Lost Self to Present Self: A Case Report of Narrative Therapy for a Woman with Acquired Brain Injury

От потерянного «Я» к новому «Я»: описание клинического случая применения нарративной терапии у пациентки с приобретенной травмой головного мозга

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Case report

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ABSTRACT

BACKGROUND: Psychotherapy for people with acquired brain injury (ABI) is considered to be an important component of a holistic neuropsychological rehabilitation approach. This helps in making sense of the loss of the sense of self they experience. Gender, premorbid personality, and socio-cultural discourses guide this process of understanding. Narrative formulation takes these considerations into account and, thus, can be used for formulating therapeutic plans.

AIM: To present a case report which highlights the use of narrative case formulation to understand the psychological, social, and cultural factors forming the dominant discourse of a woman with ABI.

METHODS: Ms. VA, a 43-year-old female, presented herself with a diagnosis of hypoxic ischemic encephalopathy with small chronic infarcts with gliosis in the bilateral cerebellar hemisphere, myoclonic seizures, mild cognitive impairment, depression, generalized dystonia, and bronchial asthma. Along with neuropsychological rehabilitation and cognitive retraining, 25 sessions of psychotherapy using narrative formulation were performed.

RESULTS: Following the therapy, microgains such as a developing strong therapeutic relationship, accommodating vulnerability in her narrative, and finding moments of independence and assertion within the constraints of ABI were observed. Acceptance of her current predicament vis-à-vis her lost self and finding meaning in her new self were facilitated.

CONCLUSION: There is paucity of research detailing psychotherapeutic management of ABI, especially in India. Psychotherapy, particularly using narrative formulation, can be helpful in understanding the intersections of gender role and expectations, premorbid personality and ABI, and aiding the post-ABI rehabilitation and adjustment. Future work in this area can explore the socio-cultural aspects that play an important role in the therapy process.

АННОТАЦИЯ

ВВЕДЕНИЕ: Психотерапия является компонентом нейрореабилитации пациентов с приобретенным повреждением головного мозга (ППГМ). Предполагается значимая роль нарративной психотерапии, которая помогает пациентам осознать серьезные проблемы, обусловленные чувством идентичности больного и безвозвратных потерь, и их связь с хроническими нарушениями функционирования. Этот метод помощи пациентам с ППГМ недостаточно исследован в Индии и других странах. Используемый авторами холистический медицинский подход требует изучения биологических, личностных и психосоциальных факторов, способствующих развитию малоадаптивного дискурса у пациента и неблагоприятному течению заболевания, а также снижающих эффективность терапии.

ЦЕЛЬ: Представить клинический случай применения нарративной психотерапии при реабилитации пациентки с ППГМ с психическими и функциональными нарушениями для изучения ее эффективности с учетом влияния не только клинических, но и личностных, психосоциальных и культурных факторов.

МЕТОДЫ: Проведена диагностика неврологических, психических, когнитивных и личностных нарушений в случае 43-летней женщины с диагнозом гипоксической ишемической энцефалопатии, проявляющейся легким когнитивным расстройством, генерализованной дистонией и миоклоническими судорогами, сопровождающейся депрессией и бронхиальной астмой. В рамках нарративного подхода был определен доминирующий дискурс и его связь с низким уровнем адаптации и восстановления пациентки. Проведены пять сессий нарративной психотерапии наряду со стандартной реабилитацией с нейрокогнитивными тренингами.

РЕЗУЛЬТАТЫ: С помощью нарративного подхода были созданы условия для принятия пациенткой текущих затруднений в связи с потерянной идентичностью и обнаружения смысла в развитии альтернативной идентичности. Показан ряд эффектов этой техники, позволивших выявить уязвимость доминирующего дискурса и изменить нарративное формулирование «Я» пациентки, что привело к повышению активности, самоконтроля пациентки и других психических функций, укреплению терапевтических отношений и результатов лечения в целом. Выявлены ограничения для нарративной терапии в связи с клиническими особенностями случая.

ЗАКЛЮЧЕНИЕ: Представлен новый взгляд на нарративный подход как компонент реабилитации пациентов с ППГМ. Он способствует формированию реальных целей для пациента и психотерапии. Описание нарративного подхода позволяет терапевтам соотносить данный опыт с собственной практикой и внедрять его. Требуются дальнейшие работы для уточнения механизмов влияния психосоциальных и культурных факторов, в том числе современных тенденций в изменении гендерных ролей, на эффективность лечения в сходных случаях.

Keywords: *case report; narrative therapy for ABI; neuropsychological rehabilitation*
Ключевые слова: *клинический случай; нарративная терапия при ППГМ; нейропсихологическая реабилитация*

INTRODUCTION

Acquired Brain Injury (ABI), particularly traumatic brain injuries (TBI), is a prominent contributor to indices of death and disability, especially in the lower and middle-income countries [1]. Published literature regarding overall burden, demographics, and interventions for ABI is limited in India [2, 3]. Within this literature, most of the focus is on the documentation of the neurophysiological aspects of the injuries of TBI and the management processes described center mostly on surgical intervention [4]. Thus, research is even more limited as relates to neuropsychological rehabilitation and psychotherapeutic management for people with brain injuries [5]. Within this subset, research on psychosocial management for women is especially under-represented. There is evidence to suggest that women with TBI exhibit unique trajectories of psychosocial recovery. These include incorporating the effect of brain injuries on the management of the socio-cultural expectations of women, as well as newer identities such as those related to motherhood post injury [6]. The only case report found in the Indian context relating to the psychosocial management of TBI in a woman was by Banerjee et al. in 2021. This work highlighted the importance of a holistic rehabilitation approach emphasizing a coherent self-narrative [7].

Research in the last three decades has highlighted the fact that narrative therapy can lead to significant improvement in restituting the lost sense of self and accepting the newer reality of the client's difficulties following TBI [8]. Narrative therapy recognizes the interface between knowledge, language, and power with the person's life experiences or narratives. These narratives are constructed with the help of societal, familial, and individual cues and influence the problems that an individual faces. It then helps them move away from these narratives and develop newer narratives not entirely consumed by those problems [9]. Post-TBI, people need to deconstruct their view of self and rewrite their identities to be in congruence with their new way of being [10]. Narrative therapeutic formulation may help practitioners by providing theoretical rigor, increasing opportunities for reflection on the factors affecting people's

view of their identities, and encouraging otherwise not obvious intervention strategies [11].

The current case report describes the use of narrative formulation for psychotherapy with a woman with ABI in India. It aims to highlight the unique psychosocial challenges she faced as relates to ABI and how they were incorporated into her newer identity. Written informed consent for publication of data was obtained from the patient.

PATIENT INFORMATION

Ms. VA, a 43-year-old married female with a Bachelor of Technology degree (B. Tech.), employed as a manager in a multinational company, of middle socio-economic status, came with diagnoses of hypoxic ischemic encephalopathy with small chronic infarcts and gliosis in the bilateral cerebellar hemisphere, myoclonic seizures, mild cognitive impairment (MCI), generalized dystonia, and bronchial asthma. The patient was also diagnosed with depression. All diagnoses were made as per the international classification of diseases ICD-11.

She felt apparently well until July 2016, when suddenly she experienced an attack of asthma. When she realized that she needed medical attention, she called her parents to take care of her children, refusing to leave them alone. Her situation deteriorated, and she experienced cardiac arrest at the hospital. Following an emergency surgery, she slipped into a coma that lasted three weeks.

After her stay in the hospital, she spent the next two years recovering and collaborating with medical professionals such as neurologists, cardiologists, pulmonologists, and physiotherapists taking care of her physical health. At the time of referral, she was experiencing difficulty with walking and used a wheelchair. She was unable to carry out her activities of daily living independently and had not been able to return to work. She was referred to the current hospital, which is a tertiary care hospital for mental health, by a friend who had undergone a similar experience and sought treatment from the author at the end of 2018. She consulted the clinical neuropsychology unit at the current hospital primarily for a neuropsychological evaluation and treatment as she was experiencing difficulties with concentration and mood-related concerns, such as lack of motivation, energy, and interest in carrying out the activities of daily living, as well as adjusting to her post-ABI limitation. In January 2019, she underwent a neuropsychological assessment and a cognitive retraining program was initiated.

Personal history

The patient had a history of childhood bronchial asthma. Academically, she was a high achiever. She had chosen mechanical engineering as her major, where she was the only female student in her class. Occupationally, she took on a leadership role at the multinational organization that she was working in after graduation and was in the midst of launching a new product when the attack occurred. She was in a romantic relationship during graduation, which culminated into marriage. She lives with her husband and her two daughters.

Premorbid history

The patient was highly competitive and often compared herself to others. She had type A personality traits [12], was a perfectionist, and had high expectations for herself and others. She would rigidly follow routines, and she seemed to derive her self-worth from her academic performance. Her hobbies included cooking and participating in adventure sports such as sky-diving, where she displayed perfectionist traits as well. She was able to make and maintain long-lasting friendships.

Family history

The patient is the first child, born into a non-consanguineous marriage. Her parents were high achievers and had high expectations for her. The father believed in strict parenting. Switchboard communication was the norm, as she would communicate via her mother to her father.

Medical history

The patient was diagnosed with the following conditions:

1. Bronchial asthma: Currently, she is not taking any medications. She uses an inhaler for emergencies.
2. Hypoxic ischemic encephalopathy with small chronic infarcts with gliosis in the bilateral cerebellar hemisphere, myoclonic seizures, and generalized dystonia: These conditions are managed with medications by the neurology team at another hospital. Details of the medication are currently unavailable. She was also undergoing physiotherapy for gait improvement. She used traditional healing practices such as Ayurveda, as well.
3. Mild cognitive impairment (MCI): Twelve sessions of cognitive retraining were undergone based on the neurocognitive deficits identified through a neuropsychological assessment.

CLINICAL FINDINGS

Her diagnosis when cognitive retraining started was myoclonic seizures, generalized dystonia, and dysarthria. In May 2019, the current psychotherapist started working with her. On further exploration, the patient reported being frustrated with herself, feeling helpless for not being independent in her activities of daily living and experiencing a sense of hopelessness. This led to interpersonal issues with family members as they pushed her to try and then berated her when she could not perform. This added to the feeling of worthlessness. Thus, the diagnosis of depression based on her clinical impression was added. It was decided that narrative psychotherapy would be initiated in her case.

TIMELINE

1. Childhood history of bronchial asthma.
2. Hypoxic brain injury in July 2016; coma until August 2016.
3. First-time interaction with the neuropsychology unit at the end of 2018 led to diagnostic assessments and the beginning of cognitive retraining in January 2019.
4. Current psychotherapeutic journey from May 2019 to June 2020 consisted of 25 sessions ranging from once a week to once a month based on her availability and accessibility.

DIAGNOSTIC ASSESSMENT

Neuropsychological assessment

The neuropsychological assessment was performed in January 2019 across 2 sessions at the neuropsychological unit of the hospital with which the author, Dr Shantala Hegde, has been affiliated with. It was held under the supervision of Dr Shantala Hegde.

Behavioral observations during the neuropsychological assessment are listed below. Her motor functions were compromised as she needed a wheelchair to move. Her overall sensory functions were adequate; she needed spectacles for reading. She was conscious, alert, and oriented in time, place, and person. Her attention could be aroused, but there was difficulty in sustaining it. Her comprehension was adequate. Speech was effortful and slurred. Motor weakness, coordination difficulties, and myoclonic jerks were observed during the assessment.

Table 1. Results of the neuropsychological assessment

Neurocognitive functions in the normal functioning range	
Functions	**Test**
Focused Attention	Color Trails 1
Attention Switching	Color Trails 2
Verbal Working Memory	Verbal N-Back test (1 and 2 Back condition)
Visual Working Memory	Spatial Span
Planning	Tower of London
Set Shifting	Wisconsin Card Sorting
Verbal Fluency	Controlled Oral Word Association (COWA)
Category Fluency	Animal Names test
Facial Recognition	Faces Test (Retention)
Neurocognitive functions in the impaired range (below 15th percentile (%le), based on Indian norms)	
Sustained Attention	Digit Vigilance Test
Mental Speed	Digit Symbol Test
Response Inhibition	Stroop Test
Facial Recognition	Faces Test (Immediate and Delayed Recall)
Verbal Memory	Rey's Auditory Verbal Learning Test
Verbal Learning	Rey's Auditory Verbal Learning Test

Note: Selected tests from the NIMHANS Neuropsychological Battery [13] were administered. The scores were compared with age, education and sex matched Indian normative data.

She was motivated to complete her assessment. The results are presented in Table 1.

Upon clinical neurological examination, there was no evidence of parietal focal signs such as visual object agnosia, form agnosia, color agnosia, finger agnosia, tactile agnosia, ideomotor apraxia, ideational apraxia, or buccofacial apraxia.

THERAPEUTIC INTERVENTION

The following therapeutic interventions were used for the patient:

1. Cognitive Retraining.
2. Narrative Psychotherapy.

Cognitive retraining

Based on the assessment results, cognitive retraining using both traditional cognitive retraining tasks, along with techniques of the Neurologic Music Therapy (NMT) [14], was planned for her. This comprehensive plan included the following elements:

1. Rhythm Speech Cueing for addressing the clarity and prosody of speech.
2. Rhythmic tapping task with one hand and both hands for improving attention and response inhibition.
3. Rhythmic placing blocks using metronome-based tasks on the Minnesota Board for improving attention and response inhibition.
4. Temporal encoding: Starting with a set of 6 words for improving verbal learning and memory.
5. Block construction task for improving visuo-spatial construction; and
6. Writing for enhancing fine motor skills. This also served as a method of therapeutic writing.

The cognitive retraining plan was implemented in 12 sessions starting in January 2019. This work was undertaken by another trainee under the supervision of Dr Shantala Hegde, who had performed the neuropsychological assessment. According to the hospital's policy, the trainee transitioned out of the unit and this cognitive retraining program was handed over to the author Mrinalini Mahajan, who became the primary therapist for Ms. VA. She was supervised by the author. During this time, she noticed symptoms of depression (as mentioned above) and on further discussion with the supervisor led to a decision to begin psychotherapy to address these concerns. Narrative therapy was chosen as the modality of choice, as it appeared that the amotivation, anergia, feelings of hopelessness, helplessness, and worthlessness were conceptualized as a consequence of her inability to reconcile her present self with her past self.

The psychotherapeutic process described below was performed in nearly 25 sessions spread across ten months, with a frequency ranging from once a week to once a month. Sometimes, she missed sessions, because she had other appointments that clashed with sessions or she took breaks to focus exclusively on physical rehabilitation when she experienced falls due to jerks. She also struggled with amotivation and anergia and found it difficult to make the commute for sessions. She had another episode of asthmatic attack during this time, due to which she had to be hospitalized and could not attend therapy. This led to breaks during the therapeutic process. When the reasons were time scheduling difficulties or amotivation, problem-solving was incorporated. However, when the break was due to falls or health-related difficulties, it triggered past traumatic memories, which needed to be addressed. The longer hiatus was caused by the COVID-19 lockdown, as it necessitated precautions for her health. Therapy was terminated in June 2020, while the lockdown continued because the therapist moved away from the site of her training. Author Shantala Hegde had follow-up sessions over the phone and carried out supportive therapy for her primary caregivers.

Narrative psychotherapeutic intervention

Psychotherapy was initiated with the client to help in making sense of the experience for her. A narrative framework was used to guide the therapeutic process, which is delineated further.

It is based on the post-structural narrative model by Meehan and Guilfoyle (2015), which aims to answer the following questions [11]:

1. Who is the client? This relates to the subject positioning of the person within the narrative.
2. How did they learn to construct their particular situation in this way? These refer to the discourses that people adopt to understand themselves.
3. How did the self and other contribute to these discourses? These are related to the normalizing judgments that self and others practice.
4. Which ways in the life of the client did not fit into the discourses, which can then be incorporated into the newer discourses.

Subject position: Narrative therapy emphasizes the belief that people participate in the understanding of their lives

and identities by creating narratives [15]. This "places" the person's identity or sense of self within the narrative constructed by them. This leads to explicit or implicit conclusions for the identity of the person; that is, these are the stories about the person.

The subject position that is used in the present case was that of her *lost self.* She was a superwoman — a person at the top of her game; did well at work, was ambitious, and managed household chores and motherhood with ease and effortlessness. However, her present identity is presented as a "weak, crippled individual" unable to carry out any of her responsibilities. This is so far from her *lost self* that she finds it difficult to accept it as reality.

Discourses: The discourses that people have highlight the way in which they construct the subject's positions. They can, therefore, be considered as coherent crystallizations of the power/knowledge dynamics which society espouses [16]. In turn, this reflects and perpetuates particular dynamics of power.

The discourses in this case that construct, enable, or support the client's problem subject position are encapsulated in the idea of being a high-achieving mother. This discourse has two aspects. One is a *high-achiever*, who is perfect, always successful in her attempts, and has no accommodations for mistakes or vulnerabilities. The other is the *mother* who held herself to these standards even in child-rearing. Currently, Ms. VA is unable to perform her responsibilities of motherhood the way she did prior to the ABI. Without these standards she finds herself floundering. She was once so immersed in this identity that she cannot relinquish it completely. She cannot participate in it nor can she escape it.

Normalizing judgements: Foucault (1977) has highlighted how discourses help to create systems of norms and values that are used to effectively organize people's positions in relation to one another [17]. It allows people to be implicitly rank-ordered relative to each other, based on their perceived value or status (e.g., standards of success, beauty, and so on in society). Such a system guarantees the fundamentally relational nature of people's positions; that is, people being ranked hierarchically. Furthermore, this discourse gets impacted by the alignment of social activities that people engage in so that these values, norms, and positions are maintained [18]. In her story, *lost self* is valued more than the patient's present self from her standards, as well as those of family members. She is constantly reminded of how amazing she was and now is not. The small steps that she takes are not appreciated; rather, they are looked down upon as they are not at the same pedestal as her earlier self. Another source of these judgments comes from her position vis-à-vis her peers, who have retained their high-achiever status. The *lost self* belongs with them. The present self does not; she is excluded from the narrative which she was once a part of.

Lost narratives: Narrative therapy encourages commitment to the idea that people have multiple discourses, and that they are more than the one particular discourse that they have chosen for themselves [16]. Discourses which are saturated with problems can be resisted. These resistances, and instances of being "more than" their problem situations, are the "unique outcomes". In the patient's story two types of unique outcomes were co-constructed. Her *lost self* was characterized by perfection, while the *present self* is riddled with imperfections. Instances where space for learning, making mistakes, and not being the best were created even where perfection was present earlier. At the same time, her present understanding of being riddled with problems started including instances of triumph in her efforts, where she had taken pride in her moving past her imperfections. This has been summarized below in Table 2.

Table 2. Summary of the narrative framework used for the patient

Narrative framework	As seen for the patient
Subject positions	*Lost self* — Superwoman: at the top of her game both in the professional and personal realms. *Current self*: weak, crippled, and unable to carry out her responsibilities.
Discourses	*High-achieving person and mother:* currently, she is neither high-achieving nor an active mother. She cannot participate in these identities completely nor can she escape them.
Normalizing judgments	Valuing *lost self* over the current self both by self and family. She is not who she was. Her peers have retained their positions, but she was not able to do so.
Lost narratives	Creating space for learning, making mistakes, and not being the best where perfection was present. Triumph of her efforts and pride in moving past her imperfections were celebrated.

Translating the formulation into therapeutic journey

A challenge in this case was the way in which her premorbid personality intersected with this framework. She and her family members had high expectations about her. When faced with the inevitability of her inability to do things the way she used to, she gave up on her agency. For example, she did not engage in cognitive retraining sessions, as she was unable to perform these tasks to her satisfaction. Instead, she fell asleep. Similarly, she did not ask for help nor did she acknowledge that something was difficult for her; instead, she withdrew and kept others at a distance, including her therapist. Keeping these challenges in mind, the therapeutic plan for Ms. VA was to use the narrative framework to identify the subject positions and discourses that she used to describe her own self and understand the judgements that she seemed to have normalized for herself.

Certain moments in therapy revealed unique outcomes. The search for unique outcomes that counter the dominant discourse is the first step towards developing an alternate discourse. For example, when, instead of her mother, she was involved as an active, equal agent in preventing sleep, it led to glimpses of herself seen as someone who can manage her time. This was a break away from her story of being riddled with problems without any agency of her own. Similar anecdotes were elicited from the patient. They helped "thicken" the alternate discourse; that is, made the alternate discourse robust and detailed. Another important breakthrough moment was when she left her stoic, blank, and emotionless mask behind and broke down. During a session, she expressed her fear of losing out on crucial years of bonding with her younger daughter because of her coma. She discussed that her elder daughter expects her to be the way she was. She feels disappointed that she cannot live up to her expectations. This culminated in her breaking down and crying over the loss: losing herself, as well as her children losing their mother. She felt especially despondent for her younger daughter as she could not be the mother that she had been with her. She was afraid that her younger daughter saw her as a mother incapable of taking care of her. These narratives represented her memories of being a perfect mother that she no longer was. Thus, reclaiming aspects of her identity of being their mother again were discussed. For example, providing inputs on the design or search for recipes online while the elder daughter bakes. Spending private time with her younger daughter playing games and watching cartoons of her choice were discussed. The younger daughter started making a game of her cognitive retraining exercises. On a difficult day, she looked at the pictures of her playing with her daughters that reminded her that she could still fulfill some of her duties as a mother. Yes, she is a mother with disability, but she is not just a disabled mother. This externalization of her disability as a problem which can be managed helped her reclaim agency.

At the same time, reclaiming her identity beyond her role as a mother was also important. For example, once she forgot her wheelchair and walked to the session with support. This was used as an opportunity to affirm her unique outcome: that she did not need to be limited by her wheelchair. From then onwards, she walked to her sessions. This was used as a "quest metaphor" highlighting her journey of triumph over adversity and helped in constructing an identity of a fighter. Other discussions focused on the feasibility of her work, such as will she be able to go back to the office? Should she teach? Should she focus on walking without support or with some support? Each of these discussions listed the pros and cons of each decision and their sub-goals.

In this way, her subject positions, discourses, and normalized judgements were identified. She moved away from them and constructed her new identity with the unique outcomes she was now noticing using techniques from narrative therapy such as development and thickening of her alternative discourse, externalization of problems, and active efforts to solve them and 'quest metaphors' to highlight her journey through adversity.

FOLLOW-UP AND OUTCOME

Since therapy had to be terminated during the COVID-19 pandemic when the therapist moved away from the site of her training, post therapeutic assessment could not be carried out. However, the supervisor had phone follow-ups with her and remained in touch with family members, thus providing some continuity. A degree of micro gains in therapy helped build a strong therapeutic alliance with the medical team and other clinicians, which helped her in recovery and provided her with a safe space to access her vulnerability and rejigger hope. There were positive changes in her mood (both as observed by others and as per her self-report), more motivation and energy in setting up and achieving realistic goals, increased social interaction, and working remotely. The overall global impression from the

multidisciplinary team, family members, clinical supervisor, and the patient herself was that there was a significant improvement in her socio-occupational functioning. These improvements were attributed to the shift from her illness identity to the alternative discourse created with the help of narrative therapy.

DISCUSSION

This report focuses on the importance of using a narrative formulation in psychotherapy with a woman after ABI as part of a holistic neuropsychological rehabilitation approach. This is unique in the Indian context, as literature on managing TBI in lower and middle-income countries has traditionally focused on surgical interventions and rarely highlights the psychotherapeutic work carried out or the need for such an approach [4]. The psychotherapeutic literature from India has focused more on psychiatric disorders with very few case reports focusing on understanding its effectiveness in the management of ABI. This case report highlights the unique challenges that women with ABI face and on how to ameliorate them by integrating their newer identities into the psychosocial expectations placed on them. An important limitation of this study is the fact that this is a single case study and, hence, generalization of the results could prove difficult. The therapeutic journey was frequently interrupted due to health and accessibility obstacles. Similarly, multiple assessments could not be carried out. Such assessments could have yielded information on the process of change. These are the practical challenges with several neurological and neurosurgical patients. A formal assessment of the outcomes of therapy could not be carried out due to practical concerns. However, as mentioned previously, the supervisor provided some continuity. Lastly, this case report does not include a caregiver perspective, which is important in achieving a holistic understanding of ABI.

Psychotherapy for individuals with ABI emphasizes a collaborative therapeutic alliance in order to improve client awareness and acceptance of their newer identity and create hope and meaning for them [19]. This translates into developing a newer understanding of self within the context of gender, psychosocial expectations, and cultural milieu [20]. Narrative therapy is one way of helping people with ABI deconstruct and co-construct their life stories that can be used in neuro-rehabilitation [21]. It facilitates acceptance of a degree of inevitability, the harsh realities of the client's life, and it allows them to build new narratives to make sense of their experiences, with the understanding that the newer narratives are limited by their injuries but are not defied by them [10].

In the Indian context, gender influences the life stories of individuals [22]. Feminine characteristics represented in skills such as cooking and taking care of others are a part of the socialization process. Motherhood dominates an important discourse in the lives of Indian women [23]. With the advent of industrialization and liberalization, women are also encouraged to aim for success in their careers [24]. Women are thus expected to succeed in these spheres both by themselves and through others. All these identities have the potential to be affected post injury. Hence, psychotherapy with women with ABI recognizes the importance of these societal and cultural expectations. It also acknowledges individual differences, which play a role in how role changes are perceived and how disability affects their lives and interactions with family members [6]. Narrative therapy, with its emphasis on interaction and effect of knowledge, language, and power on the individual's story, is able to incorporate these unique considerations. The underlying philosophy and techniques used in narrative therapy can prevent the individual from becoming completely defined by these discourses [9]. Narrative formulation can serve as an important theoretical construct to understand how these different identities keep the individual trapped in their problem-saturated stories and implement intervention strategies to support unique outcomes for them [11].

Narrative therapy can thus be used in rehabilitation to restore a connection with the former self, acceptance of one's new identity, instill hope and highlight a sense of agency for patients with ABI within their socio-cultural milieu. It is especially advantageous in promoting empowerment, self-determination, independence, and advocacy. However, narrative therapy cannot be used in all situations. Due to its heavy reliance on language, it is not a suitable method for those with severe cognitive impairments and lack of insight.

The key takeaway from this case report is the emphasis on the importance of addressing life-altering changes in the physical, cognitive, and social sequelae accompanying ABI. A comprehensive neurorehabilitation program must include the creation of a meaningful life within the constraints of injury. Therapists and medical practitioners need to focus on understanding the grief over the loss of the sense of self while still understanding the individual as a whole, not just

as defined by their problems. It involves acknowledging the strengths of the patient while accepting the new limitations post ABI. Therapists and practitioners must be willing to tolerate the helplessness and despair that may come with working with patients with ABI. Particularly as relates to working in the narrative therapy context, further training is needed to understand the impact of language, an awareness of their own understanding of dominant discourses, and the ability to remain persistent in pursuing unique outcomes. In addition to the need for further training, some of the constraints in the Indian context include the shortage of trained individuals, high caseloads, and the prevalence of high psychosocial barriers for accessing mental health services.

This case report is an attempt to demonstrate how narrative case formulation can be used to understand the psychosocial and cultural factors that contribute to the dominant discourse of a woman with ABI. This framework formed the basis for developing intervention strategies for finding alternate discourses and discovering unique outcomes for her. This allowed for microgains in therapy such as building a strong therapeutic alliance, providing space for vulnerability and promoting independence and assertion within the constraints of ABI. Her acceptance of her newer identity with hope for the future enabled her to make some meaning of her current predicament. Further work on the lines of narrative therapy will involve strengthening resilience and building the strengths of clients. Co-constructing a meaning for the accident and its aftermath, while grieving over the loss of the healthy self by using a special form of narrative therapy called "Narrative Exposure Therapy" developed specially for traumatic events may be considered. Clinical neuropsychologists can focus on a holistic evaluation of people with ABI, focusing on the intersection of premorbid personality and ABI and making individualized psychotherapeutic treatment plans for them. A holistic intervention may also include caregiver perspectives and support for them.

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