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Molloy College

The Barbara H. Hagan School of Nursing and Health Sciences

PhD in Nursing Program

A NARRATIVE ANALYSIS OF PSYCHOLOGICAL ADJUSTMENTS OF  
PROFESSIONALS TRANSITIONING TO WORK FOLLOWING CEREBRAL VASCULAR  
ACCIDENT (CVA)

A dissertation

By

Mabel Munachiso Korie

Submitted in Partial Fulfillment  
of the Requirements for the Degree of  
Doctor of Philosophy

October 2, 2020

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**Molloy College**

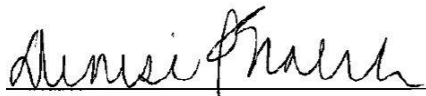
The dissertation committee of the Barbara H. Hagan School of Nursing and Health Sciences has examined the dissertation titled

**A NARRATIVE ANALYSIS OF PSYCHOLOGICAL ADJUSTMENTS OF PROFESSIONALS TRANSITIONING TO WORK FOLLOWING CEREBRAL VASCULAR ACCIDENTS**

Presented by MABEL MUNACHISO KORIE

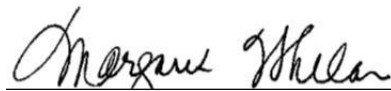
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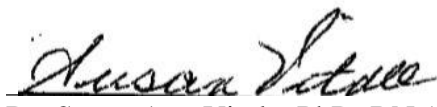
Dr. Denise Walsh, PhD, RN, FAAN (Chairperson)

Dean, School of Health Professions, Long Island University Post (LIU Post)



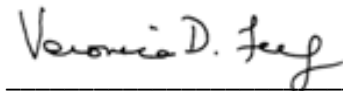
Dr. Margaret Whelan, EdD, RN (Committee Member)

Professor, The Barbara H. Hagan School of Nursing & Health Sciences



Dr. Susan Ann Vitale, PhD, RN (Committee Member)

Professor, The Barbara H. Hagan School of Nursing & Health Sciences



Dr. Veronica D. Feeg, PhD, RN (Associate Dean, PhD Program)

Professor, The Barbara H. Hagan School of Nursing & Health Sciences

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## **Abstract**

This research study was a narrative analysis of the psychological adjustment of professionals transitioning to work after a cerebral vascular accident, commonly known as a stroke. The purpose of this research was to explore the psychological adjustment of professionals who returned to work after a stroke following their subsequent rehabilitation. This has been an important subject because stroke research predominantly addresses older adults, which means that there has not been enough information on the experience of affected working-age professionals. The Roy Adaptation Model and Social Cognitive Theory were the frameworks for the study. The data collected were from audio-recorded and transcribed answers to open-ended interview questions completed on a sample of 10 post-cerebrovascular accident (CVA) professionals. The data analysis involved the steps of the paradigmatic narrative analysis approach, with results compared to the previous literature review and discussed in light of the frameworks established for the study. The paradigmatic analysis revealed eight major thematic events experienced and shared by the majority of the sample as they told their stories about the psychological adjustments of transitioning to work after a CVA. This narrative inquiry enabled subjects to share their stories and experiences to help fill a gap in knowledge regarding the psychological adjustment of professionals after a stroke experience. The results of the study led to recommendations for leaders and suggestions for future research.

## Table of Contents

ABSTRACT .....	IV
CHAPTER 1: INTRODUCTION .....	1
BACKGROUND STATEMENT .....	2
CONCEPTUAL DEFINITIONS .....	3
<i>Stroke</i> .....	3
<i>Professional</i> .....	3
<i>Psychological Adjustment</i> .....	3
<i>Rehabilitation</i> .....	3
<i>Transitioning to Work</i> .....	3
<i>Identity</i> .....	3
SIGNIFICANCE OF THE STUDY .....	4
THEORETICAL FRAMEWORK .....	5
<i>Roy Adaptation Model</i> .....	5
<i>Social Cognitive Theory</i> .....	7
RESEARCH QUESTIONS .....	8
SUMMARY .....	9
CHAPTER 2: LITERATURE REVIEW .....	11
PROCESS OF LITERATURE SEARCH .....	11
DETERMINANTS OF PSYCHOLOGICAL ADJUSTMENT .....	12
IDENTITY RECONSTRUCTION .....	14
PROCESS OF RECOVERY AND REHABILITATION .....	16
INCIDENCE OF STROKE AMONG DIFFERENT AGE GROUPS .....	18
REHABILITATION OF VARIOUS PROFESSIONALS .....	19
PSYCHOLOGICAL SYMPTOMS .....	22
RETURNING TO WORK AFTER REHABILITATION .....	24
OBSTACLES AGAINST RETURNING TO WORK .....	27
GAPS IN THE LITERATURE .....	29
SUMMARY .....	30
CHAPTER 3: METHODS .....	32
INTRODUCTION .....	32
AIM OF THE STUDY .....	32
THE RATIONALE FOR QUALITATIVE DESIGN .....	33
NARRATIVE ANALYSIS .....	34
NARRATIVE INQUIRY VS. PHENOMENOLOGY .....	37
SAMPLING IN NARRATIVE INQUIRY .....	38
CONTEMPORARY NARRATIVE INQUIRY .....	40
BRACKETING THE RESEARCHER .....	40
INTERVIEW PROTOCOL .....	41
TARGET POPULATION .....	42
PARTICIPANT SELECTION .....	44
CLARIFICATION OF RESEARCHER BIAS .....	45
DATA COLLECTION PROCEDURE .....	46
TRUSTWORTHINESS .....	47
TRANSFERABILITY .....	49
VERIFICATION .....	49
CREDIBILITY .....	49
CONSISTENCY .....	50

DEPENDABILITY .....	51
DATA ANALYSIS PLANS .....	51
RELATIONSHIP OF FINDINGS TO ROY’S ADAPTATION MODEL.....	53
<i>Physiologic Findings:</i> .....	53
<i>Self-Concept Findings:</i> .....	54
<i>Role Function Findings:</i> .....	55
ETHICAL CONSIDERATIONS IN NARRATIVE RESEARCH.....	55
IRB AND RELATED PROCEDURES.....	57
CONCLUSION.....	58
CHAPTER 4: RESULTS .....	59
INDIVIDUAL CONSTRUCTED STORIES .....	59
PARADIGMATIC ANALYSIS RESULTS.....	70
MAJOR THEMATIC FINDINGS .....	70
SUMMARY OF FINDINGS .....	84
CHAPTER 5: DISCUSSION AND CONCLUSIONS .....	85
DISCUSSION OF FINDINGS .....	85
RECOMMENDATIONS FOR LEADERS .....	89
SUGGESTIONS FOR FUTURE RESEARCH .....	92
LIMITATIONS.....	93
CONCLUSION.....	94
REFERENCES .....	96
APPENDIX A .....	102
INTERVIEW PROTOCOL.....	102
<i>Demographic Data:</i> .....	102
INTERVIEW QUESTIONS.....	103
APPENDIX B.....	104
INFORMED CONSENT.....	104
KEY INFORMATION ABOUT THIS STUDY.....	104
APPENDIX C.....	112
STUDY ANNOUNCEMENT .....	112
<i>Volunteers Needed for Research Study</i> .....	112
APPENDIX D .....	113
TRANSCRIPTIONIST CONFIDENTIALITY FORM .....	113
APPENDIX E.....	114
IRB REVIEW .....	114

### **List of Tables**

TABLE 1: DESCRIPTION OF THE SAMPLE.....	60
TABLE 2: MAJOR EMERGENT THEMES .....	71



## **Chapter 1: Introduction**

Cerebral Vascular Accident (CVA), or commonly known as stroke, is a severe medical event that affects the brain. To refer to the Mayo Clinic's (2019) layman's definition for the sake of baseline understanding, "A stroke occurs when the blood supply to part of your brain is interrupted or reduced, depriving brain tissue of oxygen. Within minutes, brain cells begin to die" (para. 1). Some CVAs can be minor, but others can be severe. It can take time and medical interventions for the patient to recover from a CVA, and in some cases, the patient may never fully recover from all of the consequences. This condition can be especially dangerous when the patient is a professional of working age. An event of CVA will almost certainly mean that the professional will need to take time off from work to attend to health concerns and engage in the rehabilitation process. The most awkward or challenging part of this process may involve transitioning back to work after the rehabilitation process has completed.

The purpose of this research was to explore the psychological adjustment of professionals returning to work after an event of CVA and rehabilitation. Multiple holistic patient needs affected by stroke include psychological, physical, spiritual, social, comfort, and safety issues. Psychological adjustment was selected because it pertained to the patient's overall lived experience of CVA and rehabilitation. One deals with all human needs psychologically. The present chapter of this project provides background information about this subject, including the significance, the theoretical framework, and the research questions of the study. The objective of this project was to identify the problems, challenges, and experiences of professionals who are trying to transition back to work after a CVA. By better understanding the nature of that experience, it would become possible for nurses to develop effective interventions that could facilitate a smooth transition by meeting the patients' holistic needs.

## **Background Statement**

A CVA is a medical event that is primarily associated with older people. However, this is misleading, because while CVAs do, in fact, statistically affect older people at higher rates, a substantial number of younger people also experience a CVA. The Internet Stroke Center (2019) has indicated that nearly 25% of all events of stroke affect people who are under 65 years of age. This statement means that a significant number of CVAs involve people who are of working age. The fact that over 75% of CVAs affect older people draws attention away from the situation faced by the working-age population. In particular, when people over age 65 experience a CVA, a majority of this older population may have retired and are not transitioning back to a career. The question of transitioning back to work after a CVA only emerges when attention focuses on the 1 in 4 stroke events that affect younger people.

Transitioning back to work after a CVA is a process that includes specific stressors and obstacles that the patient must overcome (Phillips, Gaffney, Phillips, & Radford, 2019). However, since most CVAs affect people who are already retired, transitioning back to work after a CVA is not a specific topic that has generated substantial discussion. Working-age people recovering from a CVA feel even more alienated than they already are, since not only do they have to transition back to work, but also healthcare professionals may not have had the experience of caring for this younger CVA population. This situation makes it essential to conduct research that addresses this sub-group's experiences within the population affected by CVA.

## Conceptual Definitions

Conceptual definitions are as follows:

***Stroke:*** A cerebral vascular accident, which is a cardiovascular medical event in which the supply of blood and oxygen to the brain are cut off, resulting in potentially neurological severe consequences. In this research, the term *stroke* is used interchangeably with the term *cerebral vascular accident (CVA)*.

***Professional:*** A person of working age (i.e., between 18 and 65) who is on a career track that requires specialized skills and qualifications (Macmillan Dictionary, 2019). Examples include nurses, social workers, teachers, lawyers, and bankers.

***Psychological Adjustment:*** The patient's process of assimilating the experience of CVA and integrating this experience into identity as he or she moves forward with life.

***Rehabilitation:*** The holistic healthcare process through which the patient recovers from a CVA and is once again able to carry on with life to the greatest extent possible as he or she was before experiencing a CVA.

***Transitioning to Work:*** The post-rehabilitation process of returning to work and psychologically adjusting to the new situation after a CVA.

***Identity:*** In this situation, the patient understands himself or herself as a person, as well as the integrity of his or her personality structure.

These terms cover all of the key terminology used in the title of the dissertation as well as other keywords that are closely related to those original terms.

## **Significance of the Study**

The population of this study has been, to a large extent, neglected since only 1 in 4 events of stroke affect people younger than 65 years of age (Internet Stroke Center, 2019). In most discussions of stroke, the focus is on older adults, many of whom may be retired. The implication is that the specific needs of younger people who experience a CVA, such as a problem of transitioning back to work, has not been adequately addressed by healthcare professionals. This condition is unacceptable, given that one of the vital ethical imperatives of the nursing profession is to deliver equitable care to all patients, irrespective of demographic categories (American Nurses Association, 2015). In the present case, there is a risk that younger people who experience CVAs would receive less beneficial care than older people because the focus of care has been on older individuals. This study focused on this population.

It is worth noting that if professionals are unable to transition back to work effectively after a CVA experience, this would present a significant economic problem in terms of unemployment and employee turnover. It is never a good thing when a person wants to work but cannot due to inadequate healthcare support. In the case of professionals transitioning to work after a CVA, the problem is that nurses might insufficiently deliver adequate care and the economy as a whole may be negatively affected if the professionals are willing but unable to transition back to work. The study was about the experiences of professionals transitioning to work after a CVA, with the findings leading to the development of effective nursing and other therapeutic interventions.

## **Theoretical Framework**

*Roy Adaptation Model.* One of the main theoretical frameworks of this study was the Roy Adaptation Model (Roy & Andrews, 1999). According to this framework, health is defined as a proper adaptation between the patient and the holistic environment, and adaptation proceeds through four major modes. These modes are the physiologic, the self-concept, the role function, and the interdependence modes. Within this framework, the purpose of nursing would be to facilitate good adaptation on the part of the patient across all four of these modes. This framework is advantageous when it comes to analyzing the situation of a professional transitioning to work after an experience of CVA.

At the physiologic level, the main problem with transitioning to work after a CVA would consist of simple neurological function and rehabilitation. CVAs can vary in the seriousness of their consequences, but the most severe CVAs could potentially cause permanent damage to the brain. Even less severe CVAs would likely require varying levels of rehabilitation to restore the patient's neurological function. The impaired neurological function would be a barrier against transitioning back to work since this could imply that the professional would not be empirically capable of fulfilling all of the tasks required at work. In this context, strictly physical rehabilitation would be required in order to facilitate the patient's adaptation through the physiologic mode. Aside from any further considerations, the foundation of a successful transition back to work would consist of the professional recovering the neurological capacities needed for work.

The self-concept mode has to do with the professional's identity as a CVA victim. The popular perception would seem to be that only older adults experience CVAs. When a professional is diagnosed with a CVA, this almost certainly catches that person off-guard

because there was probably a belief that he or she was too young to have suffered a CVA. This situation could cause negative feelings related to poor health and the aging process, and it could have significant effects on how the professional sees himself or herself. If the experience of a CVA is not successfully integrated into the patient's identity as he or she moves forward, then it is easy to imagine how this could potentially trigger psychological problems such as anxiety or depression. The self-concept mode is independent of the physiologic mode. Even with the patient who has thoroughly rehabilitated at the neurological level, there is still the possibility that the patient may struggle with the experience at the psychological level. This condition is another mode of adaptation that the nurse must address.

The next mode in the Roy Adaptation Model is the role function mode. This adaptation is where relational concerns may emerge regarding how colleagues may see the professional transitioning to work after a CVA. This condition may be poorly understood in the layman's mind, but it is generally known that CVAs affect the brain. So, would colleagues worry about the competence of the professional transitioning to work after a CVA? For example, would colleagues wonder if the professional's brain has been damaged and whether the professional can fulfill previous roles at work? These are considerations independent from both the physiologic function of the professional and how the professional sees oneself. If there is a negative perception from colleagues, the professional may internalize this perception and begin to see oneself in a negative way, which would affect the self-concept mode. This situation is yet another issue that must be dealt with in order to achieve successful adaptation.

Finally, there is the interdependence mode. This condition primarily has to do with whether the patient has nurturing relationships that he or she can count on when proceeding through the rehabilitation process. Interdependence is one area in which younger professionals

may differ from older adults who are affected by stroke since professionals may be more likely to be living with family members. The event of a CVA and the subsequent rehabilitation process can take an emotional toll on friends and family members, such that the professional may begin to feel weakened interdependence while working toward full rehabilitation. In this context, the nurse should do everything possible in order to provide social and emotional support for the patient and family members and to relieve the general emotional stress of the situation.

The Roy Adaptation Model is a sophisticated framework that is highly applicable to the situation of a professional transitioning to work after a CVA. In particular, this framework makes it clear that all four adaptive modes of the framework would be addressed in order to achieve successful adaptation (which in this case is primarily operationalized as transitioning to work). The interpretive element of the literature review in the next chapter is primarily informed by the Roy Adaptation Model, with various findings from the literature review correlated with the different adaptive modes of this theoretical framework.

***Social Cognitive Theory.*** Social cognitive theory, developed by Bandura (1997), also guided this study. Some of the critical constructs of Bandura's theory are cognitive factors, environmental factors, and behavior. The holistic factors influence behavior, while behavior likewise affects the holistic factor. According to Bandura, by developing self-efficacy, a person can respond to and engage with cognitive and environmental factors more effectively by changing behaviors. These changes in behavior can then, in turn, change both cognitive and environmental factors, thereby improving the holistic well-being of the person. Therefore, the social cognitive theory would suggest that there is a close relationship between self-efficacy and wellness, such that cultivating self-efficacy is a crucial pathway to the achievement of wellness. In this context, self-efficacy would refer to the extent to which the person feels empowered to

take action on one's behalf and well-being within the context of the environment in which one finds oneself.

This theory has precise application for the situation of a professional transitioning to work after a CVA. In particular, one of the primary purposes of rehabilitation is to help the patient achieve an adequate level of self-efficacy relative to cognitive factors. This self-efficacy can include both cognitive factors in the sense of neurological dysfunction as well as the mental health issues experienced by the professional in the aftermath of a CVA. It would be necessary to address the patient's self-efficacy deficits at the levels of both the physiologic and the self-concept modes. Likewise, environmental factors would pertain to the other two modes (role function and interdependence). These may not be things that the patient would be able to directly influence, suggesting a need for nursing interventions that target the environmental factors. For example, an intervention could be designed to develop an awareness of stroke recovery within the workplace or provide emotional support for family members and/or caregivers of the professional affected by CVAs. Addressing cognitive factors may help the patient develop the self-efficacy needed to deal with environmental factors, but nursing interventions could also be targeted directly at environmental factors.

### **Research Questions**

The main research question asked was: What are the experiences of professionals transitioning to work after recovering from a CVA? Again, this question is not asked often enough, due to the simple fact that most people who suffer from CVAs are elderly. Few questions arise about the situation of a professional returning to work after a CVA, given that older adults are generally retired. Sought out were the details about the experiences of a sub-



group of the population affected by CVAs to elucidate the unique aspects of that subpopulation's experience, particularly related to transitioning to work. In general, it is always valuable to produce knowledge about a group of people whose health experiences are not adequately understood, and that is what this study seeks to do regarding the selected sub-population.

The secondary research question was: What are the main barriers and facilitators concerning a professional transitioning to work after an experience of CVA? This knowledge enables the nurse to develop interventions to help overcome the barriers and enhance the facilitators regarding this sub-population. Ultimately, the goal of nursing is to ensure that professionals who experience a CVA are, in fact, able to succeed. Part of this success means that nurses need knowledge about not only the sub-population's overall experiences but also the specific factors that positively or negatively affect the transitioning process. Interventions in the future would be designed, based on a solid understanding of these factors.

## **Summary**

In summary, this chapter consisted of an introduction to the existing research. The chapter included the introduction to the topic, the background of the problem, the purpose, conceptual definitions, study significance, theoretical framework, and research questions. A critical point that can be drawn is that the sub-population of patients who are professionals transitioning to work after a CVA event has almost certainly been inadequately studied since most stroke patients are elderly. The primary significance of this study addresses the needs and experiences of this specific group of people, while helping to fill a gap in knowledge in the body of scholarly and health research.

Chapter two focuses on current research of the salient aspects of psychological adjustment of professionals transitioning to work after an experience of a CVA. The specific sections of the review are delineated below. The interpretation of the literature review was guided by the theoretical frameworks introduced above and was interpreted through the lenses of the Roy Adaptation Model and social cognitive theory.

## **Chapter 2: Literature Review**

### **Process of Literature Search**

Two primary academic databases were used to identify appropriate and relevant literature for this study: Google Scholar and EBSCOhost's CINAHL. Google Scholar is suitable for a basic initial search on a given research topic. CINAHL, on the other hand, is a precise, healthcare-focused academic database, such that almost any academic article related to nursing that is available to the public can probably be found on CINAHL. Numerous articles were selected through this search process, and then the articles were manually evaluated for salience. For example, "stroke rehabilitation" was used as a search term, but only some of the articles produced through this search were related to the topic of this study. After articles had been evaluated for salience, the reference lists were also examined and included in the review of literature.

Specific parameters were set when conducting the literature search. Only articles that were published over the past 5 years were included in the review. This is important for scientific research because the findings of older articles could quickly have become outdated by newer research on the subject. Exceptions were only made for classic or more theoretical articles that were not at risk of becoming outdated. Also, parameters were set so that only English-language articles available in full-text format were retrieved. For some articles identified through the perusal of the reference lists of the initial retrieved articles, the abstract-only format was accepted, but only if the abstracts provided enough clear and thorough information that the findings could be credibly included in the present literature review. Some sources were included based on the researcher's previous awareness of those sources and their relevance to the topic.

## **Determinants of Psychological Adjustment**

Given that the topic of this study involves psychological adjustments, one of the themes explored in the literature review consisted of the construct of psychological adjustment and its determinants. According to Harrison, Ryan, Gardiner, and Jones (2017), in the aftermath of a CVA, some of the most critical factors that contribute to psychological adjustment are "downward social comparison, social support, peer support, communication, and information provision" (p. 119). The downward social comparison involves bearing in mind that other people have struggles that are much more serious than one's struggles. Information provision refers to the patient-given information about CVA and rehabilitation, which can help the patient regain a sense of autonomy and control. The other factors listed above are relatively self-explanatory. The critical point here is that the presence of these factors can improve psychological adjustment in the aftermath of a CVA, whereas the absence of these factors would make the psychological adjustment more difficult.

These factors can be broadly correlated to the adaptive modes of the Roy Adaptation Model (Roy & Andrews, 1999). For example, the downward social comparison would relate to the self-concept mode: By remaining aware of the profound struggles of others and one's own relatively good fortune, the individual who experiences a CVA can maintain a relatively stable self-concept and remain optimistic about the prospects of successful rehabilitation. Social support would relate to the interdependence mode; the primary point here is that the patient needs to avoid feeling isolated and alienated during the rehabilitation process. It is worth noting that the importance of information provision is congruent with social cognitive theory (Bandura, 1997). By receiving useful information, the patient can develop a sense of self-efficacy and

address the cognitive factors that may prevent psychological adjustment in the aftermath of a CVA.

According to Mahmoud, Ahmed, and Elaziz (2016), the primary determinant of psychological adjustment in the aftermath of a CVA consists of physical independence. In other words, if the patient can continue living, at the physical level, in the same way as before the CVA, there is a greater likelihood of adjusting after the event in an effective way psychologically. On the other hand, if there are ongoing physical consequences (for example, if the patient needs assistance with mobility or a caregiver with the activities of daily living), then the patient has a more difficult time psychologically adjusting after the CVA. This would suggest that physical rehabilitation should be a priority when working with patients after the CVA.

This is logical in terms of the Roy Adaptation Model, given that dysfunction at the physiologic level could have profound consequences at the level of self-concept. For example, if the patient's mobility is affected as a result of CVA, the patient may consider oneself a "cripple," which would affect self-concept much more significantly than if the patient suffered from a CVA but did not experience any enduring physiologic consequences. This points toward the interconnectedness of the different modes of adaptation. Moreover, this is also connected to the social cognitive theory's construct of self-efficacy. The inability to move about freely on one's own would clearly constitute a significant deficit in self-efficacy, and the findings reported above strongly suggest that a sudden drop in self-efficacy can have substantial adverse effects on the patient's self-concept. The problem is essentially physiologic. However, psychological adjustment can be facilitated by addressing the physical roots of the problem. If the physical roots cannot be addressed (for example, if physical damage is permanent), further efforts would be required to target the patient's self-concept mode of adaptation directly.

In another study, Buono, Corallo, and Bramanti (2017) found that different coping strategies produced different effects on the quality of life. It can be assumed that psychological adjustment mediated between coping strategies and the quality of life. The authors also found that "patients who prefer accommodative or active coping strategies had a better quality of life after stroke when compared to patients who adopted assimilative coping" (p. 16). Assimilative coping refers to essentially acting as if there is no problem and trying to get things back to the way they were before, whereas accommodative or active coping refers to accepting that there is a problem and then changing oneself with the new reality of the problem. The findings of the study suggested that individuals who experience CVAs generally fared better when they pursued the latter course of action.

This latter type of coping is related to the self-concept mode of adaptation, and it suggests that it is essential for professionals transitioning to work after a CVA to accept that they have indeed experienced a CVA and that this may change some aspects of their lives in ways that cannot be directly or immediately overcome. For example, the professional may need more rest after the CVA than before the CVA. If the professional can accept a self-concept to include this need for rest, he or she is likely to psychologically adjust more effectively, instead of ignoring this fundamental reality, trying to pull through the problem as if nothing happened. Effective coping strategies could thus play an important role in psychological adjustment, and this is because different forms of coping have different effects on self-concept adaptation.

### **Identity Reconstruction**

Identity reconstruction is not a single theory, but it is a construct that emerges in various contexts in the literature. For example, Glinborg and Krogh (2015) discussed the process of

identity reconstruction in the aftermath of brain injury. One of the key points that emerged was acceptance, which was described by one of the subjects in the following way: "It is definitely about an acceptance of what is going to happen with my life and a follow-up on that. Will I be part of vocational rehabilitation, or what will happen to me, and what will happen to us?" (para. 27). As with after brain injury, identity needs to be reconstructed after CVAs, especially if the event resulted in some form of brain injury. First of all, the patient would need to accept that something has happened and that this event could potentially have long-term consequences for life. Individuals who suffer from CVAs need to accept that they may not be quite the same as before the events, which is why identity reconstruction becomes an important construct.

Theories of grief may be relevant here. The individual who experiences a CVA may experience grief over one's former self and the inability to return entirely to that self. According to Kubler-Ross (2014), the five stages of grief are denial, anger, bargaining, depression, and acceptance. In this context, the acceptance described by the subject in Glinborg and Krogh's (2015) study could be understood as an advanced stage of the grieving process, through which the subject has come to understand that he or she must move forward with the new reality of having experienced a brain injury. However, before this stage can be reached, identity reconstruction would likely get halted by the other stages of grief. This situation may be especially the case with individuals who experience CVAs, where the lingering problems during rehabilitation may sometimes be more minor and thus easier to deny.

A study on identity reconstruction during and after severe illness was conducted by Whitehead (2006), and while the study is somewhat old, it is still deserving of consideration here due to the sheer salience of its insight to the topic at hand. According to this study, subjects tended to follow a pendulum-like pattern when reconstructing their identities in the medium

term, swinging between different feelings about illness and its relationship to identity, including positive and negative feelings. The study found, though, that in the long run, most identities seemed to settle as the patients adopted coping practices that worked for them. This situation would seem to suggest that to some extent, identity reconstruction may be a matter of time. However, it is worth noting that identity reconstruction in the study was also strongly influenced by the experiences of the patients, such that a positive or negative experience could tip the pendulum toward one end or the other of the patients' spectrum of feelings. This emphasizes the importance of cultivating self-efficacy and coping mechanisms.

It can also be noted here that the concept of *identity reconstruction* is almost identical to the concept of *self-concept adaptation*. An essential point about rehabilitation from a CVA is that the patient may not necessarily be the same as before. At the very least, this will be true that the patient must be aware that he or she is now at risk of another CVA and must thus take care and change one's lifestyle accordingly. There may be actual long-term consequences at the physiologic level, but even if there are no such consequences, the fact is that a patient must accept the CVA event, which can affect both the views of oneself and how others view the patient. An essential part of the rehabilitation process thus consists of helping the patient cultivate coping strategies to integrate the experience of the CVA into a reconstructed identity. A large part of successful rehabilitation will depend on whether the patient can achieve this outcome.

### **Process of Recovery and Rehabilitation**

The literature on the subject of the CVA rehabilitation process makes it clear that a great deal depends on how the patients previously considered themselves before the CVA event.



According to Garwood and Miller (2019), rehabilitation was most difficult when the patient had a robust pre-stroke identity disrupted by the event of a CVA. In this case, much of the rehabilitation process needed to focus on the patient's self-concept and psychological needs. Moreover, it was found that the rehabilitation process was generally impeded when healthcare professionals failed to treat the patients as individual persons. This is logical, given that a critical aspect of rehabilitation would have to consist of identity reconstruction. This means that as far as healthcare professionals treated the individual who experiences a CVA as a "number" rather than an individual, they were causing further harm to the patient's self-concept and psychological adjustment.

Herbert, Lindsay, and McIntyre (2016) have also made it clear that there is a robust physiologic component to CVA rehabilitation. The researchers have produced a best practices guideline that focuses on the strictly medical aspect of rehabilitation from a CVA, including the nature of the acute treatment, and subsequent possibilities for inpatient treatment. The specific details in this regard would fall beyond the scope of the existing project. The main point is that the first step in the stroke rehabilitation process from the nursing standpoint consists of stabilizing the patient at the physiologic level within the acute care setting (Woon, 2016). Once the patient is stable, considerations can be made regarding further rehabilitation options, which will depend on the severity of the specific stroke and the particular needs of the patient. According to Herbert et al. (2016), physical recovery from a CVA is typically achieved within three months of the event, although sometimes the patient may make improvements over a time frame much longer than that.

The initial stroke rehabilitation process has two main dimensions — the first consists of ensuring physiologic stability and working toward physiologic recovery. The second focuses on

the patient's psychological and emotional factors. This is reflective of the fact that a CVA, like many illnesses, is not a merely physiologic phenomenon. Instead, it has holistic effects on the patient, which means that rehabilitation must also proceed holistically. Physiologic stability and recovery are essential, but it is also essential to bear in mind that the patient's self-concept may be shaken and that the patient may be in the process of grieving for a previous, pre-stroke self. Nurses must take both of these dimensions into account.

In this context, a final dimension of the CVA rehabilitation process for professionals would be to help them transition successfully back to the workplace. There is research that specifically addresses this subject, such as a study conducted by Ntsiea, Van Aswegen, Lord, and Olorunju (2015), and this research is discussed further below in the literature review. For present purposes, though, it is worth tracking the phases of the CVA rehabilitation process with the main adaptive modes of the Roy Adaptation Model. There is the physiologic mode, which involves stabilizing the patient within the acute care context and then working toward restoring full neurological function to the patient. The self-concept mode follows, which is the phase of rehabilitation in which the patient must come to grips with this new situation and work toward effective identity reconstruction. Finally, there is the role function mode, where CVA care for professionals needs to involve strategies for the patient to successfully return to the workplace.

### **Incidence of Stroke Among Different Age Groups**

The numbers regarding stroke and age groups have been discussed to some extent above, but it bears repeating within the context of this literature review. The fact is that only slightly less than 1 in 4 stroke patients is under 65 years of age, which means that transitioning to work after stroke may not be adequately addressed by the nursing literature since this is a topic that would

affect a relatively small number of people (Internet Stroke Center, 2019). Moreover, the numbers may be even smaller than that when considering people who are under the age of 60.

For example, it is worth considering the following data provided by the American Heart Association (2015) in research on the subject. Strokes as a percentage of the population affect 2.05% of the population between ages 40 and 59 and 5.65% of the population between ages 60 and 79. The numbers for men and women are averaged here, on the assumption that there is roughly the same number of men as women in any given age cohort. The main point is that age is strongly correlated with stroke prevalence, to the point that the number of people between ages 60-65 may be inflating the numbers on professionals who suffer from a stroke.

This correlation is not to say, of course, that the numbers are by any means negligible. About 1 in 50 people between the ages of 40 and 59 suffer from stroke, as do about 1 in 200 people between the ages of 20-39 (American Heart Association, 2015). These numbers may seem statistically small, but that still amounts to a considerable number people in need; and moreover, given the statistically small numbers, the needs of this sub-population may be relatively neglected. In short, the limited magnitude of the problem makes it all the more important to ensure that the people with the problem are not overlooked.

### **Rehabilitation of Various Professionals**

Limited research has been reported on the experiences of professionals who transitioned to work after an experience of stroke. This may be attributed to the relatively small number of professionals affected by stroke, making it necessary to consider the sub-population as an aggregate. Samples would likely become too small and/or too inaccessible for the empirical study if the sub-population were divided further by specific professions. In general, though, the

assumption could be that people whose professions involve serving others would all have relatively similar rehabilitation experiences. Such professions would include teaching, social work, medicine, counseling, and nursing. Rehabilitation for these professionals could probably be considered in an aggregate manner since these professions involve close relations with other people.

In this context, it is worth turning to a scholarly article by Zeitz (1999), which is older but probably deserves to be a classic. It is an excellent example of a case study on the nurse's experience of becoming a patient. According to Zeitz (1999), when a nurse needs medical care, the nurse experiences a "voyage of self-discovery" (p. 64). This feeling is because the nurse is generally on the other side of the equation, delivering care to those in need rather than on the receiving end of care. This feeling can have dramatic effects on the nurse's self-concept, and the stroke rehabilitation process is undoubtedly an excellent example of when the nurse would encounter such feelings. For example, the nurse would have been used to being in control, whereas she would now clearly not be in control. Likewise, the nurse would have been used to attending to the needs of others, whereas she would now be the one in need. This situation could go well, or it could go very badly, depending on how easily the nurse can adjust her self-concept. An article on this subject that is not scholarly but is nonetheless written by a nurse in the first-person perspective, deserves to be cited here as well on the basis of salience:

"Turns out that many [nurses] do not handle it well. After talking to a few co-workers, one can realize that nurses could be some of the worst patients. That can be a dysfunctional coping mechanism; people do not know to be calm and in control. So the rare times that people do not feel those ways, they project their

anxiety through behaviors that are just as unfamiliar to them" (Memon, 2013, para. 6).

In terms of the theoretical framework of this study, the implication that can be drawn is that nurses tend to experience severe self-concept conflicts when the roles are reversed and they find themselves in need of care and rehabilitation.

Something similar could be said of other professionals who are in the business of serving others and/or being in control of the situation. These professionals would have a healthy self-concept related either to the service of others or to their autonomy and self-efficacy. A stroke would put such professionals in a position where their self-efficacy becomes limited and they need the service of others rather than vice versa. It would be especially important for professionals in service-related work to focus on the self-concept dimension of CVA rehabilitation. The role conflict may be most severe for nurses (for obvious reasons), but it could easily be extrapolated to professionals in other service-related fields. Likewise, the conflict could also be extended to other professions, such as business or administration, where the professional is used to feeling in control of the situation since CVA rehabilitation requires acceptance rather than control.

Professionals have been selected for present purposes because of the unique skills and abilities required of them, which means that an experience of stroke could especially be expected to undermine professionals. In principle, the findings of this study may be applicable to non-professionals as well, insofar as lower-skilled workers could be expected to have an easier time with adjustment to the workplace than higher-skilled workers. There was not any research to back up that claim; someone who may be dependent upon manual labor as a profession would have a very difficult time adjusting to deficits, versus an educated individual with a high-level

job who may be able to pivot to another profession. The focus on this study, though, consisted of professionals.

### **Psychological Symptoms**

One of the most common psychological symptoms in the aftermath of stroke is depression. As the Stroke Recovery Association NSW (2019) has indicated, depression is a common consequence of stroke, as “they mourn the loss of their previous self...have many fears, uncertainties, and altered feelings about themselves, as well as experience losses in social activity, ponder questions about prospects, financial security, and returning to work” (para. 6). Of course, this fits perfectly with a key theme that has been developed thus far in the present literature review, namely, that one of the main dimensions of stroke rehabilitation has to do with the patient's self-concept. Aside from any strictly neurological consequences of a CVA, the critical problem is that the patient may feel psychologically confused about who he or she is or what to do next. This confusion and uncertainty can lead to depression.

Another psychological symptom of stroke is the expression of emotions (Stroke Recovery Association NSW, 2019). For example, the patient may laugh or cry without being able to control either feeling or may appear to express apathy or generally diminished effect. This behavior can be confusing for family members or caregivers, who may think that the patient is reacting to the event of a CVA. These are common symptoms that occur because of the effects of the CVAs at the neurological level, meaning that the laughing, crying, or apparent apathy do not necessarily suggest anything about how the individuals feel about their CVA experiences. In most cases, these symptoms pass with time, although they may consolidate into actual personality changes in some extreme cases. One way or another, it is clear that family members

should be aware of a neurological symptom of a CVA versus an actual psychological expression on the part of the patient.

The patient may also have diminished cognitive powers of memory and executive function in the aftermath of a CVA (Nair, Cogger, Worthington, & Lincoln, 2016). The patient is often aware of this physiologic fact, which can, in turn, cause self-concept issues for the patient. Moreover, depending on the level of awareness they have of a CVA and its consequences, family members and caregivers may be likely to misinterpret the causal pathways for the various symptoms of a stroke. For example, when the patient laughs uncontrollably, there may be a belief it is on purpose, as one forgets things, or there may be an assumption the person is not paying enough attention. Conversely, if the patient is depressed, then family members may assume that the depression may pass on its own, whereas in some cases, the depression requires independent treatment (Stroke Recovery Association NSW, 2019). Misunderstandings such as these could hurt the patient's interdependence mode of adaptation, which would cause overall harm to the rehabilitation process.

In short, the CVA's complex psychological symptoms suggest the need for holistic rehabilitation for the patient. The patient needs rehabilitation at the neurological level, and the rehabilitation of the mental or self-concept. Moreover, family members, caregivers, and in general, people who work or live with the stroke patient probably need to be given educational interventions regarding the nature of a CVA and its psychological symptoms. This is because given that a CVA affects the brain, the symptoms are multifaceted (Padberg et al., 2016). If people do not have adequate awareness of the symptoms, then there is a strong likelihood that they would interpret the symptoms in false ways. This misinterpretation would, of course, impede the success of the rehabilitation process as a whole.

## **Returning to Work After Rehabilitation**

According to a systematic review conducted by Wei, Liu, and Fong (2016), typical CVA rehabilitation is not necessarily associated with higher rates of return to work for individuals who experience CVAs. Instead, the researchers found that specialized vocational rehabilitation may be necessary to help individuals who experience CVAs return to work genuinely. However, the researchers also found that traditional rehabilitation could indirectly have a positive effect on the return to work as long as the traditional rehabilitation strives to improve cognitive function and fatigue outcomes, which could, in turn, enhance the probability that the individual who experiences a CVA will return to work. On balance, however, the researchers found that there may be more specific obstacles confronted by professionals transitioning to work after a CVA. This finding is an important one because the study was a systematic review, which generally represents the best evidence to date on a given research topic.

A randomized controlled trial conducted by Nitsea et al. (2015) found that a specialized program geared toward helping CVA survivors return to the workplace was effective at helping them successfully transition to the workplace. The study found that 60% of subjects in the intervention group successfully returned to work, as opposed to only 20% of subjects in the control group. This finding is a highly significant one, and it strongly suggests that professionals transitioning to work after a CVA face unique challenges that other stroke patients do not, and that these challenges need to be addressed in ways that specifically address the unique needs. This means that it would not necessarily be enough to give professionals who have experienced a CVA the same rehabilitation program that other patients receive. Instead, professionals must be



treated as a specific category of their own to whom specifically tailored interventions are delivered.

This treatment is logical in terms of the Roy Adaptation Model (Roy & Andrews, 1999). Based on the literature review, traditional CVA rehabilitation programs primarily focus on the physiologic and self-concept adaptive modes. However, professionals also need to develop adaptation specifically across the role function mode. This is not as significant of an issue for older adults who suffer from a CVA because older adults are often retired, and moreover, because there is a general cultural expectation that older adults are more likely to experience a medical event such as a CVA eventually. In particular, it would be necessary for professionals to develop role function adaptation, since a professional role is the epitome of role function, and the whole problem with transitioning back to work would consist of whether or not the stroke survivor can slide back into the previous professional role.

Another systematic review was conducted by Edwards, Kapoor, and Linkewich (2018), and the main finding was that there had not been enough research conducted on the specific factors that contribute to a higher success rate concerning professionals transitioning back to work after a CVA. However, the researchers did indicate that it was essential to consider how long it has been since the event of a stroke and the individualized needs of the specific stroke patient in question. This result is related to the fact that many symptoms of a CVA tend to resolve themselves over a few months, along with the fact that different strokes can produce consequences with differing levels of severity, such that it would be challenging to propose a one-size-fits-all solution when it comes to workplace reintegration for stroke survivors. The most important thing would be for the nurse to evaluate the individual patient across all modes of adaptation to determine what specific support any given patient may need.

In studying the subject of a return to work after a stroke, Kemp et al. (2017) have indicated that at least some specific factors may predict a triumphant return. The main finding of this study, contradicting some of the discussion above, was that global neurological function was, in fact, the critical predictor of return to work after a CVA. In other words, the fewer and milder the lingering symptoms experienced by the patient in the aftermath of a stroke, the more likely the patient was to return to work successfully. This matches up with common sense and intuition. If a patient does not need to significantly change the understanding of oneself and the world as a result of the CVA experience, it would likely be more comfortable to move on from the experience and return to the flow of what life was before. However, this finding almost seems tautological, in the sense that if there are no long-term consequences, then it would seem evident that a return to work would be more straightforward.

The question that is not answered by that study is what happens when the event of a CVA does produce long-term consequences with which the stroke survivor must deal. Caddick, Cullen, Clarke, and Fossey (2018), for example, investigated the effects of limb loss on aging veterans, and it was found that the mental health implications were powerful. This may be more akin to how many stroke survivors consider their own experiences of a CVA, as the CVA produces long-term alterations in cognitive function. If there are no such long-term impairments, then it would, of course, be more comfortable for the stroke survivor to return to work, since in that case, it would primarily just be a matter of time until the symptoms of a CVA resolve themselves. For stroke survivors who do in fact experience longer-term consequences, though, it is relatively clear that targeted interventions would be required to help the patient both come to terms with self-concept and then to reintegrate into role functions in the workplace.

## **Obstacles Against Returning to Work**

The main obstacles to returning to work after a stroke line up mainly with the main adaptive modes of the Roy Adaptation Model. For example, Fini, Holland, Keating, Simek, and Bernhardt (2017) found that in the aftermath of a stroke, many patients are much less physically active, often for an extended period after the CVA, than they were before the stroke. This reduction in activity would imply an empirical deficit at the physiologic level. Insofar as a higher level of activity was required for the fulfillment of job duties before the CVA, this would mean that the lower level of activity would be a real obstacle against the CVA survivor returning to work. The same could be said about other aspects of the physiologic function as well, such as memory. The fact is that the event of CVA can harm the patient's physiologic capabilities, as those capabilities were necessary for work, it would be impossible for the patient to return to work until those capabilities have been rehabilitated successfully.

McIntyre, Socyznska, and Woldeyohannes (2015) found that depression is associated with cognitive dysfunction, which in turn is associated with diminished workplace performance. This relationship is problematic when one realizes that CVAs can produce both cognitive dysfunctions through the physiologic mode and depression through the self-concept mode. This association means that the stroke patient needs to be rehabilitated not only in terms of neurological function but also in terms of mental health before successfully transitioning to the workplace. Returning to the workplace could itself alleviate depression, but nurses must also bear in mind that the depression produced by CVAs may not necessarily resolve itself and may produce a long-term obstacle to a successful transition to work. In short, depressed people are less likely to work efficiently, and if the stroke survivor is depressed, then this is an independent problem that must be treated.

Finally, at the level of role function, it is worth considering that the CVA survivor may be seen differently by other people, based on what people at work may or may not know about the effects of a CVA. For example, colleagues may think of stroke survivors as disabled and thus be unsure if they can be trusted to fulfill previous professional duties. This may especially become a problem in roles where key cognitive capabilities such as memory are essential. It has already been discussed above that people around the stroke patient may have a confusing time interpreting the meanings of the various symptoms of a stroke (Stroke Recovery Association NSW, 2019). Likewise, colleagues at work may not be sure what the CVA survivor may or may not still be able to do at work. In this context, it would be crucial for nurses to rehabilitate the individual who experiences a CVA as effectively as possible through holistic modes and to provide educational materials that can be shared at work to whatever extent possible. Educational materials would provide the stroke patient's colleagues with information about the nature of CVAs, which would help them more effectively empathize with the patient and make reasonable accommodations if required (Morris, 2011).

In general, the obstacles against the professional transitioning to work after stroke are holistic, in that they affect multiple dimensions of the person and they must be addressed holistically. There are physiologic obstacles, self-concept obstacles, and role function obstacles. Physiologic and self-concept obstacles pertain to the CVA survivor's empirical physical and mental capabilities, whereas role function obstacles pertain to how others see the stroke survivor. These obstacles can and should be handled simultaneously, but for rehabilitation, the obstacles should probably be addressed through the sequence of physiologic, self-concept, and role function. It is necessary for the CVA survivor to have the physical capability of returning to work, and then it is necessary to think of oneself as someone who would be able to return to

work. Finally, it is also necessary to persuade colleagues that the CVA survivor is, in fact, ready to fulfill professional duties again.

### **Gaps in the Literature**

Based on the above literature review, one gap in the literature has to do with the fundamental experience of professionals transitioning to work after an experience of a CVA. The epidemiological numbers show why this is the case: Statistically speaking, the number of professionals who find themselves in this situation is relatively small (American Heart Association, 2015). This number is not negligible by any means, but given that CVAs primarily affects elderly adults, the specific needs of professionals returning to work after a CVA has not been adequately explored by the research (Walker et al., 2017). Of course, much of the rehabilitation of professionals who have suffered from a CVA will be the same as the rehabilitation of anyone who has suffered from a stroke. These needs include, but are not limited to, physiologic stabilization and identity reconstruction. However, the self-concept needs of professionals may be much more severe than the self-concept needs of older adults, since while it is commonly understood that the risk of a CVA is high as one grows older, younger professionals who experience a stroke may not understand how to process their own experience effectively.

Moreover, there are specific needs experienced by professionals transitioning to work after a CVA in terms of the role function mode (Roy & Andrews, 1999). This need is precisely an aspect of rehabilitation that would not be relevant for older adults who have experienced a stroke. The present literature review has largely drawn insights in this regard from circumstantial evidence regarding rehabilitation in general and return to work after brain injury because the

literature on return to work after a CVA per se is relatively limited. This limitation makes it crucial to explore the experiences and psychological adjustment of professionals transitioning to work after a CVA and to identify critical barriers against and facilitators of success in this regard. That is what this study aspires to do. The literature reviewed above suggests that specialized programs for adjustment to the workplace after a CVA, in addition to conventional physical and mental rehabilitation, can serve as a significant facilitator of psychological adjustment for professionals. This insight needs to be further developed, and the intention of this researcher is to make a contribution in this regard.

## **Summary**

The present literature review has addressed various aspects of psychological adjustment for the professional transitioning to work after an experience of a CVA. One of the main conclusions that can be reached is that stroke rehabilitation is a holistic process, encompassing the patient's physical, mental, and social dimensions. The social dimension refers to how the professional recovering from a CVA is perceived by colleagues and treated within the workplace, as well as accommodations or lack thereof that make the transition easier or more difficult. Traditional stroke rehabilitation focuses on the physical and sometimes the psychological dimensions, but with less focus on the social dimension. Many stroke patients are elderly and thus are already at risk for experiencing medical issues such as another CVA; older adults are generally retired and thus do not need to worry about transitioning back to work after illness. Although some studies have addressed the transition to work after a stroke, this was shown to be a significant gap in the literature, with one of the most rigorous studies on the

subject indicating that not enough is known about the factors that lead to a successful transition (Edwards et al., 2018).

In this context, it is clear that this study was a necessary one. There has not been enough research explicitly conducted on professionals transitioning to work after a CVA. In particular, role function adaptation would be crucial for this subpopulation, and this is not a dimension that is commonly integrated into traditional CVA rehabilitation (Edwards, Kapoor & Linkewuer, 2018). It becomes apparent, therefore, that more information is needed on this topic. It is necessary first to delve into the extensive experiences of professionals transitioning to work after a CVA and then identify specific barriers and facilitators regarding that transition. Identifying these factors constitutes a valuable contribution to the nursing literature, and that knowledge can be useful in the future to develop targeted interventions to help this subpopulation.

## **Chapter 3: Methods**

### **Introduction**

Chapter 3 includes a thorough overview of the methodology used to carry out the present research. This chapter discusses the process of narrative analysis, rationales for the selection of the various aspects of the methodology, selection of the sample for the project, intended strategies for collecting and analyzing data, and verifying the validity of the data. Building on previous chapters, the specific methodology of narrative analysis enabled the project to make a meaningful contribution to the literature on the psychological readjustment of professionals like teachers, counselors, accountants, or nurses who are trying to transition back to work.

### **Aim of the Study**

The specific aim of this study was to provide more insight into the lived experience of different professional workers who were attempting to return to work after an experience of a CVA, specifically pertaining to psychological adjustment. The study aims were to understand how this process feels from the inside when professionals experience it. An underlying premise of the project was that it is impossible to improve psychological adjustment for different workers suffering from the aftermath of stroke without understanding what they experience as told from their subjective, first-person standpoints. Therefore, this study led to insight into the experience in question by having the relevant professionals tell the researcher their stories in their own words.

The findings of this study could be used to develop rigorous experimental interventions designed to improve the psychological adjustment of professionals returning to work after an experience of a CVA. Producing such improvements, however, was beyond the scope of this



study. Instead, the purpose of this study was to shed light on the phenomenon at hand. The premise was that, without correctly understanding what different professionals do experience, it would be almost impossible to develop an intervention that effectively takes the specific needs of these people into account. That was the understanding sought by analyzing the data about these workers experiences with as much depth and clarity as possible. The insights produced by this study are foundational for designing interventions in the future.

### **The Rationale for Qualitative Design**

The qualitative research design is well-suited for delving into matters of subjectivity and meaning (Polit & Beck, 2012). Whereas quantitative design primarily asks questions about the observed effects produced by selected interventions, the qualitative design focuses more on personal impressions and sensations as felt by human beings who have lived through selected experiences. By definition, experiences are subjective, and the qualitative design is meant to enable the researcher to delve rigorously into human subjectivity. For example, if a quantitative study wanted to gain insight into the subjects' perceptions of a given issue, it would have to use a blunt instrument such as a Likert-type survey, which may or may not allow subjects to express what they think. On the other hand, the qualitative design opens up the possibility of subjects being able to respond freely, extensively, and in their own words.

Framed in this way, it was clear that qualitative design was appropriate in light of the aims of this study. Since the purpose was to delve into the lived experience of different professionals who have experienced a CVA, it was necessary to allow these people to speak for themselves in their own words. Qualitative design enables the researcher to retrieve this kind of data. The quantitative design would not be entirely suitable to delve into lived experiences

seriously since the quantitative design was first and foremost meant to analyze and evaluate relationships of cause and effect between observed variables. The quantitative design could theoretically be used to elicit responses through the use of surveys, but the depth and richness of such data would not be able to rival what the qualitative researcher could gather through the effective use of the interview method for collecting data (Creswell, 2014; Merriam & Tisdell, 2015).

### **Narrative Analysis**

Within the general paradigm of qualitative methodology, this study design was narrative analysis. As its name suggests, this method entails first gathering narratives, or "stories," from subjects and then going through those stories in a rigorous and structured way to draw out their meanings and implications. Given that this study aims to understand the lived experience of psychological adjustment among different classes of professionals, the narrative analysis method is ideally suited for addressing the main research questions of the study. The researcher first obtained the narratives from the subjects by using the interview technique and then analyzed those narratives for their meanings and implications. The narrative analysis method was selected for present purposes.

There is an almost literary element to the technique of narrative analysis. According to Earchy and Cronin (2008), narrative analysis originates from literary theory and is associated with media and cultural studies and now used by social scientists to gain a deeper understanding of the world. According to these researchers, some of the critical terms that pertain to narrative analysis include account, narrative, and story. An account refers to the basic unit of data

constituted by a subject's responses in an interview. A narrative then refers to the account as considered in terms of a plot, and the story refers to the account considered both as a narrative and as a vehicle for the communication of meanings. The essential idea here is that when people want to understand their own lives and experiences, they tell stories that are not entirely similar to what we mean by "story" in the literary context. Therefore, the literary analysis would be appropriate for parsing the meanings inherent in people's own life stories as well — the central insight of narrative analysis is this meaning that people attach to their stories.

In particular, it is worth noting that recovery almost always follows the parameters of a traditional plot (Earthy & Cronin, 2008). In the context of this study, for example, these professionals in question did not always have a CVA. Instead, there was a long time during which these people were just "normal" working-class people without a stroke. However, a CVA then struck, causing drama and conflict and making life difficult for them. The psychological adjustment would then refer to how these people have responded to the challenge or conflict of a CVA, and the extent to which they have been successful. The goal would be to produce a happy ending where the professional is not the same person as before the experience of a CVA, but who has successfully managed a stroke and come out a stronger person at the end of the experience. Of course, not all reach this goal. The positive outcome of the experience of the CVA would have a classic narrative structure with a beginning, a conflict, and a resolution (Earthy & Cronin, 2008). Concerning these terms, it is clear why considering the accounts of the professionals with a CVA in terms of narrative terms could be illuminating.

According to Fraser (2004), an essential element of narrative analysis is empathy, in the sense of the researcher genuinely connecting with the story that is told by the subject. Throughout and following interviews, the first phase of the analysis involves listening to the

participants' stories and "experiencing the emotions of participants" reflecting on the language used and the "feelings depicted and described" (p. 186). In other words, not only is having empathy the right thing to do, but it may also be crucial if the researcher is to discern all levels of meaning present in the subjects' accounts.

This method helps highlight how narrative analysis is a qualitative design that must follow the rules of its logic. In quantitative research, the purpose is to generally minimize subjectivity and emotion to the greatest extent possible because such factors could introduce corrupting biases into the research. From the standpoint of narrative analysis, however, the subjectivity of the respondent is actually the object of the study, which means that to minimize subjectivity would entail compromising the integrity of the data. Narrative analysis is a method that is tailored to the investigation of its object, which is lived experience. It is for this reason that the method was selected for this study.

The critical insight of the narrative analysis is that when people talk about life experiences, they almost inevitably convey those experiences in the form of stories (Ozyildirim, 2009; Riessman, 1993). People share their experiences in terms of a beginning, a middle, and an end, with specific attention usually being given to scenarios of challenge or conflict. In other words, people perceive their own life experiences as stories, which is how those experiences are shared with others. The narrative analysis was uniquely effective for understanding the meanings present in life experiences, and in particular, how people can move forward from challenging life experiences. The narrative analysis helped the researcher identify potentially unresolved challenges in the narratives expressed by professionals.

Essentially, the subjectivity of the informant is taken as the object of investigation. When using the narrative analysis to investigate the lived experience of professionals following a CVA,

there is no standard of truth outside of the internal structure of the lived experience itself.

Narrative analysis is a qualified design of the qualitative method to treat subjectivity itself as the object of investigation.

### **Narrative Inquiry vs. Phenomenology**

Narrative inquiry is closely related to, but not identical with, the research approach of phenomenology. The main difference is that whereas phenomenology focuses on the first-person experiences of the subject to gain a deeper understanding of the specific phenomenon under consideration, narrative inquiry focuses much more on the structure of the subject's story itself (Cresswell & Poth, 2017). For example, in narrative inquiry, the subject's experience is considered in terms of a beginning, middle, and end, because the experience is understood as following the contours of a plot. This is why when conducting narrative inquiry, the subject is prompted to tell his or her story. In contrast, phenomenology does not presuppose this form of structure. Instead, the structure in phenomenology is understood to emerge from the specific phenomenon and not from a preconceived schema such as a narrative or plot.

It is easy to see how these approaches are very similar. For example, a narrative inquiry almost certainly sheds light on a particular phenomenon (in this case, recovery from a CVA); and likewise, many phenomena may have an inherently narrative component that reveals itself upon phenomenological analysis. Narrative inquiry was selected for this study, though, due to the fact that the structure of the story is, in fact, crucial for understanding the phenomenon of returning to work in the aftermath of a stroke. Given the naturally "dramatic" nature of this phenomenon, it was determined that narrative inquiry was the appropriate research approach to use.

Phenomenology would have likely revealed a narrative structure upon further analysis, but using narrative inquiry, that structure is simply presumed from the start.

Narrative qualitative research designs also include distinct types of analytical approaches. Paradigmatic-type narrative inquiry involves the gathering of stories through data, then applying paradigmatic analytic procedures to identify the common elements across the data set (Polkinghorne, 1995). Sharp, Bye, and Cusick (2018) stressed that there may be different approaches to data analysis within a single narrative design choice; accordingly, the combination of varied data analysis approaches provides depth to the findings, although the combination itself may not be representative of a mixed method. In other words, approaches to data analysis in a narrative inquiry may differ, although there is still a single narrative design selected from among the qualitative methodological research design choices. Sharp et al. (2018) emphasized that details from narrative inquiries can reveal the stories of individuals while the inclusion of the paradigmatic element of analysis can help researchers' discovery of the thematic similarities shared across stories. Consistent with the recommendations of the aforementioned experts, analysis for this narrative research included both the constructed stories of individuals in the sample and the identification of common and contrasting themes between stories.

### **Sampling in Narrative Inquiry**

Sampling for narrative inquiry adheres to the general parameters for sampling in any form of qualitative research. When sampling for qualitative research, the main question that the researcher must consider has to do with the extent to which the selected sample can be expected to produce a full range of deep insights regarding the phenomenon under consideration. The sampling strategy used in this context is generally based on convenience and purposive sampling

methods. The interview of 36 college women and two clinicians regarding Human Papillomavirus virus vaccination decisions is an example (Pinnock et al., 2011). These authors used purposive sampling as described by Riessman (1993). Convenience sampling refers to who is available for the study at hand. For example, the researcher's geographical location and available resources affected the researcher ability to identify and then arrange interviews with nurses, teachers, social workers, bankers, and other professionals who experienced a CVA. Purposive sampling refers to the researcher explicitly seeking out the kinds of subjects who would be most likely to add value to the study at hand. In this type of sampling, geographical location, availability of resources, and the willingness to participate and express opinions are necessary (Palinkas et al., 2015). For example, if there are nurses, social workers, and other professionals with a CVA who seem to have reflected especially profoundly on their own experiences, then the researcher may feel extra motivation to recruit those people for the study if at all possible, as per the nature of purposive sampling (Merriam & Tisdell, 2015).

This sampling strategy is appropriate for qualitative research because the narrative analysis method does not seek statistical generalizability. The value of quantitative research data generally depends on the extent to which the research findings can be statistically generalized. This means that it is crucial for the sample of a quantitative study to be randomly selected and be representative of the broader population. In qualitative research, on the other hand, statistical analysis is not even an option, given that the data consists not of numbers but rather words. Likewise, the sample size of a qualitative study is often quite small, due to logistical limitations on how many in-depth interviews the researcher would be able to conduct. Since statistical generalization is not the objective in qualitative research, it is also not necessary (or even desirable) for the sample to be randomly selected. Instead, the most important thing is for the

researcher to feel confident that the selected sample produced a broad and vibrant portrait of the phenomenon (Merriam & Tisdell, 2015).

### **Contemporary Narrative Inquiry**

Contemporary narrative inquiry is relatively old-fashioned, in the sense that it eschews postmodern notions of narrative (Wang & Geale, 2015). Narrative inquiry adheres to a more traditional or even mythical understanding of narrative, in which a story is expected to begin, proceed, and end, with a hero passing through conflicts and the narrative arc as a whole conveying a meaningful sense of human experience. Likewise, the subject is viewed as the authority in the subject's understanding of one's own lived experience is, which is the object of inquiry for a researcher who is using narrative analysis. The researcher's role was not to invent new meanings absent from the subjects' narratives but rather merely to draw out and clarify what meanings were present in the data of this study.

### **Bracketing the Researcher**

Given the central role of subjectivity when using narrative analysis as well as the implication of the researcher's subjectivity in the process as a whole, it is essential to clarify the researcher's standpoint and become self-aware of potential biases. For the present purposes, it must be noted that the researcher's interest in the topic under consideration – professionals with stroke – is related to the fact that the researcher has personally experienced a CVA. This means that it is essential for the researcher to be on guard against bias and to ensure that personal experience is not projected onto the subjects' experience when collecting, interpreting, and analyzing the data.



The researcher made a conscious decision not to self-disclose her personal stroke experience with her research participants. The decision was because she did not want to distract from their own experiences and become the topic of the interview.

There are specific implications for the role of the researcher. The researcher's personal experience with a stroke was the basis of interest in nurses, teachers, social workers, bankers, and other professionals following a CVA. Conclusions can be drawn that, with recognition and setting aside preconceived notions. This connection did not introduce any corrupting bias into the study and did not rise to the level of disqualifying bias or conflict of interest. Instead, this acknowledgment highlighted the underlying reasons why the present researcher became interested in the topic at hand. Although there was some possibility of introducing bias, it seemed possible for the researcher to control this bias through the use of rigorous data analysis techniques. Bias is not beyond the bounds of what any researcher would typically experience when exploring a topic of personal interest.

### **Interview Protocol**

The interview protocol consisted of open-ended questions to which the subjects fleshed out their lived experiences in their own words. The following questions pertained to the experiences in the aftermath of a stroke, which made it difficult or prevented the professional from returning to work. The inquiry pertained to the experience in the aftermath of a stroke that encouraged or enabled the professionals to return to work. The questions on this research protocol were congruent with the main research questions of this study, discussed at length in the preceding chapters. The Roy Adaptation Model was the guiding theoretical framework of this study, as described by Roy and Andrews (1999). Therefore, the interview questions were open-

ended, allowing the subjects to describe any dimension of their holistic experiences, including the physical, the mental, and social aspects. As the literature review of the preceding chapter made very clear, all of these dimensions are crucial for understanding the lived experience after a stroke.

The interviewer asked three key questions when beginning to conduct the narrative with a given subject.

1. Please tell me your story about your experience with the stroke. (Note: Additional prompts, clarifications, and probative question areas included: Tell me about the job you had, the experience of stroke itself, and the recovery process, up to and including transitioning back to work.)
2. What specific factors, if any, have made your rehabilitation experience and return to work easier?
3. What specific factors, if any, have made your rehabilitation experience and return to work more difficult?

These were open-ended questions that facilitated the subject talking about the main topics of this study's research questions. The researcher improvised further questions, depending on the direction taken by the subject's responses to the initial prompts.

### **Target Population**

The target population of this study consisted of professionals such as nurses, teachers, social workers, bankers, and lawyers with stroke, representing a subpopulation of the broader population of full-time working people. Other professionals were included. The professions listed above are individuals who obtained higher education degrees and pursued some

professional licensure but is not intended to be exhaustive. This population was congruent with the research purpose of this study, which was to investigate the lived experience of professionals with stroke who are seeking to adjust psychologically and return to the workforce. In order to explore this question, the subjects of the study were professionals such as nurses, teachers, social workers, lawyers, and bankers who experienced CVAs. Given the qualitative nature of this study, the sample selected for the study could not be expected to be statistically representative of the overall population of professionals with stroke. Instead, the point was to strategically recruit subjects in such a way that, even if the sample was not representative of the population, the sample was nevertheless able to produce a broad and in-depth picture of the lived experience of the impact of stroke.

Professionals were selected rather than non-professionals because of licensing, participation in collegial organizations, special training, or a higher level of cognitive skill needed for their job. These special skills needed for work were especially relevant in the case of transitioning to work from a stroke. Also, professionals were selected rather than the unemployed, since the unemployed would likely not be able to transition to work. Importantly, reported experiences were unique to the individuals in the sample, so generalizations to the general public are among the limitations in this study. The goal was to report findings as a rich insight into the experiences that could help to inform others, including those in healthcare. Analysis leading to results do not represent generalizations but can help guide others in the directions for future research and knowledge advancement.

## **Participant Selection**

Participants were selected using convenience sampling that was also a purposive sampling method. The total sample included 10 subjects, which was adequate for the qualitative data saturation required for analysis. The recruitment procedure consisted of the researcher sending IRB-approved advertisements through publicly available contact information to individuals listed on the American Stroke Association website, as leaders and participants in support groups, blogs, and networks. The American Stroke Association maintains a publicly accessible network where individuals can share their stories with others, give feedback, ask, and answer questions. Given that the website promotes rehabilitation and young survivors' networks, and contact lists are sorted by geographical regions, this recruitment process was likely to result in the volunteer of a number of eligible participants to satisfy the sample size requirements, which in this study was 10 participants. Online and social media are useful tools for recruitment because public availability and website interactions are freely accessible; there is no need to obtain additional or special permission for these recruitment efforts, although attention to informed consent and confidentiality issues become ever more important (Curtis, 2014). A total of 10 participants were recruited by these means.

The number of participants for this narrative research was determined by the saturation of data. This is where new data do not improve the depth of data or when additional data collected do not give any additional insights (Vasileiou, Barnett, Thorpe, & Young, 2015). The sample in this study was a convenience sample in the sense that the researcher had to rely on volunteers who received invitations and read announcements and who opted into the study. It was also purposive in that it involved the researcher selectively seeking, one by one, the professionals

who met the admission criteria and achieved data saturation. Data saturation was observed after the collection of data from 10 participants.

The inclusion criteria for this study were professional status, 18 to 64 years of age, and having had the experience of transitioning back to work or attempting to transition back to work after a CVA within the past five years. Eligible participants signed an informed consent form and agreed to participate in audio-recorded transcribed interviews conducted in the English language. The criterion of five years of work was to enhance the fidelity of the subjects' memories and ensure that data were related to their most recent professional work environments (as opposed to the environment from 25 years ago).

### **Clarification of Researcher Bias**

It was crucial to consider the problem of researcher bias since the researcher's subjectivity was inherent in how the qualitative researcher interpreted the subjective data produced by the research subjects. Indeed, as Fraser (2004) has indicated, the introduction of the researcher's subjectivity may well be a vital element of narrative analysis, because discerning all of the nuances and meanings of a narrative requires the researcher to empathize with subjects. However, it is still crucial for the researcher to use effective procedures to ensure that the findings of the study reflect reasonably objective meanings that are empirically present in the narrative data retrieved from the subject and that the findings are not merely the researcher's invention or superimposition. A rigorous analytical method was used when evaluating data to minimize the possibility of corrupting bias. The paradigmatic mode of analysis, advanced by Polkinghorne (1995) and applied in health research for narrative analysis, involved the

researcher reading through the data in an iterative manner to identify areas of convergence and divergence.

### **Data Collection Procedure**

Data were collected through individual interviews by the researcher. The interviews were at a time and place of each subject's choosing and were recorded using an audio device. The researcher transcribed each audio recording into text documents. This method is a standard procedure to follow for qualitative studies that utilize the interview method. The interviews were semi-structured, as discussed by Rubin and Rubin (2011), so that, while the researcher guided the interviews to ensure that they stayed on topic, the subjects spoke at length about any aspects of their experiences with a CVA that they wished to express. Additionally, pseudonyms were generated for each of the subjects to ensure confidentiality in the data-reporting process. The researcher knew which pseudonym correlated with which subject, but this information was strictly confidential.

Basic demographic information was also collected from the subjects. This information included age, gender, number of years since incurring a stroke, education level, and profession of the subject. A separate form was used for this purpose, given the simplicity of the questions and the small number of subjects. The researcher noted the information at the beginning of each interview and listed it at the top of each data transcript. Each interview lasted at least 60 minutes, with the ability to spend additional time to ensure that all relevant topics were able to be explored. The researcher transcribed the transcripts from the audio recordings, subjects had the option of reviewing the transcripts to verify their accuracy and/or to ensure they presented themselves as they intended to present themselves. Subjects were invited to provide

supplementary information in writing if they believed there were any inadequacies in the transcripts. One person added to the information.

### **Trustworthiness**

The trustworthiness of the collected data depended on whether or not the subjects were telling the truth about their own lived experiences of a stroke. A trustworthy result in narrative inquiry maintains fidelity with the actual phenomenon that the narrative is supposed to describe (Merriam & Tisdell, 2015). In order to enhance the odds that they were, the researcher attempted to maximize the comfort of the subjects. For this reason, the subjects were given the prerogative to determine the time and place of the interviews. Comfort on the part of the subjects helped make them feel more willing to open up and share their experiences with their researcher in an honest way. Efforts were also taken not to impose the researcher's preconceived ideas about the experiences with stroke onto the subjects.

Attention was directed at evaluating whether the interview questions were leading in such a way that they could distract the subjects from authentically talking about their own experiences. It was necessary to ensure that the subjects did not feel that they needed to provide the researcher with a "right" answer. They knew they were free to discuss their experiences on their terms.

A particular problem regarding trustworthiness deals with the possibility that subjects may have been experiencing residual cognitive deficits in the aftermath of a stroke. After all, the nature of stroke is that it can be expected to have some lingering consequences on cognitive function, which means that for at least some subjects, cognitive deficits may prevent them from giving an accurate account of the experience of returning to work after a stroke. This situation

presents a dilemma for the researcher, and there is no easy way to resolve it. It would perhaps be possible to use a form of triangulation based on documents or other external information provided by the subject in the event that the story itself appears to lack narrative coherence. However, using such methods was beyond the scope of this study.

Ultimately, it was necessary to accept this problem as inherent to the nature of this study and the chosen topic of investigation, since the question comes down to: How does one retrieve the story of someone who may have cognitive deficits that prevent him or her from accurately telling a story? The answer would be that one can only do the best that one can. Given that this study used a narrative inquiry approach, there was no easy way to solve this problem while still maintaining the integrity of the study's methodology. The conclusion was reached that there may be inherent limitations on the data's trustworthiness with at least some subjects as they are experiencing residual cognitive deficits but that there was still value in retrieving, reporting, and analyzing their stories.

The related limitation may be the lack of ability to remember specific information. Another may be the inability to remember time frames. However, there are no attempts to make generalizations about the experiences; the results encompass a report of what participants experienced and how they describe it. The participants' stories are still their experiences and their interpretations of the events following a CVA. It would be difficult to ascertain if the experiences are truthful or complete but important to note that it is their recollection of the experiences that is important. That is what adds to the lived experience.



## **Transferability**

Transferability is a general problem with qualitative research, given that such research by definition takes place within a limited context and with a relatively small sample of subjects. However, transferability was enhanced by explicitly considering limiting parameters and their potential effects on the transferability of findings. For example, while this study focused on human service professionals following CVA events, logic would suggest that the findings would be mainly applicable to other professionals not included in the interviews as well. In other words, the teaching profession resembles the nursing profession in such ways as would make it reasonable to imagine that some of the barriers experienced by nurses would be similar to the barriers experienced by teachers concerning returning to work (Klute, 2018). These are the kinds of valid assessments, rooted in the relevant literature when appropriate, that could enhance this study's transferability.

## **Verification**

The nature of the verbatim data helped to improve content validity, along with the peer scrutiny of the dissertation committee members, who reviewed the researcher's data analysis to identify any weaknesses or inconsistencies.

## **Credibility**

In qualitative research, credibility depends primarily on the original data trustworthiness and then on a lack of bias on the part of the researcher. Credibility is the analog of internal validity in quantitative research, and it has to do with the extent to which the internal constructs and the general protocol of the study are capable of producing meaningful results (Merriam &

Tisdell, 2015). It was assumed that subjects of the study reported their lived experiences with strokes honestly, and the researcher reported and interpreted the data in an objective way that was not colored by personal biases or desired results. In qualitative research, it is generally acknowledged that the researcher cannot eliminate subjective bias, but it is also required of the researcher to take efforts to acknowledge bias, limit bias, and report the possible effects that bias could have had on the presentation of the findings. This has been noted in the considerations of the potential biases that the researcher may have, and such considerations-enhance credibility.

### **Consistency**

Consistency in this study meant that the researcher collected all data from interviews in the same way and then analyzed the data using the same procedures. Consistency is thus the opposite of arbitrariness (Merriam & Tisdell, 2015). For example, it would be inconsistent if the researcher were to type some of the transcripts from interviews and request some subjects to type up their transcripts. To achieve consistency, either all interviews would need to be transcribed by the researcher (which was done in this study), or all interviews would need to be transcribed by the subjects, and it would not be acceptable for the researcher to switch between the options. The same procedure was utilized to analyze all transcripts. If various procedures are used, this would corrupt the transcripts, and it would be unclear whether differing reports are the result of the differences in the actual text or if they are somewhat due to differences in analytical procedures. Consistency involved a standardized procedure in this regard.

## **Dependability**

Finally, dependability assured that the researcher was transparent about the study's design and the methods used to collect and analyze data, such that readers and other researchers exactly follow what was done and could replicate the methodology of the study if desired. Dependability in qualitative research is the analogue of the construct of reliability in quantitative research. It has to do with whether, all else being equal, the same study protocol could be implemented again to produce same or similar results (Merriam & Tisdell, 2015). In qualitative research, future studies in the same subject will not be expected to produce the same results. However, qualitative reliability means that readers must at least understand what the researcher has done and how the findings of the study have been produced logically. In this sense, the present methodology chapter of this study enhances the dependability of the study, since the purpose of this chapter was to delineate various design and methodology aspects of this study, including data collection and analysis plans.

## **Data Analysis Plans**

This study's data analysis followed two procedures, encompassing both narrative analysis and paradigmatic analysis of narrative techniques. Sharp et al. (2018) noted that despite considerable progress and more frequent appreciation and application of the narrative design, there is still no set approach to undertaking a narrative inquiry, with combinations of approaches employed successfully in the literature. Practical steps with narrative analysis draw on Polkinghorne's (1995) work, who described both narrative analysis and paradigmatic analysis of narrative techniques in depth, which offer useful insights from narrative data. The first narrative analysis procedural steps focused on the constructed stories of individuals, while subsequent

paradigmatic analysis of narratives continued with inductive and deductive means to identify common and contrasting themes among participants' stories. Results from the combined approach of analysis of narrative inquiries revealed the stories of professional adults returning to work following CVAs.

The analysis applied in this narrative inquiry allowed stories to represent descriptions of real-lived human actions and experiences, whereby events and happenings are configured into a temporal unity. Polkinghorne (1995) developed the narrative analysis techniques following Bruner's work (1985), who described paradigmatic cognition as that which recognizes categorical and thematic elements, while narrative cognition relies on the constructive understanding of emplotted stories. Paradigmatic-type analytic procedures lead to the findings of common elements across the data set, with narrative-type inquiry analysis procedures producing explanations for the common findings across stories (Sharp et al., 2018). In health research, narrative analysis can produce an individual story for each subject, while paradigmatic analysis of narratives identifies common story types and breadth of emergent themes (Ison, Cusick, & Bye, 2014).

Initially, the narrative transcripts from the interviews were analyzed in terms of the narrative structure, followed by an iterative process of repeatedly reading the data to identify key meanings present within the data (Merriam & Tisdell, 2015). Analysis for the structure included identifying preludes, developments, conflicts, climaxes, and resolutions, with a focus on how the subjects' experiences were framed as stories. As Earthy and Cronin (2008) have indicated, the researcher draws out those story-like elements in the study's data analysis phase. Doing so helped reveal specific points of unresolved conflict and produced recommendations for future interventions.

The paradigmatic analytic procedures that followed involved repeatedly combing concepts from the whole data set of participants' interview answers until critical themes based on the points of convergence and divergence of the data began to emerge, as recommended by Sharp et al. (2018). This narrative analysis style encompassed a broader consideration of the meanings that were collectively expressed by the stories. Bruner (1985) emphasized that the construction of knowledge involves the construction of relationships among concepts and ideas, which can be captured from stories. The relationships, paradigms, or common thematic findings used to answer primary research questions cannot be isolated to any one point in the research, but it is expected to be an overarching atmosphere or ethos that runs through the work from beginning to end (Merriam & Tisdell, 2015). Likewise, when analyzing interview transcripts, the paradigmatic-type analytic procedures emphasized by Polkinghorne (1995) for analysis in narrative inquiries allowed the researcher to look at the data in a more synchronic way rather than draw attention to the simpler linear progression of the individual stories, which occurred in this study.

### **Relationship of Findings to Roy's Adaptation Model**

The findings of this study were evaluated in terms of three major categories of the Roy Adaptation Model (Roy & Andrews, 1999). These are the physiologic, the self-concept, and the role function categories. The Roy Adaptation Model also has a fourth mode, the interdependence mode. This was not independently evaluated in this study but was instead treated as an emergent property of the needs within the other four modes.

**Physiologic Findings:** One expected finding was that professionals who suffered a stroke could experience ongoing neurological dysfunction, preventing them from achieving

psychological adjustment when attempting to return to work. For example, if stroke causes lingering memory problems, then this could be an objective problem when it comes to a nurse having the duty to retrieve appropriate medications for patients, or a teacher remembering the planned lessons, or a social worker remembering a case, or a lawyer remembering a client's name. This situation is an example of how there could be a real barrier to subjects returning to work, such that they may not have the full objective capacities required in the aftermath of a stroke in order to fulfill all professional duties. This would imply that some special accommodations would be needed for the staff to return to work or that the particular staff cannot return until physiologic improvements have been achieved. If the subjects report ongoing physiologic dysfunction as a result of stroke, this would be an objective barrier to returning to work, in the real sense that these people could not return to work if they find themselves unable to perform the duties required of their professional role. Physical rehabilitation would then turn into a baseline priority when working with people who would like to return to work in the aftermath of a stroke.

**Self-Concept Findings:** The self-concept mode corresponded to mental health issues related to a stroke, as long as those issues were not neurological but rather a matter of how the nurse with the stroke understands herself and her place in the world in the aftermath of a stroke. For example, a nurse (a woman, for the sake of an example) or other professionals in the group may feel depressed not because of a neurological problem but rather merely because she now feels damaged and senses that her social status may have been diminished. She may also believe that she is a burden to those around her and that she will never be as competent as before her experience of a stroke. Such findings relate to self-concept in that they have to do with the mind but rather with the brain but rather with the mind. This would be the domain of psychological adjustment

proper, in that addressing problems of self-concept would require the nurse, or teacher, or even social worker to change how she understands herself and her holistic situation in the aftermath of the experience of a stroke.

**Role Function Findings:** Finally, it was also worth considering issues related to role function. This is connected to the social aspect of having a stroke, or how one really might be treated differently by others due to potential stigmas surrounding a stroke. For example, patients may not want a nurse with a stroke to care for them if they know that the nurse had a stroke. Likewise, other nurses may not trust a nurse with stroke history to carry out specific responsibilities. The nurse may struggle with going from the role of delivering care to others to the role of a stroke patient who needs care from others (and this could be unusually severe if the nurse previously had negative feelings about stroke patients). Role function is not independent of the other modes, in that physiologic dysfunction and maladjusted self-concept could result in inhibited role function. However, discrete findings were expected in role function area that both build and expand on findings produced in the areas of physiologic and self-concept modes, as per the Roy Adaptation Model.

### **Ethical Considerations in Narrative Research**

The ethical considerations in narrative research are relatively minimal. This is true of qualitative research more generally, because, in qualitative research, no intervention is being implemented, which means that potential risks to the subjects are very minimal. However, when it comes to narrative research, the researcher may broach sensitive topics that could cause the research subjects some mental or emotional distress. As Holloway and Freshwater (2007) have noted, when subjects tell their stories, they may make themselves vulnerable, and it is

exceptionally easy to see how this could be the case when it comes to professionals with stroke. In this context, the researcher ensured that adequate tact and empathy were utilized to make the subjects as comfortable as possible and minimize the risk of hurting feelings or causing distress to the subjects as they told their stories and responded to the interview questions.

If anything, though, there was a strong reason to believe that participation in this study could have proven to be a healing experience for the subjects. This feeling is because when a person has a challenging experience that others do not share, it is often difficult to find a sympathetic listener. This condition can exacerbate feelings of loneliness and alienation that are associated with a painful experience. One could imagine that this would especially be the case when it comes to stroke. Some of the symptoms can themselves produce social isolation, as has been discussed extensively in the literature review in the preceding chapter of this study. In this case, there could have been actual therapeutic value in the researcher offering the subjects an opportunity to share their lived experiences of stroke in a safe and non-judgmental context. While there may have been some risk of emotional distress present, this was minor to start with and then almost certainly outweighed by the positive emotional effects that participation in the study may have had on subjects. The researcher had a list of referrals for anyone who was upset and desired to see a doctor or psychologist. Participants were aware they could have withdrawn from the study if they so desired without any penalty or questions asked. There were no withdrawals and no requests for referrals.

Another ethical consideration consisted of the protection of the subjects' privacy. Data transcripts across all stages of the research process should not include the actual names of the subjects (O'Keefe & Connolly, 2010). Real names may only be accepted in the researcher's appointment book, and this should be kept separate from all even potentially publishable



research material. In general, it is unacceptable for any given data set to be associated with any single identifiable person in the final, published version of the study (O'Keefe & Connolly, 2010). There were no identifying data such as actual names of hospitals, employers, home residence medical care names, or family names. All participants were identified with pseudonyms and the researcher coded subjects in such a way that the identities of the subjects were not apparent to anyone who read the findings of the study other than the researcher.

### **IRB and Related Procedures**

The protocols of institutional review boards stress the principle of respect for the autonomy of human research subjects. The proposal of the study was submitted to the Molloy College Institutional Review Board and approved. The informed consent form (Appendix B) was signed by each subject willing to volunteer data, and participants were informed of their rights to withdraw at any time. There were no incentives for participation or penalties for not participating or withdrawing from the study. The risks of participation were minimal, as confidentiality was maintained, participation involved approximately one hour of interview discussions, and there were no other intrusions or deceptions involved in the research process. The researcher informed participants that they might have felt a sense of catharsis as a result of telling their stories and they could have experienced some emotional distress or discomfort in telling their stories. Participants were aware that interviews could be terminated at any time, and a referral to a counselor or psychologist was available to them. No names or identifiers were linked to participants in any published reports, and the use of pseudonyms protected identities in data collection, analysis, and findings. Data were maintained in a password-protected computer with any hard copies or external storage of electronic data maintained in a locked cabinet, with

the researcher in sole possession of the password and key. All data will be maintained and later destroyed according to Molloy College IRB regulations.

## **Conclusion**

In summary, the present chapter consisted of the methodology section of this study. An effort was made to delineate all relevant aspects of this study's design and methodology in as thorough and rigorous a way as possible. It has been shown that the methodology and the data collection and analysis plans were in full congruence with the key aims and main research questions of the study. With all of this groundwork in place, the next phase of this study involved implementing the methodology delineated here and carrying out the research study. Chapter 4 includes a presentation of data and findings retrieved from the subjects.

## **Chapter 4: Results**

The data collection in this study included 10 audio-recorded and transcribed interviews with full-time working adults, who recovered from a CVA, which was referred to during the interview sessions as a stroke. Narrative inquiry methods were useful for revealing the complexities of human experiences and understanding sense making within social, cultural, and historical contexts. Narrative analysis procedures revealed the constructed stories of individual participants, while the paradigmatic analysis of narratives involved inductive and deductive identification of common themes across stories, as recommended by Sharp et al. (2018). These analysis methods were used in combination in this study. The analysis began with participants' individual stories, followed by identifying common themes that emerged from the data.

### **Individual Constructed Stories**

The analysis began with the participants' individual stories. Ten participants shared their individual stories with their experiences of a CVA, recovery, and return to work. Table 1 below includes a description of the sample. The majority (80%) of participants in this study were Black (which includes African Americans, among other races). All but one participant held a master's degree or higher level of education. Four participants worked in nursing, three worked in education, one in accounting, one in law, and one in cosmetology. The age range was 45 to 61, with an average of 52 years of age. All participants answered the same set of interview questions, with some participants offering more detailed recounts of their experiences than others. Some participants still had some lingering speech difficulties, but all participants had opportunities to participate in the member-checking process and offer

additional data to the study after their interviews concluded. The retelling of their stories in the section below occurs in the order in which the interviews occurred.

Table 1: Description of the Sample

Name	Age	Gender	Race	Education	Career
P1	57	Male	Asian	Graduate Degree	Nursing
P2	59	Female	Black	2 Years of College	Cosmetology
P3	61	Female	Black	Graduate Degree	Nursing
P4	48	Male	Black	Graduate Degree	Professor
P5	45	Male	Black	Graduate Degree	Teacher
P6	57	Female	Black	Graduate Degree	Nursing
P7	49	Male	Caucasian	Graduate Degree	Accountant
P8	55	Female	Black	Graduate Degree	Lawyer
P9	54	Female	Black	Graduate Degree	Nursing
P10	57	Male	Black	Graduate Degree	Teacher

**Participant 1 (P1)**

P1 was age 57 at the time of the interviews, and as an Asian-American male, he had worked in the nursing profession for more than 30 years. He suffered a stroke about 18 months before the interviews and then returned to work after 3 months of rehabilitation services, following his neurologist’s instructions. He considered himself “extremely lucky because the infarct was very small and pretty much everything had returned” after rehabilitation exercises. He described “some” ongoing “weakness after the stroke,” but when he was ready to go back to

work, his “strength was returned.” It was reassuring to him that he “was not going back to work with less than 100% capability.” His return to work was welcoming, and then after the first couple of days, “pretty much everything was the same.” However, he began to limit his hours, take a lunch hour, and perform “movement exercises, range of motion exercises,” and began to “set boundaries” to “leave work on time” and “take care” of himself. He explained, “Unfortunately, in this profession [nursing], we are always thinking about doing the best we can for our patients but sometimes we end up sacrificing ourselves to too much.” Prior to the stroke, he skipped lunches and breaks, but after the stroke, he worked to “maintain those boundaries to limit stress.” After the stroke, he became more aggressive about his healthcare. His concerns were also about taking care of his family, and he described the “fear” that he would not be able to do that, asking, “When I am gone, who is going to take care of my family and my kids? They are old enough to take care of themselves, but it would be better if I was still around.” He went back to work because he was “not quite ready to retire yet.”

### **Participant 2 (P2)**

P2 was a 59 year-old African-American female cosmetologist who had worked in the profession for about 20 years, when she had a stroke. Following her stroke, she was in the hospital for about two weeks and then to a rehabilitation facility for about three months, engaged in occupational and speech therapy. Although she described the therapy as “very helpful,” she did not “enjoy the nursing home experience. It was just too controlled. When you’re in one of those facilities, everything is on their time; it’s not about you...I was more than happy to leave the place and go home.” At home, her out-patient rehabilitation therapy was interrupted because of insurance issues, but she found therapy to be “very helpful.” Her return to work has been

difficult, as she cannot resume her usual work due to the stroke. She said, “It is very finger and hands intensive...It changed totally because of the stroke,” which affected her left side to the extent that she could “no longer use it...My work as it used to be is done...It’s very frustrating...I’m in work limbo.” P2 also took care of her aunt, but after the stroke, “can’t help her anymore now.” Previously independent, she is frustrated having to “depend on people” and the “need for somebody to help do everything.” She said the “hardest part is I am the one who was depended on, and now I need this help.” She also described frustration and anger about how the stroke happened to her, adding, “I thought I lived a very healthy lifestyle. I lost weight, changed my diet – to like a vegetarian diet – eating healthy, having smoothies every day and doing all this healthy stuff and working, and here I am, and I don’t get it.” She did admit to not monitoring her blood pressure which was “too high.” To go back to work, she is trying to “search within to find the talents and things that don’t require use of my hands.” She is in training as an adult daycare provider.

### **Participant 3 (P3)**

P3 is a 61 year-old Black female who worked as a registered nurse for 30 years. Her stroke occurred four years before the interviews, and she returned to work in a different capacity after about a year. She was living with her adult son at the time of the stroke. She remained in the hospital for one week before going to rehabilitation to relearn speech and how to walk again, which she could not do when she was discharged from the hospital. She became reliant on others for “everything.” She described the first three weeks of “intense therapy” as “very, very painful - getting back the feeling and learning to walk again.” She became depressed, constantly worried, and feared not being able to help herself having “to do everything all over again.” Close friends

and family visited her. She called them her “strength” and through them she “developed that faith.” She changed her diet and started new medications and went home when she could walk with assistance and a walker. She continued therapy at home and “used to cry” and get “so depressed every day when the professional therapy would come.” The therapists said she would never walk alone again, and she “gave up” until her pastor, friends, colleagues, and family helped her to “walk more every day.” She depended on her son for transportation until trying the bus. With growing strength and confidence, she returned to work and described her colleagues as “very supportive.” She said it was the “motivation, mood, and the support of friends and family that made it easier to go back to work.” Routine and motivating socialization is what helped her transition back to work. She called herself “lucky in an unlucky way – to be alive and be able to go back to work and to help others.”

#### **Participant 4 (P4)**

P4 is a male African American, age 48, with a doctorate and a career as a college professor. He suffered a stroke a year before the interviews and returned to work after seven months, with some limited responsibilities that transitioned him into his normal full responsibility level. Following his stroke, he “could not speak for a long time” and had financial concerns about being “able to pay my mortgage.” He was angry that he “had spent all these years going to college to end up in a wheelchair. It was not easy.” He engaged in months of “occupational therapy and speech therapy...not less than four times a week...the physical condition is resolving gradually.” About returning to work, he said, “A few months into the stroke, some colleagues visited and started discussing the possibility of returning back to work.” They “motivated” him so much that after their visit, all he “thought about was work and work

and work...Do not look at what you cannot do. Look at what you can do...It must have been an angel that sent them.” He “became energized and motivated to go back to work” and “started paying more attention to the therapies, more than 12 hours a day doing different things...read, wrote, walked, exercised, played games...every little thing helped.” After returning to work, he questioned “the way people look...people think about,” and if they would “sympathize.” He said, “People have mixed feelings about people who have strokes returning to work. Some think the protocol for returning to work is unclear.” He felt that going back to work helped with his recovery and that his “colleagues” helped him find “zeal and energy.” About therapists’ roles in his return to work, he said, “Some aren’t used to rehabilitating stroke victims. According to some of them, one is lucky to be alive.”

### **Participant 5 (P5)**

P5 is a 45 year-old African American male educator, who suffered multiple strokes during his 15 year-teaching career. A man of faith, he talked about the role of the church and his spiritual beliefs in keeping him positive and motivated toward recovery. He spent the four months prior to the interview recovering from his most recent stroke, which was his fourth and most severe stroke. The support of his family was meaningful to him and his wife became the primary breadwinner, working daily. He claimed, “There’s no preparation for having a stroke... people can live a good life, eat well and do the right stuff to be in good shape...but you know with high blood pressure, your body does not tell you.” He was “not even talking for months, but believed that “lost skills will come back, but a little assistance helps.” He said after the last stroke, his “lifestyle changed.” He changed his diet and “self-motivated” because he did not “receive any therapy geared towards work...people can recover and go back to work. That was



not the focus...a little help geared towards those skills would help...work is possible.” He recalled, “the wheelchair, the cane, the staggering and the speech...difficulty swallowing...all those are gone now...I know I will return to work.” While P5 credited his wife, family, friends, and faith with his motivation to recover, he felt that there was not enough support oriented toward the return to the workforce of stroke victims. He felt that returning to work following a stroke had to be a self-motivating process, with few formal access to programs that would assist him with those efforts.

### **Participant 6 (P6)**

P6 is a Black female, 57 year old nurse of approximately 18 years before her stroke, which occurred about four years before the interview. She spent a year in recovery before returning to work when she was “demoted and transferred to a more stressful and acute unit.” Prior to her stroke, she “did not believe” that she had “any medical problems and wasn’t a sickly person...ate right was of moderate weight, had been to the doctor the week before and go to the doctor regularly and no history or predisposing factors...and blood pressure was right and had always been.” Most of her stroke complications and “symptoms were cognitive, remembering things” as she “would forget things” as soon as she would hear it,” which for her was “unbearable.” She stayed in the hospital for about two weeks, then “the recovery from stroke was not easy...about 9 months after the illness...and went back to church and other activities right away but not work.” What contributed to her recovery and transition to work were her children and other “people...family, friends, and church people were involved in my case. People really wanted to help me...Friends, family and immediate coworkers were amazing. Everything helped.” Rehabilitation, “the writing, reading, storytelling all helped” As her “focus then was to

get really better and go back to work, she said it required “persistence, persistence, and persistence.” She slowly improved “from week to week...understanding better and retaining better.” However, her transition to work was disappointing. She said, “They want you to be better but they do not want you to return to work. Really...it was so negative...It is like people think that once one has a stroke, the person will not be able to work well.” She was happy to have “proved them wrong, but...the support was not enough, to be fully back to the situation one was in before the sickness is not possible.” She believed that, especially in healthcare, “a program should be in place to support people” who are transitioning back after recovering from a stroke.

### **Participant 7 (P7)**

P7 is a male Caucasian, accountant, age 49, who worked in the field for approximately 12 years before his stroke, which was about two years before his interview. He spent almost a year in recovery before returning to work with limited responsibilities that transitioned into fuller responsibility. He held a second job he did not yet resume at the time of the interview. He had a history of elevated blood pressure and diabetes before his stroke. He spent about a month in the hospital, and his “memory, other cognitive skills, language, speech, writing, coordination, movement, sense of time were not the same.” He “did not understand why somebody who tried to do the right thing would have such an experience.” A man of faith, he was “grateful to be given a second chance at life. He said his “recovery from the stroke was very dramatic...very frustrating and long...it was that rehab that helped transition me to where I am today.” He was unaware that he qualified for and should have been pursuing rehabilitative services until a friend helped him set it up. He would have liked “somebody to follow up with the doctor’s instructions

...with the rehab, there were no standard protocols.” He had “language therapy, communication, and psychological therapy” and “gradually started to get better.” He said, “The games, the bingo, the coloring the card and word games did not make much sense initially, but they all had a purpose and it all worked out. One needs to have patience.” When he felt it was time to resume work, his “boss” and “all the staff were ready...offering themselves and asking in what ways they can assist...assist with any process.” He believed that “going back to work helped with recovery.” He credited his colleagues with making him feel “very comfortable” and “colleagues were not judgmental,” which he thought helped him “transition very smoothly.” After resuming work, he took “more frequent breaks to prevent more stress and continued “opportunities to go for appointments and therapy,” which his workplace made possible. He believed the supportive environment of his workplace was unique and not characteristic of most job sites.

### **Participant 8 (P8)**

P8 is a 55- year-old black female lawyer who was hospitalized after her stroke and then started a “recovery process” that she described as “so slow – so slow.” The stroke affected the “right side and right leg and movements [which] would feel so weak” and she began using a “walker.” After being discharged from the hospital, she began medications and the therapists made home visits. About home health visits and therapy, she would “walk a little bit and then was so depressed.” Colleagues visited her and encouraged her recovery so she could return to work. Despite her “fear”, she knew she “was happier when back to work.” She “feared talking to people and challenges.” After working toward recovery, she resumed work and considered it a “welcomed challenge.” She said at work, it “wasn’t as before the stroke” but tries “to do well even when” she may “feel weak.” Changes included the fact that she does not “talk much” and

the way she “used to walk is no longer” the same, and the use of her “hands to especially write” changed. She now relies on other people more than before the stroke, which is what she used to do for others before the stroke, for example, with transportation. She said, “Getting to work is more difficult and getting there on time is a challenge...taking a bath and preparing – all of those things are difficult.” However, she also said, “The support is there from coworkers. They try to help as much as they can.” She is fearful of the future, and “the constant fear of the sickness is the greatest challenge.”

### **Participant 9 (P9)**

P9 was a black American female nurse. Her stroke happened about two years before the interview. The stroke happened in June 2018. She woke up, unable to speak and lift up her extremities. Her son called 911, after which they took her to the hospital and diagnosed a stroke. She was not on any medication and had no known medical problems. She recovered fully physically with ambulation. The speech problems lingered, and she had cognitive deficits. She had to “start afresh to learn alphabets and words.” Her bishop called her one day and asked her what she wanted the Lord to do for her. She said to “recover words.” The “next day” she “started speaking fluently.” The “therapist and everybody was amazed” for her recovery. From there, her speech returned to her and she began speaking fluently, remembering things, which did not happen before this miracle. She said, “God’s hands were in my recovery as far as this stroke was concerned.” The therapists continued their work and “encouraged her,” which “helped me a lot.” She had “joy going to the therapy, especially the ambulation one,” but she “was not excited at the speech therapist” and was “discouraged” having to learn speech from her “ABCs.” She felt that the “nature of the sickness made it difficult” to return to work because “the sickness was in

the brain.” She described herself as a “moron.” Memory was a particular problem, which “made recovery difficult” and going back to full-time work was slow, which she is still planning, as she returned to part-time work as a case worker.

### **Participant 10 (P10)**

Participant 10 is a 57 year-old African-American male who is a teacher. His first stroke occurred almost eight years ago, and the last was about two years before his interview, and he “spent a year in recovery before returning to work.” He had a history of “high blood pressure and cholesterol” but was also active in exercising daily and taking steps to control his diet. He was “supposed to be using a CPAP machine because of sleep apnea, but the machine was not always comfortable,” and he was not consistent with its use. He took “blood pressure medications” but did not monitor his blood pressure regularly. The stroke affected “memory and the right side” of his extremities. He was “doubtful” even after the diagnosis that it was a stroke. He was not especially compliant with the recovery process due to difficulties with transportation. He remained “out of the workforce for almost a year” when he had weekly appointments and at-home exercises. His wife was “proactive in searching out alternatives” for recovery. He was able to “collect disability for about a year” and felt that he returned to the workforce too soon. However, returning to work was helpful for him to “regain skills” and “test” himself and his “abilities.” He claimed that coworkers were “happy to see him return and were supportive” to him after returning from work. It was “nothing specific that they did other than be nice and kind” and made him feel welcomed to be back and “appreciated” for his “efforts to return.” Changes he experienced after the stroke included “trying to prioritize” his “health and family over work,” and he made “adjustments” to the way he uses his affected hand. He reported some “ongoing

problems with the one leg” he did not have prior to the stroke, but which is “not really getting much better” even years after the incident. He was “tentative about the future” because the stroke happened “relatively young.” He reported being “more careful” with his medications, follow-up appointments with the doctors, tests, and is “even more committed now to a better diet and a more intensive exercise” program.

### **Paradigmatic Analysis Results**

The paradigmatic analysis of data revealed eight major themes representing shared concepts from across participants’ stories. Member checking occurred following the transcription and the initial interpretation of data. Participants had opportunities to review the thematic findings described below and then offer additional clarifications, refuting or further substantiating the initial interpretations of the data. Participants who completed the member-checking process substantiated the findings by agreeing with the initial interpretations of data. Identification of the thematic findings includes exemplary quotations from the participants’ stories that support the significant findings.

### **Major Thematic Findings**

The eight thematic findings that were common across participants’ stories included a general sense of good health or well-being that preceded the stroke. Denial was the first experience immediately following the stroke. Rehabilitation was a helpful but sometimes frustrating process that lacked an emphasis on the return to work. There were necessary changes in work attitudes and behaviors following recovery. The support of family and friends facilitated recovery and a return to work. There was little difference in coworker relationships following a

return to work. Returning to work was a welcome challenge that facilitated identity reconstruction and recovery. Belief in the concept of luck or faith surrounded recovery, but fear surrounds the future. Table 2 below presents a summary of these findings.

Table 2: Major Emergent Themes

Theme	Finding
Theme 1:	A general sense of good health or well-being preceded the stroke.
Theme 2:	Denial was the first experience immediately following the stroke.
Theme 3:	Rehabilitation was a helpful but sometimes frustrating process that lacked an emphasis on the return to work.
Theme 4:	Necessary changes in work attitudes and behaviors followed recovery.
Theme 5:	The support of family and friends facilitated recovery and return to work.
Theme 6:	Little difference in coworker relationships followed a return to work.
Theme 7:	Returning to work was a welcome challenge that facilitated identity reconstruction and recovery.
Theme 8:	Belief in the concept of luck or faith surrounded recovery, but fear surrounds the future.

**Theme 1. A general sense of good health or well-being preceded the stroke.** The majority of participants felt that they were in good general health or were trying to be in good health before their stroke. Most felt that they were taking steps to control their diet, blood pressure, and cholesterol and were engaged in some type of exercise program or were aware of the need to do so. There was general unpreparedness based on their lack of expectations for a stroke event. For example, P1 said, “My cholesterol was always very low.” P2 explained, “I thought I lived a very healthy lifestyle...I don’t get it.” P4 said, “I had been a healthy young man, ate right and did my exercises. I have a gym equipment at home. I know I have a history of high blood pressure, but it was under control...I did not see myself a risk.” P5 said, “I had a history of high blood pressure and other medical issues, but I did not know it would turn to this. I managed it well, I thought.” P6 said, “I was a person that thought that I did not have any medical problems and I was not a sickly person.” P6 added, “I ate right, cared about my weight...that stroke caught me off guard. I’d been to the doctor the week before and I go regularly. There was no history or predisposing factors. My blood pressure was always right.” P7 said, “My primary doctor said that there was an incidence of elevated blood pressure and diabetes, but that was just one incident...I did not understand why somebody who tried to do the right thing would have such an experience.” P9 claimed, “In my case, there was no stress, no high blood pressure, no low blood pressure, and my weight was within minimal. So I do not know what caused it.” P10 said, “I had high blood pressure almost all my adult life and just recently higher cholesterol but was taking steps to address that.” Although participants were aware of some risk, most did not believe they were at high risk for a CVA.

**Theme 2. Denial was the first experience immediately following the stroke.** The majority of participants felt that something happened to them and could describe the physical



changes experienced. However, the majority of the sample reported that they remained in a state of denial until, and sometimes even after the stroke diagnosis at the hospital. For example, P1 said, “As all patients do, I went into a state of denial...the denial aspect was so strong.” P2 explained, “Sometimes I am okay with it and sometimes I am just frustrated and angry and can’t believe it and am still trying to figure out how this happened.” P3 claimed she was suspicious but doubtful, anxious and worried, then “The doctor came and talked to me and confirmed I was having a stroke...the scans showed I was having a stroke...Eventually my son called up the doctor and they confirmed I was having a stroke.” P4 shared, “It seemed like a dream. A real dream but it was not a dream...I did not understand what was going on...couldn’t believe it...could not believe how somebody could have a stroke at that age.” P5 explained, “There is no preparations for having a stroke...it’s hard to believe...It’s only when it hits sometimes that our eyes open.” P6 said, “It took me time to comprehend. I could not believe that I had stroke.” P7 said, “I could not believe it was me.” P8 explained, “they told me I had a stroke. I didn’t have this before, know what it was like, or what to think or believe. I was alarmed, and there I was and had it.” P10 said, “I was really doubtful it was a stroke because I had never experienced anything like that and believed that it could not really happen to me that way, which really is just my own denial.” Although symptoms conveyed that a stroke occurred, the majority of participants shared an initial reaction of denial.

**Theme 3. Rehabilitation was a helpful but sometimes frustrating process that lacked an emphasis on the return to work.** Most participants agreed that rehabilitation services were beneficial to them in regaining physical readiness to return to work. P1 said, “I saw my neurologist and she recommended some physical therapy exercises I could do at home with myself...[for] months, I worked on rehabilitation exercises.” P2 described “occupational and

speech therapy that was very helpful.” P3 said, “Physical therapy is very helpful.” P4 said, “My therapists also helped me a lot. I had physical therapy, occupational therapy, speech therapy...I was scheduled for therapy not less than 4 times a week. I never missed any therapy.” P6 said, “I was scheduled for rehabilitation right away...staff worked hard to help me...I did everything I was told to do.” P9 shared, “The therapists helped me a lot. They encouraged me...I had joy going to the therapy, especially the ambulation one.” P10 claimed “rehabilitation is helpful, but you have to stick with it, be consistent, and then you will see results.” The majority of participants described therapy and rehabilitation as generally helpful in their recovery.

However, there were issues related to access, insurance, duration, and/or frustrations with the process that were challenges for some participants. For example, about coverage, rehabilitation, and therapy, P8 said, “The recovery process was so slow – so slow...they give me a walker and a cane and came to the house and walked a little bit and then I was so depressed.” P2 claimed, “It was terrible except for the physical therapy part – that was really good. Everything else, I just wasn’t feeling like it was that helpful.” At one point in her recovery, P2 “changed from one type of insurance to another and haven’t been getting the physical therapy and have to wait...I can’t wait to get back into that full steam.” P7 said, “I cannot imagine why they did not tell me to make an appointment with a rehab specialist...A friend came to my home and asked me about my therapy. It was then I found a therapist and made an appointment.” P7 added, “I think if somebody called to ensure that I had somebody to follow up with the doctor’s instructions, it would have been better...I was surprised. If somebody does not insist, the person will miss out.” P10 said, “Some of the treatments after the stroke were not covered by insurance, so we had to figure out ways to pay out of pocket for what could help me at the time.” Some of

the participants encountered difficulties or were unaware of how to best access recovery support services.

Others became more proactive in their own rehabilitation. For example, P3 said, “It was very very painful getting back the feeling and learning to walk again – very intense – it left me crying.” However, after returning home, P3 started to go to a community center where she “did meditation and yoga for 6 months. I was there when I was not at rehabilitation and they helped me and motivated me a lot.” P5 said, “Therapy, I give this to myself. You cannot wait and receive all therapies from your doctor. I went into research. I self-motivated myself. Most of what I do now is what I found myself.” P5 further explained, “I cannot wait for the doctor to tell me what to do...if I got as much assistance, I would have recovered well enough to go back to work, but that is not the focus of the therapy.” P10 said his “wife was proactive in searching out alternatives” for therapy, treatments, and his recovery. Most of the participants described having to be active in the pursuit of rehabilitation and therapeutic recovery services.

There was a lack of therapeutic emphasis on the return to work that several participants described. For example, P4 explained, “It was frustrating discussing the criteria for returning to work. Many therapists have issues with returning to work...Some are not used to rehabilitating stroke victims. According to some of them, one is lucky to be alive.” P5 said, “I did not receive any therapy geared towards work. I did not know that that is possible. The thinking is if you’ve had a stroke, that’s it for you for work. Help geared towards those skills would help.” P6 said, “It is now that I know that people can recover and go back to work. That was not the focus. A program should be in place to support people.” P7 said, “Even with the rehab, there weren’t standard protocols. I was surprised. If somebody doesn’t insist, the person will miss out. During rehab, I told them I was good to be discharged to start work, but they wouldn’t release me.” P10

said, “The doctors’ and therapists’ focus was the status of the body and not really understanding what it would take for me to get back to the job at the same level as before, if that was even possible.” Although many participants referred to “occupational” therapy, about half of the sample specifically noted that rehabilitation and therapy had no emphasis on goals to return to their full-time work.

**Theme 4. Necessary changes in work attitudes and behaviors.** The majority of participants reported that a return to work required a change in attitude and behaviors, such as reducing work hours, restricting activities, or changing work tasks. Most often, this change pertained to reducing job-related stressors and/or adapting their work activities to their change in physical capabilities. P1 said, “I returned to work and pretty much everything was the same. Although the difference is that I do not work 60-70 hours a week anymore. I limit myself to 40 and when it’s 5 pm, I go home.” P1 further explained, “I also make sure I take my lunch, a walk ...about 10000 steps a day...and maintain those boundaries to limit my level of stress.” P7 said, “I was able to transition very smoothly. They gave me opportunities to have more frequent breaks to prevent more stress on my system. They told me that I didn’t have to work the way that I was working before.” P7 added, “The experience I had with my colleagues was perfect...nonjudgmental and accommodating...They made me feel very comfortable. They reoriented me, offered themselves without making me feel I was a bother. I don’t think this is what happens in other places.” About working, P3 recalled thinking, “I was going back to work. Nothing can stop me. My colleagues were very supportive. Everyone was happy to see me. I stick to my routine and therapy.” P10 said, “I changed some things I do. I had to. But the outcome for the most part is almost the same.” P10 added, “My duties and schedules are all the same, but I always wonder what it would be like if I was still the same as before the stroke, but I

will never be able to know.” The majority of participants who discussed their return to work talked about necessary changes to their schedules, a reduction of overtime, or differences in the ways they handled stress.

Others had to adapt to what they perceived as negative work experiences following their stroke. For example, “People have mixed feeling about people who have stroke returning to work...I am not sure if there is any standard protocol regarding return to work for stroke victims. It was frustrating discussing the criteria for return to work.” P5 was disappointed with his work experience, saying, “Lost skills will come back, but a little assistance helps. I had to make a turnaround. My lifestyle changed...but at least I can do something. I believe, if I recovered this much, one day I can fully recover.” P6 said, “It is like people think that once one has a stroke, the person will not be able to work well, but my case has proved them wrong. But at that time, they could not tell.” P6 explained, “It seems the support wasn’t enough. If not for my stubbornness, I wouldn’t have returned to work because they want perfection. They want one to be fully back to the situation before the sickness and it isn’t possible.” P2 said, “I have to find something else I can do...I have to really search within myself to find the talents and things that I have.” P8 said, “It wasn’t as before the stroke. I tried to do well even when I feel weak.” Less than half the sample noted that the return to work was difficult and disappointing because of their coworkers’ or leaders’ attitudes and lack of supportive processes to facilitate a smoother transition.

Some of the participants felt that they prepared for their workdays differently, in part because of physical limitations following the stroke. For example, reported changes included grooming patterns and modes of transportation, such as not driving oneself to work and relying on others for help. P1 said, “It’s very frustrating to have to depend on people. I need somebody

to help me do everything.” P3 claimed, “Transportation was a difficulty.” P5 said, “I want to be independent, but I need assistance.” P6 said, “I used to start work at 8am before I got sick; now I start at 9:30 am.” P7 explained that the hardest part of transitioning back to work is, “Getting there - taking a bath and preparing myself and all of those things are difficult.” P8 said, “Getting to work is more difficult, and getting there on time is a challenge.” P10 said, “I do things a little differently now, but you just have to adapt and make it work however you possibly can...driving is much harder because of the pain I still have in my leg, but I do it anyway.” The majority of participants explained that the personal changes they made to work are not all pleasant or easy but are necessary to be able to keep working after their CVAs.

**Theme 5. The support of family and friends facilitated recovery and a return to work.** The majority of participants reported that family and/or friends were present at the time of the stroke or in the immediate aftermath and that their support helped them to accept the stroke, recover, rehabilitate, and feel positive about their return to work. Most participants emphasized the role of their families. For example, P1 credited, “my family and my kids” with the motivation to return to work. P2 said, “Friends and family – very supportive – they came every day.” P3 added, “Motivation, mood, and the support of my friends, and family made it easier to go back to work.” P10 said his primary support system was “family.” P5 said, “My family will put drinks, food, medicine and phone and radio around me so that I will have human sound around me.” P6 referred to, “family friends and church people. People were involved in my case. People really wanted to help me. Friends, family and immediate coworkers were amazing.” While the majority of the sample cited family in particular as a great support, several participants talked about faith and church as primary supports during recovery and after that.

Others emphasized the role of friends and colleagues in their recovery and return to work. For example, P3 said, “Old colleagues were my strength – to come to see me and help me to get back up and walk again. They would tell me I would walk again, and I developed that faith.” P7 said, “It was when a friend came to my home” that he started to pursue therapy and that “there were people that I did not have that kind of close relationship with before I got sick, but after the process, they became close to me. It was unbelievable.” P8 credited the “support of people” in her recovery and return to work. P4 talked about the support of “Colleagues - after they visited, I found zeal and energy. I’m happy I had them. They weren’t only there during the good times; they were there when things didn’t go well to support me. I’m happy I had them.” P10 said, “I didn’t see a lot of my coworkers right after the accident, but they reached out to me through Facebook and texts to wish me well and hope for my recovery and my return.” Not all participants had ongoing face-to-face contact with coworkers, but most felt supported by at least one or more coworkers through social media, telephone, texting, and other means.

**Theme 6. Little difference in coworker relationships followed a return to work.** The majority of participants reported little change in their relationships with coworkers after a return to work. While some of the participants shared that some coworkers acknowledged their stroke prior to returning to work, most participants did not feel they were treated differently after their return to work from a stroke. P1 said, “The first day back, people were a little bit concerned and they were trying to help ease me in. But pretty much after the first day, everything went back to the way it was.” P3 said, “My colleagues were very supportive. Everyone was happy to see me. I stick to my routine.” P7 said, “The experience I had with my colleagues was perfect...They really worked with me...My colleagues were not judgmental and accommodating.” P8 said, “The support is there from coworkers. They try to help as much as they can.” P10 shared, “My

coworkers were very happy to see me return and were supportive...It was nothing specific that they did other than be nice and kind and make me feel appreciated for my efforts.” Most participants returned to work without many changes in attitudes from others.

Others had less positive experiences and perceptions of coworkers’ attitudes towards them when they returned to work. For example, P2, who worked independently, explained, “if you can’t, you won’t be able to do your work, so that’s where I am – I am in limbo – work limbo.” P4 said, “I think some people wanted me to just sit home and not return to work. People have mixed feelings about people who have stroke returning to work.” P5 shared, “The thinking is if you’ve had a stroke, that’s it for you for work. It is now that I know that people can recover and go back to work. That was not the focus.” About his coworkers, P6 said, “They want you to be better but don’t want you at work. Really. I saw it with my eyes. I experienced it. It was so negative.” P6 added, “People think after stroke, the person will not be able to work well, but my case has proved them wrong.” Some of the participants in the study struggled to accept disappointing treatment from others when they returned to work.

**Theme 7. Returning to work was a welcome challenge that facilitated identity reconstruction and recovery.** The majority of participants felt that the opportunity to return to work facilitated their recovery. For example, P1 said, “When I was ready to go back to work, my strength returned.” P3 claimed that returning to work “helped me a lot and motivated me a lot.” P4 shared, “I am beginning to think that work helps with my recovery and all that. Even after returning to work, I continue to see myself get better. I could not believe what work did for me.” P7 said, “I loved my job. I love my profession. I love working. I think that going back to work helped me with recovery.” P8 explained, “Coming to work – I love being here, but I like the challenge. I am doing what I used to do and am better now at work...I was happier when I went



back to work.” P10 said, “Being able to return to work was scary but helpful to test myself and to see if I really could do it. I could regain some of my lost skills and continue to test my abilities.” Most of the participants felt that a return to work helped them recover more than they would if they just stayed home.

Those who had a more difficult time returning to work because of limitations due to health or the workplace expressed dissatisfaction with the lack of opportunities that impeded their full recovery. For example, P2 said, “It’s very frustrating and I’m a little bit angry because I can’t do what I want to do. I don’t know where to go next. It’s day by day.” P5 said, “Now that those physical symptoms are not so much there, I must tell you, if you are the type that has worked for years, stopping work abruptly can hurt one.” P6 said, “I was bent on getting better and I got better. When I went back to work, I don’t know what happened. People will react negatively...It was so negative.” A lack of perceived acceptance and support at work made it more difficult for some of the participants to feel as if work could help them in their recovery.

In both circumstances, the anticipation of a return to work, combined with the support of family, friends, and colleagues helped participants with the necessary identity reconstruction following the CVA events. Identity reconstruction was a necessary step for some of the participants. For example, P2 described her “work as it used to be” as “done” and talked about being in “work limbo.” She has had to “search within” in an effort to reconstruct her own vocational and personal identity. P10 also talked about his work as an integral part of his identity, saying, “I always thought about wanting to get into something else for work, but my job really does define me, as it has for years. It is something I’ve been doing for many, many years. It’s really who I am.” For P9, work gave her “joy” and she was “discouraged” having to reconstruct herself, which was “difficult.” For example, accepting part-time case work instead of

her previous full-time job required a reconstruction of identity as it changed with her role in the workplace.

**Theme 8. Belief in the concept of luck or faith surrounded recovery, but fear surrounds the future.** Having had a stroke at an early age, most of the participants said they were lucky or had faith in God's grace. For example, P1 said, "I consider myself very lucky...I have been lucky, I am doing well...I was very lucky as the symptoms were mild...I was extremely lucky because the infarct was very small and pretty much everything had returned." P3 shared, "I realized I was lucky in an unlucky way – to be alive and be able to go back to work and to help others." P4 felt, "lucky to be alive." P6 was driving at the time of the stroke and said, "Luckily, no serious injuries by God's grace." P7 recounted, "The emergency doctor said that it was by God's grace that it was not worse, that I was lucky I was able to survive." Faith was a common experience among participants. For example, P9 said, "My bishop called me one day and asked what I wanted the Lord to do for me. I said to recover my words. The next day, I started speaking fluently." P10 said, "I was really very lucky that it wasn't far worse." All of the participants were grateful that the CVA experiences had not harmed them more.

With some faith-based exceptions, there was a persistent sense of fear from the majority of the sample about the future. P1 struggles to "keep the right frame of mind" and he also worries about the "incidence of return of stroke." Worried about having another stroke, P1 said, "My fear is when I am gone, who is going to take care of my family and my kids. They are old enough to take care of themselves, but it would be better if I was still around." P3 said, "My fear was that I couldn't help myself...I feared the medication would dissolve the clot – I thought I would bleed to death...I went to go shopping and I was scared I would have another stroke." P8 said, "The constant fear of the sickness is my greatest challenge." P10 says, "I worry but also

feel helpless to really be able to control my future.” Faith and a belief in God helped many of the participants in the study to cope with their CVA experiences and to recover. Despite a faith in God and/or a positive outlook, there is still ongoing fear of a future CVA event, especially in light of the unexpected nature of the first CVA experienced at a relatively young age.

Fear of the future prompted further attention to their current health condition, lifestyle, and well-being to protect themselves from subsequent strokes, which would prevent a return to work in the future. There was a particular emphasis on change in diet by the majority of the participants in the study. For example, P1 said, “I am trying to watch my diet and doing the things that a good patient is supposed to do – keeping appointments with neurologist, cardiologist and pulmonologist.” P3 said, “My diet – I wanted something to eat like my cake and sweets – I couldn’t do that – it was very hard for me.” P2 talked about changes to her “diet and lifestyle.” P3 thought, “My diet had to change.” P5 said, “I have modified what I eat. I do not eat too much. I eat a little at a time.” P6 said, “I should watch my sugar to prevent it from getting high.” P10 said, “I know I need to do a better job of taking care of myself. If I have a few years ahead of me, I really want them to be the best that they can possibly be.” Most of the participants identified a change in diet as necessary to prevent future health problems. However, others mentioned adherence to medication regimes, compliance with medical orders, and a more active lifestyle as necessary to protect them from future CVA events.

## **Summary of Findings**

The research question for this study was: What are the experiences of professionals transitioning to work after an experience of CVAs? The individually constructed stories, together with the paradigmatic narrative analysis of data, revealed the answer to the research question. Eight major thematic findings that were common across participants' stories, derived from paradigmatic narrative analysis, indicated a general sense of good health or well-being preceding the stroke. Denial was the first experience immediately following the stroke, even after being diagnosed in the hospitals. Rehabilitation was a necessary process, but sometimes frustrating and generally lacked an emphasis on the return to work. There were necessary changes in work attitudes and behaviors so that participants felt the need to make following recovery and upon their return to work. Family and friends' support facilitated the recovery and was a source of encouragement that led them to a return to work. There was little difference in coworker relationships following a return to work with some noted exceptions. Returning to work was a welcome challenge that facilitated identity reconstruction and recovery for most of the participants. Belief in the concept of luck or faith surrounded recovery, but fear surrounds the future, as participants felt that they needed to keep making changes to prevent additional CVA events.

## **Chapter 5: Discussion and Conclusions**

Ten audio-recorded and transcribed interviews with full-time working adults who recovered from a CVA helped to answer the overarching research question: What are the experiences of professionals transitioning to work after the experience of CVAs? Narrative inquiry methods revealed the complexities of their human experiences to understand sense making within social, cultural, and historical contexts. Narrative analysis procedures revealed the constructed stories of individual participants, while the paradigmatic analysis of narratives involved the inductive and deductive identification of common themes across stories. This chapter includes a discussion of the results, in light of the conceptual framework and previously published findings. The chapter culminates in recommendations for leaders and suggestions for future research, leading to the conclusions drawn from the study.

### **Discussion of Findings**

This discussion of findings occurs in light of the conceptual framework and the previously reviewed literature that framed the study. The format for this discussion is based on each thematic finding from the paradigmatic analysis of narratives. Included is the address of how findings help improve understanding within related social, cultural, and historical contexts.

The first finding pertained to a general sense of good health or well-being preceding the stroke. The social cognitive theory suggests a close relationship between self-efficacy and wellness (Bandura, 1997). Self-efficacy would refer to the extent to which the person feels empowered to take action on one's well-being within the context of the environment. In this study, the majority of participants felt that they were taking actions to enhance health. However,

they also admitted that the steps taken were insufficient to protect themselves from future CVAs. Theories of grief are also relevant, as the individual who experiences a CVA also experiences a loss, which, according to Kubler-Ross (2014), begins with denial. With acceptance of the CVA event, participants shared the common sentiment that they needed to adhere to more optimal diet and lifestyle changes, including the reduction of stress and adherence to medical regimes to prevent future CVA events. Findings make sense in light of the historical and socio-cultural context that affects an individual's understanding that a CVA event is generally something that affects older people. Accordingly, denial was the first experience immediately following the stroke. Although age is strongly correlated with stroke prevalence, it affects younger professionals in growing numbers (American Heart Association, 2015).

Regarding rehabilitation, participants talked about therapy as a necessary but sometimes frustrating process that lacked an emphasis on the return to work. Results are consistent with previous findings by Wei et al. (2016), who noted that typical CVA rehabilitation is not necessarily associated with higher rates of return to work. Instead, specialized vocational rehabilitation may be necessary to help individuals who return to work after a CVA. Wei et al., like participants, did characterize typical CVA rehabilitation as not necessarily oriented toward a return to work but indirectly enhancing the probability that the individual who experiences a CVA will return to work. Nitsea et al. (2015) found that a specialized program geared toward helping CVA survivors return to the workplace helped successfully transition to the workplace. However, it was not only the specialized programs that the participants were offered or able to take part in that helped them return to the workplace, specifically.

Instead, participants had to discover what necessary changes in work attitudes and behaviors they needed to make following their recoveries. Findings are consistent with the Roy

Adaptation Model (Roy & Andrews, 1999) and Social Cognitive Theory (Bandura, 1997). Specifically, a person can respond to and engage with cognitive and environmental factors more effectively by changing behaviors and adaptations that revolve around self-concepts, the role functions, and interdependence. As previously noted, generally, the obstacles against the professional transitioning to work after stroke are holistic in that they affect multiple dimensions of the person and they must be addressed holistically, which would include making the necessary adjustments at work to enhance performance while reducing stress. Findings are consistent with previous reports that the patient must be aware that he or she is now at risk of a CVA and must thus take care and change one's lifestyle accordingly, including actions at work.

Findings in this study were that personal and social support through family and friends (including colleagues) facilitated recovery and return to work. The results are consistent with the Roy Adaptation Model because social and emotional support for the patient and family members can help relieve the general emotional stress of the situation. Social support would relate to the interdependence mode, the primary point being that the patient needs to avoid feeling isolated and alienated during the rehabilitation process (Roy & Andrews, 1999). According to Harrison et al. (2017), in the aftermath of a CVA, some of the most critical factors contributing to psychological adjustment are social support, peer support, and communication, which participants in this study claimed were critical to their successful recovery and return to work.

There were mixed findings about differences in coworker relationships following a return to work. While most participants reported little differences or positive treatment from coworkers when they returned to work, some of them reported negative experiences and feelings. Findings were consistent with the previously noted determination that, at the level of role function (Roy & Andrews, 1999), CVA survivors may be seen differently by other people, based on what people

at work may or may not know about the effects of a CVA. Stroke survivors may be seen as disabled and thus untrusted to fulfill previous professional duties. Educational materials could provide colleagues with information about the nature of CVAs, which might help them more effectively empathize and make reasonable accommodations if required (Morris, 2011).

The majority of participants considered returning to work as a welcome challenge that facilitated identity reconstruction and recovery. Viewed in light of previous findings, the results are consistent with the concept of *identity reconstruction*, which is affected by testing one's abilities, such as in the workplace (Glintborg & Krogh, 2015). Whitehead (2006) noted that identities seemed to settle as the patient adopted coping practices that worked for them, suggesting that identity reconstruction may be a matter of time, strongly influenced by patients' experiences, self-efficacy, and coping mechanisms. Findings are also consistent with the ideas expressed by Herbert, et al. (2016) that CVA recovery frequently involves making improvements over a time frame much longer than the few months that follow the event. The phases of the CVA rehabilitation process with the main adaptive modes of the Roy Adaptation Model starts with an acute care context; self-concept mode follows striving toward effective identity reconstruction, leading to role function mode when professionals apply strategies to the workplace successfully.

The majority of study participants expressed a belief in luck or faith as a reason they were able to work toward recovery but remained fearful about the future. As the Stroke Recovery Association (2019) highlighted, as a common consequence of stroke, patients "mourn the loss of their previous self...have many fears, uncertainties, and altered feelings about themselves, as well as experience losses in social activity, ponder questions about prospects, financial security, and returning to work" (para. 6). Glintborg and Krogh (2015) discussed the process of identity



reconstruction, which requires “acceptance of what is going to happen” in the future.

Acceptance involves grasping the event and the idea that the event could potentially have long-term consequences for life. The experiences were pertinent to social, cultural, and historical contexts. The participants acknowledged that they needed to make changes to the lifestyle, which has socio-cultural origins, and that based on their history of a CVA, another event is possible or even likely.

### **Recommendations for Leaders**

Based on the findings from this study, there are some recommendations for leaders. Leaders who can act on the conclusions of this study include medical professionals, employers, and those in society. The recommendations for leaders follow the format of the findings from this study.

Participants expressed a general sense of good health or well-being preceding the stroke. Denial was the first reaction immediately following the stroke, even after being diagnosed in the hospitals. Socio-cultural and historical contexts shaped the beliefs of participants. There was an enduring belief among the sample that although there may have been some risk factors, they were aware of healthy choices and were too young to have a CVA. Medical professionals can better emphasize the prevalence of CVA among younger patients. They can impress upon those patients the importance of adhering to medication and care regimes, optimal dietary choices, and the effects of exercise in preventing CVA events. Workplace leaders can also become aware of the possibilities of CVA among the workforce and emphasize the importance of healthy work habits, including taking breaks, engaging in sufficient exercise programs, and reducing stress.

Although rehabilitation was a necessary process, according to participants, it was sometimes frustrating and generally lacked an emphasis on the return to work. Participants perceived a lack of procedures or protocols for younger individuals who experience a CVA who wished to return to work. Leaders in healthcare can emphasize occupational and vocational therapy that assists these individuals in their return to work. Although traditional therapy and rehabilitation helped participants in this study regain losses and eventually return to work, a specialized program that focused on workplace rehabilitation would be beneficial. In addition, several participants encountered insurance issues and other obstacles to their rehabilitation and recovery. More structured processes and protocols for recovering working-aged individuals who experience a CVA could help alleviate stress, aid in recovery, and help patients make a timely and smooth transition back to work.

Returning to work was a welcome challenge that facilitated identity reconstruction and recovery for most of the participants. There were necessary changes in work attitudes and behaviors that participants felt the need to make following recovery and upon their return to work. In addition, there were mixed findings of differences in coworker relationships following a return to work. Healthcare and rehabilitation leaders can prepare individuals who experience a CVA for the possibilities that they may encounter these changes upon a return to work. Workplace leaders can also help to educate and equip others in the workforce with educational materials that could help them understand the experiences and needs of individuals who experience a CVA and are attempting to return to work. Educational materials would provide the stroke patient's colleagues with information about the nature of CVAs, which would help them more effectively empathize with the patient and make reasonable accommodations if required (Morris, 2011).

Family and friend's support facilitated recovery and was a source of encouragement that led them to a return to work. Social support would relate to the interdependence mode, as the patient needs to avoid feeling isolated and alienated during the rehabilitation process. Family members, caregivers, and in general people who work or live with the stroke patient could benefit by educational interventions regarding the nature of a CVA and how they can help patients overcome the multifaceted array of symptoms (Padberg et al., 2016). In this context, the nurse should do everything possible to provide social and emotional support for the patient and family members and to relieve the general emotional stress of the situation. An intervention proposed could be designing and developing an awareness program of stroke recovery within the workplace and providing emotional support for family members and caregivers of the professional affected by CVAs. An important step would be for nurses and nurse leaders to evaluate the individual patient across all modes of adaptation to determine what specific support any given patient may need.

Belief in luck or faith surrounded the recovery, but fear surrounds the future, as participants felt that they needed to keep making changes to prevent additional CVA events. There is a general cultural expectation that older adults are more likely to experience a medical event such as a CVA eventually. However, the younger individual who experiences a CVA becomes even more acutely aware of their vulnerability and the dangers that lifestyle, behaviors, and human weaknesses may pose. By remaining aware of the profound struggles of others and one's relatively good fortune, the individual who experiences a CVA can maintain a relatively stable self-concept and remain optimistic about the prospects of successful rehabilitation. The younger individual who experiences a CVA becomes more acutely aware of the need to be proactive in health maintenance and prevention. By receiving useful information, the patient can

develop a sense of self-efficacy and address the physical, cognitive, psychological, and socio-cultural factors that may prevent optimal adjustment in the aftermath of a CVA.

### **Suggestions for Future Research**

Additional research could help to illuminate some of the aspects of participants' stories that could inform improvements to leadership and healthcare programs. A general sense of good health or well-being preceding the stroke and denial was the first experience immediately following the stroke. Qualitative research could focus more on the experience or phenomenon of the stroke, and the meaning of those experiences to the sense making in participants' lives. The focus could be in the stages of grief, as experienced in the aftermath of the CVA. Belief in luck or faith surrounded the recovery, but fear surrounds the future, as participants felt that they needed to keep making changes to prevent additional CVA events. A study focused on the social and behavioral adaptations of working-aged individuals who experience CVAs could help to complete an understanding of those experiences.

Additional research could focus on rehabilitation and therapy, specifically as a means to return to work. Comparisons of vocational and occupational rehabilitation approach, and the availability of these services to recovering individuals who experience CVAs, could be helpful to inform leaders on how to improve rehabilitation services for those patients who intend to return to work. Some of the participants described generally negative experiences with therapists who discouraged them from returning to work. Accordingly, research into rehabilitation therapists' attitudes and approaches toward younger individuals who experience CVAs could reveal insights into how to address possible misconceptions of therapists serving the younger age groups.

A study that focuses explicitly on necessary changes in work attitudes and behaviors of individuals recovering from CVAs who are returning to work could help to inform leaders about ways to improve workplace experiences. Similarly, a study to capture colleagues' attitudes, experiences, and perceptions could reveal insights that could help shape effective educational interventions in the workplace. Returning to work was a welcome challenge that facilitated recovery and identity reconstruction for most participants; a study that focuses on the specific reasons that returning to work facilitated recovery could fill a related gap in the body of knowledge.

Family and friends' support facilitated recovery and was a source of encouragement that led them to a return to work. There was also little difference in coworker relationships following a return to work, with some noted exceptions. Additional survey research into the attitudes, opinions, and understanding of others about CVA events could reveal insights into the degree to which people may hold inaccurate beliefs or subscribe to myths or misunderstandings. Cultivating a support system for individuals in recovery from CVAs requires correcting fallacies in thinking based on sociocultural contexts and norms of understanding. Surveying patients about the nature and degree of support they perceive as ideal could inform others how to optimally support them.

## **Limitations**

There were some limitations in the study, which further research could help to address. The sample was mostly composed of a single racial category (Black) and had a majority of males. A study to compare the differences one might experience based on demographics could be revealing. In addition, the sample was from the New York area. A repeat study in different

locations could help to establish a more universal understanding of the experiences with recovery and return to work of individuals who experience CVAs. A focus on distinct types of industries, workplaces, and particular types of jobs and even coworkers could help to fill gaps in the general body of knowledge related to an individual's return to the workplace following a CVA. A research of people that suffered multiple incidents of stroke and their experiences with returning to work can reveal insights different from those with single stroke incidents.

## **Conclusion**

This research study was a narrative inquiry into the psychological adjustment of professionals transitioning to work after a CVA, commonly known as a stroke. The results led to greater insight into those experiences related to the adjustments of professionals who returned to work after a stroke, following some level of rehabilitation. This study helped to fill a gap in the body of literature; because stroke research predominantly addresses older adults, there has not been enough information on the experience of affected working-age professionals. Adding to the significance of this study was its application to theory, using the Roy Adaptation Model and Social Cognitive Theory as frameworks for the study. The data collected from audio-recorded and transcribed interviews using open-ended questions led to a collection of personal stories from a sample of 10 post-CVA professionals. The data analysis involved the steps of the paradigmatic narrative analysis approach, leading to the report of both the constructed stories of participants and eight major thematic events experienced and shared by the majority of the sample. The reported experiences were unique to the individuals in the sample such that the goal was to report findings as a rich insight into the experiences that could help to inform others, including those in healthcare. Results are not generalizable but can help guide others in the

directions for future research and knowledge advancement. Accordingly, this narrative inquiry led to recommendations for leaders and suggestions for future research.

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## Appendix A

### Interview Protocol

**Greeting:** “Thank you for agreeing to participate in this interview. I know you signed the informed consent terms, were assigned a pseudonym for the purposes of this research, and are aware that this interview will be audio recorded and transcribed. Did you have any other questions or concerns before we begin?”

**Questions:** “I will begin to record us now and then will ask the first question.” Ask all questions and follow-up answers with additional probing or clarifying questions as necessary and appropriate in response to answers.

### Demographic Data:

1. What is your age?
2. What is your gender?
3. What is your ethnic background?
4. What is your highest level of education?
5. What is your profession?
6. When did you have the stroke?
7. How long were you in this profession before your stroke?
8. Were you working full-time or part-time?
9. When did you return to work?
10. Did you have any rehabilitation services since after the stroke?
11. How did the nature of your work change following your stroke?

## **Interview Questions**

1. Please tell me your story about your experience with stroke. (Note: Additional prompts, clarifications, and probative question areas can include: Tell me about the job you had, the experience of stroke itself, and the recovery process, up to and including transitioning back to work.)
2. What specific factors, if any, have made your rehabilitation experience and return to work easier?
3. What specific factors, if any, have made your rehabilitation experience and return to work more difficult?

**Conclusions:** “Thank you for your time in participating in this study. Your story has represented a great contribution to this research but will only be identified by your assigned pseudonym. I am wishing you the very best in all of your personal and professional endeavors.”

## Appendix B

### Informed Consent



Barbara Hagan School of Nursing

Rockville Centre, NY 11570

516 323 3652

#### **Title of Study:**

“A Narrative Analysis of the Psychological Adjustment of Professionals Transitioning to Work Following Cerebral Vascular Accident”

**This study is being conducted by: Mabel Munachiso Korie** (telephone 516-270-7577, email [mkorie@lions.molloy.edu](mailto:mkorie@lions.molloy.edu)), **under the direction of** Committee Chairperson, Dr. Denise Walsh.

#### **Key Information about this Study**

**This consent form is designed to inform you about the study you are being asked to participate in. Here you will find a brief summary about the study; however you can find more detailed information later on in the form.**



The purpose of this study is to provide an analysis of the professional's experience and psychological adjustment towards returning to work. Eligibility for participation in this study is prior experience as a full-time working professional, diagnosed with cerebral vascular accident (stroke) and who are attempting to go back to work or went back to work in the past 5 years. If you agree to participate, we will meet in person or over the telephone for approximately one hour, when you will share your experience of diagnosis and going back to work and/or attempt to go back to work. Your identity will be kept confidential; although interviews will be audio-recorded and transcribed, there will be no identifying information accompanying your interview data and data will later be permanently destroyed. There are no financial or tangible incentives or compensation for participation in this study, and you may decline to participate or may withdraw from the study at any time without any penalty or consequences.

### **Why am I being asked to take part in this study?**

You are being asked to participate in this study because you may meet the eligibility requirements to become a confidential research informant who can be helpful to fill a gap in knowledge about working professionals' experiences with strokes. Eligibility for participation in this study is prior experience as a full-time working professional, including but not limited to nurse, teacher, lawyer, social worker, and banker, among other professions requiring higher education and/or professional licensure. Following work in the profession, eligible participants will be individuals diagnosed with cerebral vascular accident (stroke) and who are attempting to go back to work or went back to work in the past 5 years.

### **What will I be asked to do?**

If you agree to participate, you will be asked to meet in person or over the telephone for an interview, which would last approximately one hour. The interview included your discussion of

your experience of diagnosis and going back to work and/or attempt to go back to work. A set of interview questions are intended to enable you to share your personal story with work, stroke, and recovery, which will be recorded and transcribed into a written narrative.

**Where is the study going to take place, and how long will it take?**

If you agree to participate, we will meet in person or via the telephone at a mutually agreeable time and private quiet place for approximately one hour.

**What are the risks and discomforts?**

It is not possible to identify all potential risks in research; however, there should be no discomforts, risks, or harm, other than that which might be experienced through the normal course of daily living, such as being on the telephone or sitting or standing while talking for approximately one hour. It is possible that recalling difficult experiences might lead to feelings of discomfort, and interviews can be terminated at any time in the event of any such discomforts.

**What are the expected benefits of this research?**

There are no financial or tangible incentives or compensation for participation in this study, which is completely voluntary. However, this information may help other professionals going through the process of returning to work. It may help professionals in developing coping strategies to deal with the aftermath of stroke. Your participation in the research will be of great importance to assist in social change in ensuring that our professionals receive adequate and effective care by supporting them through their endeavor to return to work.

**Do I have to take part in this study?**

Your participation in this research is your choice. If you decide to participate in the study, you may change your mind and stop participating at any time without penalty or loss of benefits to which you are already entitled.

**What are the alternatives to being in this study?**

**Instead of being in this research, you may choose not to participate.** You may withdraw from the study at any time and there are no consequences or penalties for choosing not to participate or for withdrawing from the study.

**Who will have access to my information?**

There will be no identifiable information or biospecimens collected during the course of the research and no personal information or physical specimens will be available to any other person at any time.

**Certificate of Confidentiality**

The Department of Health and Human Services (HHS) has issued a Certificate of Confidentiality to further protect your privacy. With this Certificate, the investigators may not disclose research information that may identify you in any Federal, State, or local civil, criminal, administrative, legislative, or other proceedings, unless you have consented for this use. Research information protected by this Certificate cannot be disclosed to anyone else who is not connected with the research unless:

1. there is a law that requires disclosure (such as to report child abuse or communicable diseases but not for legal proceedings);

2. you have consented to the disclosure, including for your medical treatment; or
3. the research information is used for other scientific research, as allowed by federal regulations protecting research subjects.

You should understand that a Confidentiality Certificate does not prevent you or a member of your family from voluntarily releasing information about yourself or your involvement in this research. If you want your research information released to an insurer, medical care provider, or any other person not connected with the research, you must provide consent to allow the researchers to release it. This means that you and your family must also actively protect your own privacy.

Finally, you should understand that the investigator is not prevented from taking steps, including reporting to authorities, to prevent serious harm to yourself or others.

### **How will my [information/biospecimens] be used?**

There will be no identifiable private information and/or identifiable collected nor will any information collected be used for future research studies or distributed to another investigator for future research studies without additional informed consent. Data will be not be shared with databases.

Your identity will be kept confidential, although interviews will be audio-recorded and transcribed. There will be no identifying information accompanying your interview data. No person will be able to link your interview answers with your identity and published accounts of your stories will be through the use of pseudonym, such as P1 (which would stand for participant number one). Although there will be no way to link your identity to your data, data will be maintained initially on a password protected computer, and then downloaded to an external drive

and stored for a period of 3 years in a locked cabinet, after which time it will be permanently destroyed. I am the only person who will have access to the password for the computer and the key to the locked cabinet in my own home.

**To ensure that this research activity is being conducted properly, Molloy College's Institutional Review Board (IRB), whose members are responsible for the protection of human subjects' rights for all Molloy-approved research protocols, have the right to review study records, but confidentiality will be maintained as allowed by law.**

**Can my participation in the study end early?**

If you decide to end your participation in the study, your request to withdraw (in person, via telephone, electronic or regular mail) will be immediately accepted and no data collected prior to the end of the study will be included in the data used for subsequent analysis.

**Will I receive any compensation for participating in the study?**

There are no monetary or other compensation/incentives for participating.

**What happens if I am injured because of the study?**

If you are injured during the course of this study, you should seek immediate medical treatment from your primary provider or at an emergency care facility. Also, contact the researcher at 516 270 7577. Payment for any medical treatment must be provided by you and your third party payer (such as health insurance or Medicaid). This does not mean that you are releasing or

waiving any legal right you might have against the researcher or Molloy College as a results of you participation in this research.

**What if I have questions?**

Before you decide whether you'd like to participate in this study, please ask any questions that come to mind now. Later, if you have questions about the study, you can contact Mabel Munachiso Korie at 516 270 7577 or email [mkorie@lions.molloy.edu](mailto:mkorie@lions.molloy.edu)

**What are my rights as a research participant?**

You have rights as a research participant. All research with human participants is reviewed by a committee called the *Institutional Review Board (IRB)* which works to protect your rights and welfare.

**If you have questions about your rights, an unresolved question, a concern or complaint about this research you may contact the IRB contact the Molloy IRB office at [irb@molloy.edu](mailto:irb@molloy.edu) or call 516 323 3000.**

**Documentation of Informed Consent\*:**

**You are freely making a decision regarding involvement in this research study. Signing this form means that**

- 1. You have read and understood this consent form**
- 2. You have had your questions answered, and**
- 3. After sufficient time to make your choice, you have decided to be in the study**

**4. You consent to the audio recording and transcription of your interview answers.**

**You will be given a copy of this consent form to keep.**

\_\_\_\_\_

Your signature

\_\_\_\_\_

Date

\_\_\_\_\_

Your printed name

\_\_\_\_\_

Date

\_\_\_\_\_ Mkorie \_\_\_\_\_

Signature of researcher explaining study

\_\_\_\_\_ 11/18/19 \_\_\_\_\_

Date

\_\_\_\_\_ MABEL KORIE \_\_\_\_\_

Printed name of researcher explaining study





## Appendix D

### Transcriptionist Confidentiality Form

This confidentiality form is to verify each transcriptionist hired for this study will agree to maintain confidentiality of the participants and their data before and throughout the transcription phase of this study.

I am aware that the information contained in each study transcript belongs to the primary investigator of this study, Mabel Munachiso Korie MS, RN, PhD(c). I am also aware that privacy and confidentiality of this study will be maintained by me during and after the transcription phase of these interviews.

Researcher Signature: \_\_\_\_\_

Transcriptionist Signature: \_\_\_\_\_

Transcriptionist Name (Print): \_\_\_\_\_

Date: \_\_\_\_\_

## Appendix E

### IRB Review



**Institutional Review Board**  
1000 Hempstead Avenue  
Rockville Centre, NY 11571  
[www.molloy.edu](http://www.molloy.edu)

Tel. 516.323.3711

**Date:** December 11, 2019  
**To:** Dr. Denise Walsh and Mabel Korie  
**From:** Patricia Eckardt, Ph.D., RN, FAAN  
Chair, Molloy College Institutional Review Board

**SUBJECT: MOLLOY IRB REVIEW AND DETERMINATION OF EXEMPT STATUS**  
**Study Title: A narrative analysis of psychological adjustments of professionals transitioning to work following cerebral vascular accidents.**

**Approved: December 11, 2019**  
**Approval No: 13111518-1211**

Dear Dr. Walsh and Ms. Korie:

The Institutional Review Board (IRB) of Molloy College has reviewed the above-mentioned research proposal and determined that this proposal is exempt.

It is considered an **EXEMPT category 45 CFR 46.104(2)(2)** per the requirements of Department of Health and Human Services (DHHS) regulations for the protection of human subjects.

As per **45 CFR 46.115(b)** and **21 CFR 56.115(b)** require that all IRB records be retained for at least 3 years, and records relating to research which is conducted be retained for at least 3 years after completion of the research.

Please note that as Principal Investigator (PI), it is your responsibility to be CITI Certified in both the Responsible Conduct of Research and Human Subjects Research and to submit the evidence in order to conduct your research.

Remember, all consents and recruitment flyers for any research protocol need to have Molloy IRB dated stamps of approval. To obtain the official stamp, please contact Ms. Gina Nedelka ([gnedelka@molloy.edu](mailto:gnedelka@molloy.edu)) to arrange a time to meet with her in her office in Kellenberg-Room 009. You will bring one clean consent (of each consent and/or assent) and any recruitment flyers to the meeting with Ms. Nedelka for IRB dated stamp of approval. You then make copies of stamped materials and use those copies for recruiting and consenting.

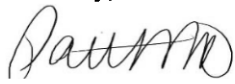
You may proceed with your research. Please submit a report to the committee at the conclusion of your project.

This acknowledgement expires within three years- unless there is a change to the protocol.

However, the IRB requires an annual ongoing report of your exempt protocol (the application for ongoing/continuing review) is available on the IRB webpage.

If there is a proposed change to the protocol, it is the responsibility of the Principal Investigator to inform the Molloy College IRB of any requested changes before implementation. A change in the research may change the project from EXEMPT status and requires prior communication with the IRB.

Sincerely,

A handwritten signature in black ink, appearing to read 'Patricia Eckardt', written in a cursive style.

Patricia Eckardt, Ph.D., RN