challenges. However, as Jennifer began to explore her environment post-accident, she began to realize that she could not rely on her orienting capacities. She recalled a particularly difficult time when she was walking home from a café, which was only a 15 minute walk from her home, and at one point realized that she was completely lost and did not know her way home. She had to call her partner for assistance and felt embarrassed, frustrated and shaken by this event.

The challenge of being-able-to-be in light of the changes in her capacities was further complicated by the fact that Jennifer struggled with being able to *perceive her abilities accurately.* In the initial sessions of our work, Jennifer reported feeling content for much of the day. This began to change as Jennifer became increasingly aware of her limitations. As she began to realize her decreased cognitive capacities, she began to feel anxious. She realized that she could not always trust her perception. Additionally, Jennifer found that her various rehabilitation professionals were not particularly helpful in this regard. For example, after two years Jennifer attempted to return to her job as an automotive mechanic. In preparation for this, a neuropsychological assessment was conducted by an external consultant. The evaluation revealed that Jennifer should be able to return to work with only minimal difficulties. A graduated work return was set up by an occupational therapist, but had to be terminated since Jennifer was not able to sustain the physical energy or cognitive demands required for her position. Since no other position within the company could be found, Jennifer was eventually forced to resign.

The emotional consequences of the changes in her capacities and of her challenges in perceiving her abilities accurately were significant. Jennifer felt frustrated with herself and with the fact that she could not perform tasks that previously would have been easy. She frequently over-estimated her abilities, would agree to take on tasks or attempt activities only to find that she lacked the en-

ergy or cognitive capacities to complete them. The increasing awareness that Jennifer could not trust her perceptive capacities to determine her abilities and limitations also resulted in symptoms of anxiety. The foundations of her world, which previously had been known, predictable and relatively stable, began to shake as Jennifer realized that she could not trust her perceptions. Furthermore, she realized that the professional evaluations in her case were of limited assistance in this regard.

What capacities were required at this stage of the accompaniment?

S. Längle (2018) asserts that accompaniment at this stage requires the accompanier to remain firm and steadfast in situations which may shake the ground of existence. Patients need to sense that the accompanier can be in such situations, that they can allow the patient to be as they are and can allow the situation to be as it is. Accompaniment is facilitated by providing *protection, space and support.*

Protection is an element that is needed to facilitate our being-able-to-be. Protection is grounded in the experience of acceptance, in being-accepted in relationships, in belonging to a family, a community, and in the experience that someone advocates on one's behalf. Jennifer fortunately found herself in a supportive relational environment; her partner, Dave, sought to care her needs and support her emotionally. This was especially evident in the early stages of recovery, when Jennifer required significant help in managing the activities of daily living. This included everything from preparing food to managing hygiene or attending doctor's appointments. What was evident in Dave and Jennifer's relationship was that Dave cared deeply about Jennifer and was committed to her, even with the obvious limitations now. Jennifer repeatedly noted in our sessions that she could count on Dave, that he was there for her. Jennifer and Dave also had a number of close friendships whom they sought out for emotional and practical support. These friendships became increasingly important to both Jennifer and Dave as they learned to receive care and support from these friends.

One of the challenges that emerged in Jennifer's relationships with Dave and with her friends related to Jennifer's desire for independence. Prior to her accident, Jennifer had been fiercely independent; she was proud of her accomplishments and determined to make her own decisions in life. In the initial months of recovery, Jennifer lacked both the capacity to live with much independence as well as the awareness to notice these changes. She was somewhat blissfully ignorant of the extent of the changes and of her dependence on Dave. Over time, however, Jennifer gained both greater capacity for independence (e.g., the ability to drive a car, ability to go shopping on her own, volunteering in the community, etc.) as well as increased awareness of her limitations. This was a painful realization for Jennifer. Conflict began to emerge in her relationship with Dave, who was naturally concerned for Jennifer's well-being and, at times, doubted her capacities and self-awareness. Part of our accompaniment work involved helping Jennifer to gain a realistic assessment of her capacities, and negotiating her level of independence with Dave. This also required Dave, who was naturally more anxious than Jennifer, to explore his capacity and willingness to accept some level of risk in Jennifer's life.

Space is found through the experience of breadth, of not being or feeling pressured, inwardly or outwardly, through expectations or demands on performance. Space expands through a phenomenological attitude of openness towards what is. Space was immensely important for Jennifer, especially as it related to being afforded the appropriate amount of time for her activities. As Jennifer began to reengage with life, she began to realize that the non-brain injured world moved at a pace that was simply too fast for her. Jennifer required a reduction in pace, quiet spaces in which she could pursue her activities, and she needed freedom from both inner and outer demands on her performance. Accompaniment with Jennifer focused on assisting her and her partner in creating spaces for Jennifer that were generous in terms of time and corresponded to her cognitive and physical limitations.

Finally, *support* is gained through clarity of perception, through knowing what the other requires and through a clear, anthropologically-grounded understanding of the needs of the patient. This sense of support was crucial for Jennifer, as she was unsure about whether she could trust her own perception of the world and of her own capacity to navigate it effectively. Accompaniment during this time focused on assisting Jennifer in being able to look at and learn from her experience, looking with clarity and calmness at her situation, her abilities and being able to see her limitations. Jennifer's perceptions were augmented by those of family and friends and various rehabilitation professionals. As Jennifer learned gradually to gauge and predict her limitations, she gained the capacity to see her abilities with greater realism and could then make decisions about living within the limits of this reality.

What were the personal and situational outcomes?

As the accompaniment progressed, Jennifer gradually began to realize that she could not live her life like she could before. No matter how much she wished it to be

different, Jennifer came to realize that her brain simply could not function like it used to. From the moment she awoke in the morning to the moment she fell asleep, Jennifer was reminded again and again that her functional capacities had changed. No matter how much she would like to function how she used to, she simply could not.

Endurance of this new reality was the easiest place to begin for Jennifer. Endurance involves testing our inner ground to see if there is sufficient support in order to stand up for ourselves, and coming to the decision that we will take our place and not give way. Jennifer understood herself as a 'fighter' and was able to point out the many circumstances that she had been able to endure in the past. She had endured bullying in school, had survived years of depression and had fought against sexism in the workplace that told her that she could not, as a woman, take on mechanical or practical work. Through these various struggles, Jennifer had gained an increasing confidence that she could overcome. Initially, we drew upon these experiences to re-awaken in Jennifer the memory that she had been successful in enduring these situations. Jennifer repeatedly reminded me with a smile and a twinkle in her eye that she knew how to be stubborn.

Acceptance was a more difficult process for Jennifer. Acceptance means that we do not push away whatever is unwanted, but rather we allow it to be part of life, a courageous taking into our being (Tillich 1952/2000). It is more than the bracing against, but rather it is an allowing, a giving space to a new reality. Initially, it seemed that Jennifer might be able to find an 'inner yes' to her new situation with relative equanimity. However, as she began to realize, that she had far more limitations than she initially understood, acceptance became more challenging. Through repeated attempts, Jennifer began to realize that she would not be able to return to her job. Jennifer's journey toward acceptance was lengthy and marked by moments when she was able to say 'yes' to her limitations and times when she would suddenly realize yet another consequence of her limitations and become frustrated or anxious. Over time, however, Jennifer was increasingly able to consent to her new life situation. As I accompanied her through this part of rehabilitation, Jennifer became increasingly calm. She had tried her utmost and come to the realization that she simply could not return to work. As Jennifer processed this realization, the inner calm gradually gave way to an inner movement; the tears began to flow.

Relating to Life: Grieving Losses and Reconnecting to Values

Although accompaniment begins with acceptance, more is required as the process of 'saying yes to life' unfolds over time. Being human goes beyond the immediate securing of existence as we begin to relate to life itself with its values and relationships. Such a relating requires the capacity for empathy, for an engagement of feeling with oneself and with the other. Such empathy emerges from the fundamental attitude that "I like living", that I enjoy experiencing life and feeling my own vitality. This attitude is also present when we relate to loss, when we turn towards where our lives are hurting. The flow of our feelings, whether joy or sorrow, are part of life and need to be lived.

How were the personal-existential challenges expressed in Jennifer's life?

The realization that she was unable to continue in her job and Jennifer's increasing acceptance of this fact, were critical in moving Jennifer into the next phase of her recovery. What followed for Jennifer was a deep encounter with loss, a time of grieving for the values that she had lost as a result of her brain injury and inability to return to work. The loss of life-relevant values did not end there; she was unable to return to work because of the limitations and losses of cognitive and physical capacities. These, too, deserved her emotional attention as she turned towards her losses.

The physical posture associated with this *turning-towards* is a repositioning of one's body towards where life is hurting. Rather than turning away through avoiding or distracting oneself from the pain, we turn towards it. Turning-towards leads to inner movement, we are filled up emotionally, we establish relationship, and are present in suffering. During this time of sadness and tears, the pace of speaking in session slowed down and the therapeutic relationship gained in intimacy. I aimed to hold a space in which Jennifer could feel and grieve the value of what had been lost. At varying times, there was an impulse to move forward more quickly, prompted at times by her partner or other members of the rehabilitation team. But Jennifer, too, had the wisdom to not want to move too quickly. She withdrew from some of these relationships for a while, gained time and closeness with herself, and took the time to feel and mourn the value of her losses.

What were some of the values that Jennifer grieved during our time? Of course, there was the loss of the value of the job, an occupation that gave structure to her days, an activity which she enjoyed, an opportunity to experience

herself as uniquely capable. Jennifer also enjoyed the fact that she had been able to break into a profession that was largely dominated by men and had gained respect and admiration of others in this.

Jennifer also grieved the loss of cognitive and physical capacities. These were, initially, more complicated because they were less tangible than the loss of a job. Additionally, there was also the complication that neither Jennifer nor her rehabilitation team was sure about which capacities might recover. It became clear that Jennifer would likely continue to struggle with a variety of deficits, such as problems with short-term memory and attention, multi-tasking, and cognitive processing speed. Jennifer especially grieved her losses of memory, sustained attention and multi-tasking as these were the losses that had ultimately contributed most to the loss of her job and presented challenges for engaging in ongoing hobbies.

What capacities were required at this stage of the accompaniment?

Accompanying Jennifer during this phase of her recovery required different skills than were needed when we were dealing with the acceptance of a new reality. Previously, cognitive clarity and a calming, grounding presence were required. Grieving is an intimate process, a process that requires closer and emotionally-attuned accompaniment and a process that benefits from relationship, time and closeness.

All human activity takes place within *relationship*. We can intensify these relationships by stepping into them more personally and therefore increase our felt presence in them. The accompaniment relationship with Jennifer had naturally begun at the time when we began our work together. The process of dialogue, of relating to oneself and relating to the other, was helpful as we stepped into a more intensive and intimate phase of the accompaniment. My sense was that both of us felt the intensification of relationship during this time as Jennifer allowed herself to feel the values that had been lost.

Accompaniment during this phase also benefitted from a slower pace, from taking *time* to feel what had indeed been lost. Such slowing down, taking the time for feelings to come and to be felt, is intensified through the accompaniment relationship. This requires a focus on the present, on what we are feeling right here and now. My aim was to be present to Jennifer wherever and however she found herself. This slowing down also required some effort and protection, as others in Jennifer's life were urging her to move on, find another job, and to look for volunteer work. But both of us knew that this grieving was important, and it required setting boundaries in relationship and prioritizing grief.

Closeness is the third quality that characterized accompaniment during this time. It included being touched and therefore requires an openness on behalf of the accompanier to allow the feelings of the encounter to permeate his or her role. Closeness creates feeling, a flow. Life is flowing in us in closeness. The consequence of good closeness is the experience of more vitality and reconnection to life. Closeness intensified with Jennifer during this phase of our work. The closeness was also one that awoke vitality and joy. Tears of grief mingled easily with ones of laughter and joy. And in the midst of this Jennifer began to notice that life was still flowing through her and that she was being drawn back into life.

What were the personal and situational outcomes?

The initial outcome of participating in this mourning process was the realization for Jennifer that the losses she experienced were real to her. Her work embodied Jennifer's values and therefore also part of her. She discovered that being physically active, creative, and helping people were deeply important to her. She realized that she could not embody these values in the way that she had in her previous work. The question that now could be asked was how these values might find expression in the avenues of life that were still open to her. This required a taking seriously of the values to which Jennifer was drawn with the realism that had been gained.

Jennifer initially decided to take some time off from moving back into work. Her partner Dave and some close friends found it hard to see Jennifer struggle with her grief and wanted to help her move quickly back into some kind of work. However, she took her time in being with herself and her losses and then gradually began to explore how the values might be lived anew. This led into two movements. The first was an exploration of herself – the question that emerged for Jennifer was who she was now as a person in light of her limitations. The second movement was the exploration of various hobbies and activities. Jennifer began to put effort into various woodworking projects for herself and also began to inquire with friends who might need help with handiwork. She discovered that more help was needed than she could provide. Jennifer was re-engaging with life and gradually began to feel the joy and appreciation for the ways in which she could live her values, even in light of limitations.

Relating to Oneself: Sensing What is Right and Finding Orientation

A natural question that emerges following the intimate engagement with the loss of life-relevant values and the taking up of a new and renewed connection to life is where and how this re-engagement with life can be lived. In these contexts of loss and the renewal of life values, the question around who I am and whether I am free to be myself are questions that frequently emerge for TBI patients. Like every person, TBI patients want to be seen, want to be respected in their boundaries, and want to experience appreciation for their uniqueness and singularity. Given the fact that TBI patients frequently experience significant losses in relation to their cognitive and physical abilities, the question of fundamental self-worth, that 'it is good to be me' may be of particular importance. Many clients have told me that it was precisely the loss of their abilities that required them to ask themselves questions of self-worth, and whether it was founded in who they were as persons.

How were the personal-existential challenges expressed in Jennifer's life?

The first question that emerged for Jennifer regarding this theme was the question of who she actually was. Jennifer had turned-towards the loss of some significant life values; she had come to a greater clarity about the loss of her cognitive and physical capacities and she had faced the loss of her beloved job. However, the question of 'who am I', who is the self that is experiencing this new reality and who is grieving these important losses, this question was very much alive. The reason why Jennifer was asking this question, at the age of 68 years, was of course largely due to the fact that she had experienced such a significant change in her capacities. And so it made sense that Jennifer would be asking herself now, who am I now?

A good place to begin the exploration of this question was in relation to the self that she had known prior to her accident. Initially Jennifer began by describing her life roles. As we already know, she was a mechanic by profession. We explored this choice more deeply and I began to appreciate how uniquely challenging the choice had been for Jennifer. Although Jennifer knew that she was gifted mechanically, it had not been easy for her to convince others of the fact that she wished to pursue this trade. Jennifer recalled that she experienced a lot of sexism and discrimination during her schooling and in the initial years of her work life. However, there had also been a determination; Jennifer had learned to stand with and for herself, had been able to affirm her self-worth in spite of the resistance that she had experienced.

Jennifer also identified as a lifelong learner. She explained that she had enjoyed education in high school and had subsequently enrolled in university courses, particularly enjoying Philosophy and English. These qualities made her stand out even more. Even though she loved working with her hands and eventually pursued training as an automotive mechanic, she identified as a "jack of all trades", someone who loved philosophy and poetry as much as woodworking and fixing cars.

As we explored the questions of who Jennifer was, two things began to happen. Firstly, I began to develop an appreciation for who Jennifer was in her singularity. Her beauty, tenacity, openness, and many talents helped me to appreciate her increasingly as the unique person that she was, and I reflected this back to Jennifer as I found myself moved in our interactions. I, as the accompanier, became more visible to Jennifer in our sessions. My being-moved mirrored the areas in which she was moved, too. We rediscovered how much she had cared for her existence, how tenaciously and persistently she had stood with herself throughout many instances in her life. We discovered that there were some essential characteristics of Jennifer that could not be eradicated by a brain injury. There was something inescapably unique and particular to Jennifer in how she lived her life, even a life of reduced capacity and with a brain injury.

We also explored Jennifer's relationships. She had been married previously and had two children and 5 grandchildren. Her former partner had passed away, and the children and grandchildren were living in the United States. After the passing of her first husband, Jennifer had focused on her career and had moved to Canada. Here she had entered into another relationship approximately 10 years ago and remained in this relationship at present. Jennifer's current partner, Dave, had taken on the role of her caregiver. While Dave was happy to step into these roles in their relationship and was a supportive and loving presence in her life, Jennifer also experienced Dave as anxious and controlling at times. We explored and sought to understand the reasons for why Dave may be concerned for Jennifer's well-being and safety. Our sessions sought to help Jennifer understand where and when Dave's help may be needed for her well-being, and when Dave's worry for Jennifer's safety felt constricting and limiting. In her conversations with Dave, Jennifer sought to set boundaries in her life, seeking to assert her freedom where appropriate.

Throughout my accompaniment of Jennifer during this phase, we both discovered and rediscovered who Jennifer was. Although limited to a real and significant extent by

her brain injury, we both realized increasingly that there was also a continuity in Jennifer's life, characteristics that could not be eradicated by a brain injury; she remained uniquely who she was in her essence. Remembering these characteristics and distinguishing them from the effects of the brain injury, was essential to recovering Jennifer's sense of self. In dialogue we paid attention to who Jennifer was; we took her feelings seriously, set boundaries, and jointly gained an increasing appreciation for her personhood. She was uniquely and beautifully Jennifer, and this needed and wanted to be lived.

What capacities were required at this stage of the accompaniment?

The accompaniment competencies that were needed during this stage of our work shifted again. Following the close and emotionally-intimate process of grieving, greater distance was needed initially. Jennifer and I both took a step back when we asked how she perceived herself. The question of who she was, of who she had been prior to her brain injury, and how she was revealed in and through her activities was a starting place. However, her capacities and activities also revealed the values that were important for Jennifer and thus began to disclose who she was. As we explored the values that were represented in her activities, we began to discover consistency over time. Although Jennifer had lost abilities, she had not lost the essence of who she was.

Dialogue was an important aspect of our accompaniment work during this phase. Jennifer was invited to step into dialogue with herself, to look at herself, to explore what she did and did not understand about herself and to engage in cognitive and moral self-evaluation. Self-evaluation required Jennifer to take her feelings and own subjectivity seriously; only she could tell us how she felt about herself, only she could know whether her actions were in resonance with her moral conscience, and ultimately only she could decide whether she wanted to stand with herself. It was not difficult for me to allow Jennifer to know how I perceived her. My perceptions and feelings about her in turn stimulated and affirmed her own evaluations.

What were the personal and situational outcomes?

The dialogical engagement with herself and important other people in her life led Jennifer into a greater awareness of herself, to a clearer sense of her relational boundaries, and to a firmer positioning in relation to herself, the important people in her life and her life situation. Our exploration of who she was prior to the brain injury, how she was revealed in her essence through her activities and her values, allowed us to gain a clearer picture of who Jennifer was in her uniqueness.

The attention to and increased understanding of who Jennifer was in her essence naturally raised evaluative questions. How was this for Jennifer to re-discover who she was in her uniqueness? May she be like this before herself, before her partner, in relationship with others in her world? Through the inner and outer dialogue, Jennifer began to discover her own position in relation to herself. Jennifer began to remember and rediscover that she liked herself as she was. It was helpful to remember how she had stood with herself in the past. Jennifer had sensed back then and rediscovered now, that she could and wanted to trust her ownmost sense of what was right for herself. This ultimately led Jennifer to rediscover a certain power and authority over her life and her activities; she would receive feedback from her others, but ultimately Jennifer wanted to be the one who made decisions for herself.

This standing-with-herself had significant practical and relational outcomes. In her relationship with Dave, Jennifer began to set boundaries about what she did and did not want to do. Dave was naturally extraverted. Jennifer often found Dave's pace of life to be exhausting. As Jennifer began to take her own feelings more seriously, she started to pull back. Jennifer enjoyed spending time quietly in her woodworking shop and found that she did not need or want as much social contact as Dave. This was also a place in which the limitations of her brain injury became evident; Jennifer simply did not have the same capacities with respect to energy levels that she had prior to the accident. She tired more easily, especially in situations which were cognitively and emotionally demanding. While it was initially difficult for Dave, Jennifer began to attend more to the activities that she found to be life-giving and resonant with herself. A similar outcome became evident with respect to Jennifer's vocational choices. Rather than attending to the volunteering suggestions made by others, Jennifer opted to ask her friends and family for woodworking or repair projects. Although this decision led to some unexpected consequences, Jennifer had begun a journey to rediscover who she was in her uniqueness and was committed to continuing this journey with herself.

Relating to the Future: Finding Meaning and Purpose

After discovering our ability to be in a given situation, identifying and connecting to important life values and relationships as well as grieving significant losses, and then

affirming who we are essentially, the next step focused on actively stepping back into life. As human beings, we are constantly in the process of becoming; the flow of life happens in and through us and includes an inherently transcendent dimensions. Indeed, this is our understanding in EA of what it means to be a person (Längle 2003); our existence emerges in a continuous flow of life which precedes and transcends us both temporally and with respect to the wider relational, cultural and spiritual context in which we live. As human beings, our becoming matters to us. We care (cf. Heidegger 1967) about the values that are actualized through our living, and we are interested in questions of the meaning and purpose of our life and our suffering.

How were the personal-existential challenges expressed in Jennifer's life?

For Jennifer, questions concerning the meaning and purpose of her suffering and of her life more generally were natural matters of concern. Jennifer had previously studied philosophy and had also encountered the work of Viktor Frankl in that context. She had read "Man's Search for Meaning" (Frankl 1984) in university and it had left a profound impact on her. Jennifer took great interest in spiritual writings and considered herself to be a deeply spiritual person. Over the decades of her development, she had read some Buddhist philosophy, and topics of meaning and spirituality were regularly part of her life.

The theme of the meaning and purpose of her suffering emerged at various points during our accompaniment and we circled back to it repeatedly. Initially, Jennifer and I spoke about the meaning of her suffering during the earlier months of our accompaniment. At this stage, she was interested from more of a philosophical perspective. As we circled back to the theme of meaning and purpose later on in our work, the questions took on a more personal tone. Jennifer had attempted, unsuccessfully, to return to work and even her subsequent volunteer placements were not as fulfilling as she had hoped. The question that she was wrestling with now was: How may my life retain meaning and purpose in light of my substantial limitations?

Jennifer and I began initially to look at where she might be needed and uniquely placed in her life. Could she detect any needs or opportunities in her life that might correspond to her values and to her sense of who she was as a person? The first clear answer that emerged was Jennifer's relationships to her children and grandchildren. Jennifer had regular contact with her family and found that her children were eager to involve her in their lives. Jennifer made several extended trips to visit with her children and their families. Jennifer began to be called on more frequently about parenting questions and found this increased involvement with her children and grandchildren to be meaningful and enjoyable. The visits to her children and their more frequent requests for emotional and practical support also gave Jennifer an opportunity to test the limits of her capacities and re-assert her boundaries.

A second opportunity for discovering new meaning and purpose for her life emerged rather serendipitously. Jennifer and Dave lived in a close-knit community and Jennifer had explained with some satisfaction that she knew many of her neighbours quite well. When Jennifer sustained her TBI the neighbours had been very concerned for her well-being and had supported in a variety of ways. Two years after Jennifer's TBI, one of their neighbours experienced a stroke. Jennifer was not only eager to help but had gained the capacity and experience that made it possible to offer meaningful emotional support.

What capacities were required at this stage of the accompaniment?

Helping Jennifer detect where life was calling her to become active required an understanding of her physical and cognitive abilities and limitations, of her values and significant relationships, and of who Jennifer was as a person. All of these aspects were significant issues during accompaniment and prepared Jennifer sense and see where she may be uniquely needed. Questions of meaning and purpose followed closely after Jennifer had learned that she would not be able to return to her job. Jennifer knew that she wanted to be active in her life, but she also wanted to be active in ways that were congruent with her values and with herself.

The question of where she may be needed in her life, of what she uniquely might be able to accomplish was a helpful one for Jennifer. The first answer that Jennifer sensed was the opportunity to be more involved in the lives of her children and grandchildren. The second opportunity emerged surprisingly, as Jennifer offered comfort and support to her neighbours after the stroke. Phenomenological openness was crucial for both situations; it allowed Jennifer to sense where she was being drawn in her life and to see the opportunities that emerged. She did not need to seek meaning and purpose in activities outside of her current life; there were plenty of opportunities right in front of her if she was open to being drawn in by them.

What were the personal and situational outcomes?

Jennifer's involvement with her family and with the neighbours led to a sense that she was needed as a pro-

ductive member of her community. She had been the recipient of many professional services and had received support from family and friends. Being able to offer support again to friends and family had a positive outcome on Jennifer's mood and energy levels. She began to feel more hopeful about her life and began to see how meaningful activities might be possible for her.

To allow the new meanings to emerge required Jennifer to let go of the future that she had envisioned. A return to her previous job was not possible. Although Jennifer could no longer work as a mechanic, many friends were calling on her to assist them with automotive and home repairs in their lives. Here, too, Jennifer had to discern and practice setting boundaries and living within her limits. Over time, Jennifer learned what her realistic physical and cognitive limits were and also learned to assert these limits in relationships with family and friends.

Conclusion

Rehabilitation with TBI patients has characteristically been dominated by psychotherapeutic approaches which emphasize the treatment of psychiatric diagnoses and the rehabilitation of functional limitations. While this focus is valuable, it is possible that the person with their particular personal-existential challenges is somewhat forgotten. Through the case study, I have sought to offer an example of what a personal-phenomenological approach to accompaniment might look like. The approach is grounded in EA, which emphasizes that accompaniment is meant to facilitate an inward change of attitudes and the development and adjustment of the personality of the patient through the facilitation of personal competencies. The foci of accompaniment are facilitated through a phenomenological process which attends to existential challenges of finding inner consent to the world, life, the self of the patient and a meaningful future. My hope is that this case not only highlights the possibility and necessity of accompaniment in cases of brain injury but also encourages EA practitioners to offer their services to TBI patients in need of such a person-centred approach.

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