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NARRATING THE NEURALLY-DISRUPTED SELF: BRAIN, SELF, AND SOCIETY  
IN THE ATTRIBUTION OF DYSREGULATED ANGER

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## ABSTRACT OF THE DISSERTATION

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Dysregulated Anger

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We live in a time of all things “neuro-.” Images of PET-scanned brains grace the pages of popular magazines, terms like *neuroplasticity* are in common use, and theories of the brain’s central role in everything from relationship difficulties to political identity to crime rates abound. Yet even as neuroscience’s jurisdiction over different facets of our lives expands, we know very little about how we actually relate to our brains in the context of the neurotechnologies and neurodiscourses all around us. To address this, I focused on people who have experienced a sudden change to their brain, followed by distressing emotional changes: a situation in which questions of who one is in relation to one’s brain are forced to the foreground. Through in-depth interviews, a diary study, and analysis of published memoirs, I investigated how people construct a sense of the relationships between brains, bodies, selves, and others in the ways they talk about their brain injury and the emotional disruptions that have followed it. The research supports the hypothesis that brain injury and post-brain-injury anger represent threats to selfhood in our present cultural climate, but it also shows that people have a diverse set of tools for

navigating these threats in ways that can protect their own and others' view of them.

Moreover, some people's ways of asserting their personhood in the midst of this crisis point the way, I argue, toward a new cultural ethos of interdependence as an alternative to the neoliberal imperatives of rationality and self-management encoded in dominant neurodiscourses.

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## Chapter 1: Introduction

Sociologists have described many strategies by which individuals maintain or reconstruct a sense of self when their embodiment is disrupted by illness or disablement (e.g. Beard 2016; Frank 1995; Williams 1984). But what happens to selfhood when the *brain* intrudes upon awareness as a troubled and troubling organ? Brain injuries are experiences that abruptly foreground “the ghost in the machine” as something rooted in physical substance and subject to damage. While it is certainly possible to survive a brain injury without feeling or being seen by others as damaged or seriously changed, many people report feeling deeply different after the injury. Some changes—such as partial paralysis, foot drop, and other primarily physical effects—are not unlike those brought about by many other illnesses, injuries, or disablements. Other effects—such as memory deficits, slowed processing speed, shortened attention spans, and a host of other primarily cognitive effects—are rather unique to brain injury. As deeply troubling and troublesome as these physical or cognitive changes can be, they are like the effects of other illnesses and injuries in that they are identifiable with expert assistance, measurable, and locatable at the level of abilities. Here, I argue that where the experience of brain injury truly exceeds other experiences of illness and injury is in its socioemotional effects: changes that alter a person’s way of *being* in the world, and which can *potentially but never definitively* be traced to material damage to the brain. How does this uncertainty impact the selfhood of the injured individual in a cultural context wherein the brain may be synecdochal for the self? Sociologists have addressed selfhood in situations of emotional disorder (Karp 2006; Weiner 2011) and degenerative neurological conditions such as

Alzheimer's (Beard 2016; Strohminger and Nichols 2015). But we have not yet taken a narrative approach to people experiencing emotional disorder after a brain injury—a sudden, identifiable insult to the material brain, from which one expects and is expected to recover—and I argue that there is something uniquely illuminating at this intersection of experience: an attributional complication wherein one is caught between claiming problematic emotions and claiming a damaged brain. As brain-injured people and their families negotiate over the possible causes, meanings, and solutions to the socioemotional disruptions that follow a brain injury, they reveal valuable knowledge not only about what it is like to live with a brain injury, but also about the ways it is possible to think about selfhood and the material body in a time when the brain is believed to be the engine of our identity and source of our personhood.

Of the many socioemotional sequelae of brain injury, *anger* stands out as deserving of greater attention. In everyday life, anger—“the ‘central emotional enemy’ for contemporary Americans” (Thoits 1989:335)—demands attention and carries potential for social disruption. And problematic anger is common after a brain injury: 31 to 64% of injured people experience anger that has become more frequent, intense, unpredictable, or sudden in onset (Demark and Gemeinhardt 2001; Lezak and O'Brien 1988). Such changes in the experience or expression of anger carry additional potential for disruption of selfhood, as *abrupt inversions* of the taken-for-granted, stably-“recovered” or progressively-“recovering” (Nochi 2000) self lead to the confusing and contentious aftermath of interpersonal accounting for an episode of anger: where the anger originates, what it means within relationships, and who is responsible for its control (see Thoits 1989; Turner and Stets 2005 on anger as a social signal). Among these

uncertainties, narratives are produced, and in these narrative accounts we can see negotiation of questions of agency, selfhood, sociality, and the meaning of the material brain.

Using data from multiple sources—memoirs of brain injury, and semi-structured interviews accompanied by a diary study—I analyze accounts of post-brain-injury anger made by injured people and caregivers. The stakes of these accounts are personal: each carries notions of causality and responsibility (Orbuch 1997); each is a set of attributions and an indication of work to be undertaken by the party or parties framed as responsible. But cultural discourses of brain, self, and society are also at stake. As theorists of their own condition, people dealing with brain injury must negotiate questions of identity, selfhood, embodiment, emotion, brain, and mind. As “ethical pioneers” (Rose and Novas 2005) telling stories of disruption in any or all of these domains, they have the opportunity to reinterpret or challenge hegemonic discourses of “life itself” (Rose 2001). In their narratives, I have found resistance to the notion that one’s injured brain has as much power to affect selfhood as the discourse of “brainhood” entails, narrative experimentation with alternative configurations of the brain-self-society relationship, and interaction with key components of neoliberal selfhood, including autonomy, personal responsibility, and emotional control. I show that sufferers’ uses of various narrative strategies and discourses in their accounts of troublesome anger can teach us something about how it is possible to think of the self and its social relations in the neuroscientific era.

In this chapter, I will first outline the phenomenon of post-brain-injury anger. I show how it is particularly likely to call forth accounts, and I review the literature on

narratives of disruption in order to show how post-brain-injury anger complicates the avenues of accounting we might expect injured people to take. I then discuss the way in which neurocultures and neurodiscourses complicate this work still further and conclude with an overview of the dissertation's chapters.

### **A Primer on the Phenomenon of Post-Brain-Injury Anger**

Millions of people live with the disabling effects of brain injury, from veterans coping with the invisible disability of a blast injury, to abused women whose rate of brain injury has only recently begun to be tracked, to the children and athletes whose coaches and families are demanding better protection on playing fields. Cognitive, physical, emotional, and social consequences may not correspond neatly to the region or extent of the injury; they may interact with each other and with pre-existing traits, and among these entanglements, even the most impactful consequences of brain injury may elude diagnostic efforts. While neuroscientists develop ever more sensitive technologies and treatments, brain injury remains a frustratingly underdiagnosed, undertreated, poorly understood condition, and the evidence suggests that socioemotional effects such as dysregulated anger are some of the most slippery to diagnose and difficult to treat (see Hart et al. 2012).

The distinctions between anger, irritability, and aggression are not entirely clear, and statistics on post-brain-injury anger are scarce, but the research clearly shows that anger which increases in frequency, intensity, or suddenness of onset is a common consequence of brain injury (Demark and Gemeinhardt 2002; Lezak and O'Brien 1988). In a prospective study of people with traumatic brain injury and matched controls who

had suffered other kinds of bodily trauma, Dikmen et al. (2010) found that while temper and irritability were reported almost equally by both groups at one month post-injury, these symptoms were less frequent in the non-brain-injury group at one year, whereas reports of irritability declined only slightly and reports of temper actually increased for people with brain injury. Temper and irritability were two of the three problems most likely to arise as a newly-reported symptom between the one month and one year point for people with brain injury. Hart et al. (2012) contend that post-brain-injury anger may differ from other neurobehavioral symptoms in that it worsens over time, and Corrigan, Whiteneck, and Mellick (2004) found that managing emotional upsets and controlling temper were two of the top three areas in which people with traumatic brain injuries felt they still needed more help at the one year mark after a traumatic brain injury (TBI). Lezak and O'Brien (1988) found rates of moderate or severe anger ranging from 39% to 64% over the first five years post-TBI, and Demark and Gemeinhardt (2002) found reports of anger in up to 36% of injured people and reports of irritability in 39-71%, in their review of the rehabilitation literature on acquired brain injury (ABI: a category including injury by stroke, tumor, or illness as well as by head injury). In sum, anger problems are likely to arise in the first year following a traumatic brain injury, to remain among the top three problems for which people feel they still need more help one year after their injury, and to worsen over time.

The causes of post-brain-injury anger can be as difficult to distinguish as its manifestations. Miller (1990) argues that anger episodes can arise directly from seizure-like activity, indirectly via a lowered tolerance for frustration or provocation, or from some combination of these factors. Neuropsychological symptoms such as motivational

deficits, impulsivity, or impaired problem-solving can intersect in ways that elicit uncharacteristic anger, or they can expose a pre-injury disposition toward anger. While we know something of the physiological correlates of each of these variants of anger (see Demark and Gemeinhardt 2002 for an overview), Miller points out that many cases are too causally complex to be categorized as one type. There is no scan or test that can distinguish among these causes, or even between anger that arises from one of these causes or from more ordinary provocations that could be managed in ordinary ways.

Anger that continually disrupts the lives of injured people and those around them poses serious problems for identity and social belonging. It can disrupt social relationships, compromise role performance, and threaten an injured person's view of herself or others' views of her as a person who is fully recovered or on a steady upward trajectory of recovery (see Nochi 2000 on the importance of recovery identities). It can even put overall recovery at risk, as outbursts of anger may disqualify a person from some rehabilitation programs (Hart et al. 2012) or isolate them from the support network they would need to access treatment. Yet post-brain-injury anger is exceptionally difficult to account for. As this excerpt from Geo Gosling's memoir *TBI Purgatory* suggests, it differs substantially in several ways—its pacing, provocation, and extent—from what we think of as ordinary anger:

*I would go from being happy, relaxed, and mellow, to being absolutely furious in the blink of an eye. I skipped being annoyed, upset, a little angry, or even mad, and went straight to homicidally furious. [...] Whenever someone or something upset me, I could literally feel anger growing inside of me, and it grew by leaps and bounds until I was all consumed by it. [...] There is no word in the English language that even comes close to describing how angry I was. So I made up my own word: FURIADAGE. It's FURIOUS + MAD + rAGE. I was furiadage 99.99% of the time. (Gosling 2010:29)*

Gosling thus describes the need to invent new language to try to communicate the extreme nature of his experience, while the contradictory elements of the passage—“in the blink of an eye,” “growing,” “by leaps and bounds,”—suggest that his anger continues to elude description. The practical question of how others can comprehend and respond to an anger that exceeds the bounds of language arises.

### **Bodily Disruption and the Narrative Response**

When scholars have addressed the narration of selfhood by people with traumatic brain injuries, they have tended to focus on coping and adjustment, for the valuable rehabilitation purpose of inquiring into what makes a successful coping narrative. Toward this end, researchers with narrative interests have predefined and selected well-adjusted participants (e.g. Nochi 2000), focused explicitly on strengths to counter the medical focus on deficits (e.g. Lorenz 2010b), or assessed the degree to which participants approach very specific qualities known to be eufunctional (e.g. Biderman et al. 2006). Other studies address the narration of selfhood in situations of emotional disorder (e.g. Karp 2006, Weiner 2011), but I know of no study that takes a narrative approach to people experiencing disrupted, disruptive emotionality after a brain injury. Here, I outline the factors that show how this exceeds the experience of other bodily disruptions, and therefore, the existing literature on the narrative management of disruption.

#### *A Brief Phenomenology of Bodily Disruption*

Leder (1990) argues that among all the bodily organs, the brain is phenomenologically unique in the extent to which it must “disappear” from awareness in

order for us to function as fluently embodied selves. When the action of *any* organ is significantly disrupted, or even called into question, that aspect of the material body—normally *absent* from our awareness—becomes disturbingly *present* for the sufferer. This exposes the body's delicate balance of presences and absences and replaces the unconsidered "I can" of the agentic body-self with limiting experiences of "I cannot," forcing the sufferer to recognize her material body as resistant to her command. For many organs, this experience is localized to the part in question. But the brain is the ground of all actions and perceptions, diffused throughout the body, implicated in every perception, emotion, and volitional act, yet resistant to control and supremely inaccessible to awareness. When this most necessarily absent organ becomes problematically present, the self is revealed as founded on an illusion of volition and control. Our working resolution to the problems of the body (Frank 1995) is disrupted at a profound level. In narrative terms, the standard story of the self, featuring an unproblematically agentic "I" (see Tilly 2002), is challenged by forces and presences previously unknown or unattended-to. When attention is called to the brain as potentially implicated in a serious socioemotional disruption like outbursts of anger, we can expect this inward turning of awareness toward the least accessible organ to disrupt brain-injured people's sense of self, and this disruption to reveal itself in their narratives.

According to Leder, the self can only extend into the world as an agentic presence when certain parts and functions of its body and environment are absent from awareness: to constantly think of the neurons that fire and muscle fibers that twitch in order for us to move, of the organs' constant labor toward homeostasis, would turn our attention inward, invert the foreground and background of experience, disrupt our intentionality, impede

intercorporeal communion with others, and restrict our ability to be present as actors in the world. This inward-turning is precisely what a bodily disruption can do to us.

Leder argues the experience of pain, disablement, or other bodily disruption replaces the unconsidered “I can” of the agentic body-self with localized and limiting experiences of “I cannot.” This “I cannot” has two senses. First, certain actions are impossible or forbidden by the nature of the bodily problem, a distressing experience well-documented by scholars of illness experience (e.g. Charmaz 1991; Toombs 1998). Second, the pain or incapacity originates from a place that a sufferer is forced to recognize as resistant to her command. *Uncontrollable absences* in the body-world now obtrude on awareness as *uncontrolled presences*: disrupting intention, turning attention inward, constricting time and space to the problematic here and now, revealing the self as founded on an illusion of volition and control. An organ that fails to perform as usual or to recede from awareness threatens our sense of self, our working resolution to the problems of the body (Frank 1995), by upsetting and *exposing* the body’s delicate balance of presences and absences. The self’s stage teems with actors, crowding out the previously relatively unproblematically agentic “I”. The standard story of the self is disrupted, challenged by forces and presences previously unknown (see Tilly 2002).

### *Narrative Management of Disruption*

Although Bury’s original, influential work on chronic illness as biographical disruption has been criticized as well as elaborated over the years, it links the literature from narrative studies with the literature from medical sociology, and I therefore use it as a framework for this review. Bury (1982) claimed that serious chronic conditions disrupt

a sufferer's life in three key ways, and that each disruption spurs the narrative project.

**First:** as attempts to normalize and naturalize troubling sensations fail, previously taken-for-granted parts of the body intrude first on the sufferer's and then on others' consciousnesses. The body becomes an object and a problem; troublesome body parts and experiences take center stage and demand a new script. The story of "what is going on here" (169) must be reassessed and revised, both to indicate the way forward and to tame the terrible uncertainty brought about by the "threatening and seemingly arbitrary events" (175) striking at the body. This revision is not as simple as adopting a medical explanation: to do so, the symptoms must be recognized as matching one of medicine's multiple overlapping narratives. And a medical narrative is far more than just an explanatory device. Narratives point the way toward future action, and adopting a medical frame for one's situation calls for time-consuming, expensive, potentially emotionally exhausting labor (see Corbin and Strauss 1985): the work of finding specialists, scheduling appointments, undergoing tests, and maintaining trust and hope. In the process, the medical narrative calls for elaboration by personal experience:

"the realisation that medical knowledge is incomplete, and that treatment is based on practical trial and error, throws individuals back on their own stock of knowledge and biographical experience... [there is a] need to *complete* knowledge gained from specialist sources; a need to tie in formal knowledge with the person's total biography" (Bury 1982:173-4).

To resolve this first Burian disruption, then, of the body as an object and a problem, the individual is driven back again and again to "examination of the constellation of familial and biographical experiences" (175). Williams, for instance, describes sufferers of rheumatoid arthritis who are unwilling to accept a doctor's explanation of probable genetic inheritance, and who instead search their histories of social action—the details of

jobs performed over the life course, for instance—to answer the burning question “How the *hell* have I come to be like this?” (1984:184).

The process that begins in seeking to recognize the cause and nature of a bodily disruption can amount to more than just ransacking biographical memory for explanatory evidence; the new experience also casts revisionary light back over the past. In Williams’ later development of Bury’s theory, the demand on a narrator is to restabilize a body-self-society relationship in the present, and “to reaffirm the impression that life has a course and the self has a purpose or *telos*” (1984: 179), or to construct continuity between past, present, and future. Williams discusses how beginnings, present states, and ends are mutually constitutive of the “cause” that people seek. As Garro argues, memory is “reconstructive” (2000:70)—filtered and shaped by social, psychological, and cultural context. The narrative project recruits memory as a resource for making meaning in the present and planning for the imaginable future. Collective as well as individual memories may be called upon as part of this revision (Carricaburu and Pierret 1995), which may be as simple as identifying precursors of symptomatology in previously unremarked phenomena, or as complex as identifying a root of which the disruption may then appear as the fruit: Frank describes Audre Lorde’s narrative identification with the Amazons as her ancestors as a means of creating a narrative continuity in which her experience of breast cancer and mastectomy makes her “become what she always has been” (1995:130). Carricaburu and Pierret (1995) similarly describe how reflection on their HIV-positive status awakened in some homosexual men a historically continuous sense of the self as an activist member of a marginalized community. Others were forced by their HIV diagnosis to confront disruptions they had previously normalized or bracketed

off from their biographies, as when hemophiliac men could no longer deny the extreme difficulty of starting a family after learning of their new HIV-positive status. An entire biographical narrative can be destabilized or deconstructed by a bodily disruption; reviewing and recasting the past to make meaning of bodily disruption can cast new light on selfhood and social belonging across an individual's past, present, and projected life course.

This already begins to address Bury's **second** disruption: in serious illness or disablement, understandings of oneself and one's world are violated as sufferers come up against failures of medicine, the realities of pain and death, the loss of abilities and certainties, and foreclosure of potentials, all of which force a revision of one's biography and self concept. In Frank's analysis of people's narrative responses to the disruption of their physical health, he argues that illness disrupts us in deep, precognitive, embodied ways that—if they can't be minimized or corrected—can be addressed in part through narrative. Illness, he argues, destabilizes the individual's "working resolution" (1995:29) to the problems of the embodied self: our relationship to embodied others, the extent and contours of our bodily control, the management and maintenance of desires, and the relationship between body and self ("Do I *have* a body, or *am* I a body?" [1995:33]). A major bodily change disrupts our action potentials by altering the contours of control, closing off previously taken-for-granted avenues of action or desire, and creating new avenues such as the possibility of empathizing with other sufferers on a bodily, emotive level. Disrupted body-selves thus call for a new resolution to the problems of the body, so that the sufferer may continue to live and act in the world. Frank describes disruption's double call for stories, first as a way to make a map from "narrative wreckage"

(1995:53), and second as a response necessitated by the various audiences who observe the disruption and ask for an explanation (or an account: a point to which I will shortly return).

An entire biography—not just the segment in which an injured part has played a key role—may demand revision when the parameters of certainty or the promise of the happy ending are removed, as Frank (1995) and Charmaz (1999) discuss. But a story is far more than just a personal project to set the individual's mind at ease or to answer the questions of curious others; Williams writes that along with the reconstruction of a sense of temporal continuity, the sufferer attempts to narratively “realign [...] self with society” (1984:197). At the interface of personal and social experience, “all of us come to *be* who we *are* (however ephemeral, multiple, and changing) by being located or locating ourselves (usually unconsciously) in social narratives *rarely of our own making*” (Somers 1994:606). Part of the work of reconstructing the self involves discovering a narrative that fits the contours of the disruptive experience without violating the expectations of the group to which the narrator belongs, or which the narrator addresses in the hope of belonging.

Tilly (2002) points out that the shared stock of stories built up over an interactional history sets limits on the types of stories which may be generated in the future, such that certain stories are hearable within the flow of sociality, and others are disruptive, unhearable, or untellable. He argues that in present-day Western society, “standard stories” are those with interest-motivated, independent characters whose actions are consequential within a delimited time and space. These stories

“do essential work in social life, cementing people's commitments to common projects, helping people make sense of what is going on, channeling collective

decisions and judgments, spurring people to action they would otherwise be reluctant to pursue. Telling [standard] stories even helps people recognize difficulties in their own perceptions, explanations, or actions.” (2002:27)

Forces that overspill the boundaries of the standard story form—those which are “indirect, incremental, interactive, unintended, collective, and/or mediated by the nonhuman environment” (2002:32)—are not easily narrated or easily heard. The experience of having an invisible disability, the troubles of adjusting to disability in an ableist society, and needing to account for unpredictable symptomatology, for instance, may violate the dominant or standard story form.

Our local narrative expectations are more nuanced than can be seen at Tilly’s level of analysis. More specifically, some of our shared expectations for narrative are encoded in “schematic narrative templates.” According to Wertsch, templates are “abstract meaning structures” (2008:142) or “generalized structures used to generate multiple specific narratives with the same plot” (140) that members of the group to which the templates belong generally use without noticing. Wertsch argues that templates are deeply emotionally resonant, that they “coauthor” (142) our stories, and that they are one means of uniting the identity of a group. But in a critical situation—where structures, attitudes, and knowledges of everyday life are disrupted (Giddens 1979)—not only our individual narratives but the narrative templates by which we have ordered the stories of our lives can be revealed as insufficient or otherwise problematic. Although the multiplicity of templates and the overlaps among them leave room for narrative linkage and other agentic, authorial work (see Garro 2000; Gubrium and Holstein 1998; Somers 1994), an individual whose experiences are well outside the normal experiences of other group members may find that none of the templates can be linked or adapted or made in

any way to fit. He may then be torn between a story that feels true or livable or motivating, and a story that others, who still rely on the group's customary templates untroubled by significantly disruptive experiences, are able to receive. Between those extremes, the narrator may be stranded in Frank's chaos state (1995) or in catastrophic, anxiety-ridden tales of the sort Erikson (1976) collected from survivors of the Buffalo Creek disaster. If telling stories that accord with, reinforce, and incrementally develop upon shared templates is a moral responsibility of any member of the group, then alienation from—or even opposition to—the shared templates that aligned one's pre-illness biography with others' feeds into the third and final disruption that Bury described.

Bury's **third** type of disruption arises as a sufferer mobilizes certain resources and conserves others in order to manage the illness and resulting disruptions; the pattern of this necessary work can disrupt relationships and role performances. Forced into restructuring social involvements by the inability to perform accustomed tasks or by the need to conserve energy and other resources, the individual may also voluntarily withdraw from social life to avoid the feeling of being judged as unacceptably different from the way they used to be, or to avoid distressing social comparisons (Charmaz 1983). Charmaz adds that the social world also withdraws, causing the world of the sick person to contract and opportunities for constructing a socially valuable self to dry up. Social partners who fail to adjust to the sufferer as a changed person operating under changed conditions cause further isolation by letting social bonds wither.

Narrative—particularly if driven by a disruptive event (Charmaz 1999)—can be a way to manage the social world without losing moral status. Frank (1995) outlines three

prototypical templates or forms (restitution, quest, and chaos or the absence of a form) that he believes represent the dominant narrative responses to chronic illness. But based on published, polished narratives and polemical in its insistence that the highest virtue of the ill person is to emerge from chaos and become a morally excellent, Benjaminian provider of counsel (Benjamin [1936] 1968), Frank's work neglects some of the complex, situated negotiation of status that can occur in illness narratives. Charmaz (1999) describes how narrative can be used to conserve or even elevate moral status, when it is threatened by the losses illness brings about. She explains that stories have a moral tone, suggesting for instance whether a person is truly suffering, whether they are deserving of help, and whether their suffering is amenable to help (see also Clark [1987] on the sympathy economy). Hunt (2000) more specifically argues that the narrative linkage of present troubles to ongoing or past troubles can be a practical strategy that reconfigures one's role and others' responsibilities toward that person. Disruption in certain situations can even be a source of empowerment; when the conflict one faces as a result of illness overlaps with a conflict that is burdensome in daily life, one has an opportunity to address the ongoing conflict in the way one narrates the illness. Studying Mexican women and men who framed the consequences of reproductive surgery in ways that eased the burdens of restrictive gender roles, Hunt found that some

take this opportunity to redefine the self and social roles in ways that address broader personal and social conflicts and contradictions than those encountered in the illness itself. In naming the heroes and villains, dramatic conflicts and resolutions that compose the illness narrative, the teller may influence the ways the illness and, indeed, the self are conceived and understood. (2000:89)

Consider how a story attributing emotional disturbance to PTSD might reframe the teller as a blameless victim of trauma or as a heroic veteran of a fight for some greater good,

and the different kinds of claims that might be made on either basis. A narrator can use the context of illness to negotiate a higher moral ground and more comfortable role occupancy; narration can be a way of restoring or preserving protective social arrangements.

While Hunt's strategists worked to exempt themselves from the larger structures of oppression, leaving the structures themselves unaddressed, others link their narrative explicitly to structures of oppression as part of an activist agenda (see Frank's citation of Lorde, above), while others take a middle ground. Williams (1984), for instance, describes several British informants whose narratives of rheumatoid arthritis (RA) show how sufferers may take on broader social themes in their stories. One informant described her RA as part of her loss of self to the socially prescribed, gendered roles she had filled all her life. Another informant's story came to be about exploitation in the workplace rather than about genetic determinism (as suggested by his doctors); his story included the sufferings of his workmates as well as his own:

“Within [his] reconstruction Bill encompassed what had happened to his body, the nature of his social roles, the quality of his immediate milieu, and the structure of power in society. In doing so, he linked his own demise with that of others, transcended the particulars of his own illness, and redefined his personal trouble as a public issue” (1984:187).

Explanation of disruption occurs at the interface between a person and society, and these illness narratives incorporate much more than the teller and the immediate audience.

Garro (2000) argues that a narrative exists not only within a life history but also within a group's social history. While much of the argument above describes the personal and social burdens of being ill, illness may also in some cases be an opportunity to link one's individual life to the greater moral life of the community.

Now, it is important to note that Bury's argument has attracted a range of critiques and is especially vulnerable to postmodern conceptualizations of the self as unfixed, processual, necessarily fragmentary, and situational. Postmodern conditions of reflexivity and continual narrative reassessment (Williams 2000), accompanied by a sense of the body as something that can and should be perpetually altered through body projects (Brumberg 1997), a sense of emotion as situationally manageable (Hochschild 1983), and membership in multiple, disjointed social groups (or audiences) in an increasingly spoke-structured society (Pescosolido and Rubin 2000), challenge the notion of anything as coherent as a narrative or bodily-emotive self that exists to be noticeably disrupted. Work on bodies that experience significant but normal change—along a trajectory (e.g. puberty or aging), cyclically (e.g. menstruation), or episodically (e.g. pregnancy) (Leder 1990; Young 1984)—suggests the same. Riessman describes an informant who “resists the idea of a continuous essential self, performing instead a multiplicity of selves, a stance that anticipates contemporary research on adult identity: it is neither continuous, coherent, nor universal in its stages” (2002:13-14): selfhood is always multiple, always disjointed, always in flux, always being negotiated. And under certain conditions we would expect to be quite disruptive, such as stroke, some people are able to work an event into the flow of their biography by framing it as part of aging, or an expectable development of a pre-existing condition, or just a minor plot point in an ongoing story of troubles (Faircloth et al. 2004). Carricaburu and Pierret (1995) described instances of “biographical reinforcement” and argued that parts of a biography can be underscored rather than disrupted by an expectedly disruptive experience. Reeve et al. (2010) even argue that emotional labor and practical action—keeping on keeping on,

maintaining routines, or taking one day at a time—are more important than narrative work in managing disruption. This particular research team was working with an arguably limited view of narrative, a rigid reading of the literature on biographical disruption, and a highly specific sample of cancer patients facing death within the year. Yet Corbin and Strauss (1985) also note that biographical work is only one of three types of work the chronically ill person must perform, and it is certainly thinkable that the work of managing the disruption may be carried out in one of the other, less explicitly narrative domains: illness trajectory work (performing illness-related labor, including managing emotions) or everyday life work (pursuing pre-illness goals, managing relationships, etc.). Alternatively, it is also thinkable that the narratives collected by Reeve et al. represent lives wherein the other lines of work were taxing enough to draw most resources away from a potentially more satisfying sort of reflective biographical labor. In any case, the current study focuses on those *who feel themselves to have been disrupted*, whether through their embodied sense of themselves as changed, others' judgments, or the looking glass of others' reactions to them (Cooley 1902), and I find that the call to narrative in the situation of interest—disrupted emotionality after a brain injury—is organic rather than artificially imposed by the research question.

Zooming in to a tighter focus than an entire biography, I argue that post-brain-injury anger is theoretically significant in the way that it poses unique challenges for many typical ways of *accounting* for anger. Accounts that attempt to *normalize* angry outbursts as meaningful socioemotional expression are compromised by their unexpected, eruptive, often frightening nature. To claim them as one's own threatens one's status as an emotionally intelligible individual; defending the rightfulness of raging at others over

minor provocations may even compromise one's moral status, suggested by Strohming and Nichols' findings (2015) to be crucial to others' perception of the identity of people with neurological impairment. *Medicalized* accounts, which we may expect to lift blame from the sufferer (see Dumit 2003), are similarly challenged. Having shown that the medicalization of migraine has not raised the condition above moral doubt, Kempner (2014) argues that neurobiological explanations do not seem to have the destigmatizing effect of other biomedical accounts. While one might attribute a slow walking pace to an injured leg or high blood sugar to a dysfunctional pancreas, attributing one's problematic emotions directly to a brain injury effectively states one's possession of an emotively damaged brain. I would expect such an attribution to be deeply discrediting in a cultural context of brainhood and cerebral subjectivity. Leder's (1990) point that the brain is the ground of all experience and perception, and necessarily absent from awareness, suggests that making one's own brain problematically present in one's awareness would be to question constantly the grounds upon which one perceives and acts. Once the brain has been perceived as emotively damaged, its power for generating and monitoring appropriate emotion comes into question, and *every* emotion and action may be subject to doubt, as Weiner showed to be the case for people with bipolar disorder, whose rationality could only be validated through a constant attitude of "detachment and suspicion" (2011:470) toward their thoughts and emotions. It is alternatively possible to medicalize emotion by attributing it to *processes* of the brain via psychiatric diagnoses. But none of the diagnostic labels for anger—intermittent explosive disorder, disruptive mood dysregulation disorder, oppositional defiant disorder—has a foothold in the popular imagination. The more culturally salient post-traumatic stress disorder includes anger as a

symptom; however, anger is neither necessary nor sufficient for this diagnosis.

Psychiatric accounts, which carry stigma potentials of their own, are unlikely to resolve the problem of accounting for troublesome post-brain-injury anger.

More generally, the episodic recurrence of outbursts, the close social quarters in which they recur, and the particular stigma potentials of brain injury challenge every type of account in Scott and Lyman's (1968) foundational typology. Among the accounts they describe as excuses, the "appeal to accidents" (e.g. environmental or natural variables, or the limits of human nature) works when one actor's accidents are irregular and infrequent, as repetition of this excuse suggests that one is unusually accident-prone or out of control of her actions and creates stigma. But the kind of emotional disturbance I study here has become interesting to those involved *because* of its recurrence; the excuse that it wasn't intended has a limited number of uses, and those who experience repeated emotional disruption likely use these up after a certain point. "Scapegoating" seems similarly unlikely to work more than a few times for the same type of episode, especially as disturbed emotionality is likely to manifest and to be most troubling among close social partners, where scapegoating would often take the form of pointing the finger at the person calling for the account. Similarly, "appeal to biological drives"—which could include psychiatric diagnoses—is marked by a mysteriousness that does nothing to combat the anxiety associated with waiting for the next in a pattern of repeated episodes, especially when they have interpersonal consequences. "Appeal to defeasibility" (saying the act was performed not through free will but under duress or an internal or external influence such as madness or intoxication) is a problem in that it is likely to hit too close to the bone for people whose injury is understood in the popular imagination as a cause of

insanity, childishness, or irresponsible behavior. This excuse carries a particular stigma threat for people with brain injury. Justifications addressed by Scott and Lyman include denial that the damage caused by the act was significant, denial that the target of the act was truly a blameless victim, comparison to the accusing others (who are worse), appeal to loyalties (e.g. a higher cause), sad tales, and self-fulfillment. The first three are impeded by the same trouble as the scapegoating excuse, and the last three by the problem of recurrence. This is not to say that these types of accounts or elements of them will not be present in injured people's descriptions of neuro-emotional disruption, but rather that none of them appears to be without significant limitations vis-à-vis accounting for post-brain-injury anger.

Finally, Mills' hypothesized "background expectancies" (1940:53) and commonsense knowledge of motives are rendered less certain after a brain injury, when the grounds of experience have been destabilized and when the occurrence of injury suggests that a new medical model should pertain, but as raised above, the question there is "which one?" Mills points out that "discrepant situational patterns" call up multiple vocabularies of motives, thus leading to "'mixed motives' and 'motivational conflicts'" (912). Medical models offer more than one vocabulary (e.g. stress and trauma from the psychodynamic model, chemical imbalance from the biopsychiatric model, frontal-lobe dysregulation and organic irritability from the neuropsychology model), the history of interaction between the actors offers another, and the local vocabulary of motives for emotional display (between two people who may now seem as strangers to one another and are less able to rely on their interpersonal history) is another. There is room for a great deal of uncertainty and contradiction.

Because the field of attributions for anger may be especially troubled, episodes of troublesome anger following brain injury are fertile ground for narrative negotiation. While I would argue that we are presently in a Senecan period with regard to anger, such that we acknowledge few if any pro-social uses for the emotion (see Nussbaum 1994; Seneca 1928 [trans.]; Stearns 1994), it is important to note that multiple discourses for understanding anger exist, whether in widespread circulation or special niches. A quick survey of the works included in any high school literature curriculum reveals that alongside the proliferation of practices and techniques for anger management in American society, we remain fascinated with uses and potentials of anger, whether the epic and many-layered wrath of Achilles, the cold fury of Dickens' Madame DeFarge registering the names of the guilty in her knitting, or Plath's Lady Lazarus rising from ash to eat men like air. We see arguments for the use of anger in social movements, for instance, when Baldwin asserts that to be Black in America is to be in a state of constant rage, when bell hooks calls Black women to find healing and the roots of resistance in this rage, or when a protestor inks onto a sign, "If you're not angry, you're not paying attention." Anger is tied to masculinity, honor, and heroism in video games and action films; even the Disney Pixar movie *Inside Out*—widely popular and praised by psychologists—included a role for anger as assistive in motivating action and overcoming obstacles. Alternatives to the view of anger as a polluting or destructive force to be controlled or eradicated abound. Likewise, while Kövecses (2010) argues persuasively that anger is nearly universally conceptualized as the contents of a container under pressure, it is important to note that there is much cultural variation in the metaphors deriving from this central concept, and there is potential for many more to be

generated in the context of an experience which exceeds normal anger. And while anger has a markedness that demands attention and threatens to cast whatever normalcy has been achieved post-brain-injury as merely the taken-for-granted background to anger's central presence, Zerubavel (2018) and Brekhus (2003) show that there is certainly more than one way to approach the problem of a stigmatizing markedness. Finally, Williams (1984) described how individuals unwilling to accept the medical attribution of their disability to a biological abnormality work with precursors, beginnings, present states, and ends to constitute another cause of their problem. Williams uses Aristotle's typology of formal, efficient, material, and final causes to illustrate how the identification of causality is far more complex than the question of whether a bodily wound or difference caused a symptom. All of these different metaphors, discourses, and strategies are resources people can call upon as they account for their anger.

### **Discourses and Cultures of the Neuro**

I turn now to the broader theoretical and social significance of the research question through attention to the constraints that our broader sociocultural context places upon the narrative work described above. Identifying the brain as a disrupted and disruptive organ has the potential to be deeply *discrediting* for the injured person. Vidal (2009) has argued that the brain has come to be understood as identical to the self in Western culture. As a master narrative, "brainhood"—the belief that we *are* rather than simply *have* our brains—is "denarrativized" (Somers 1994) as unquestionable, objective knowledge. The brain cannot easily or comfortably be conceived of as existing at any distance from the self, and damage to the brain cannot be easily conceived of as separate

from damage to the self. Moreover, damage to the brain likely threatens not only the particularity of one's self, but also the possibility of being *any* kind of socially creditable self. In neoliberal society, the proper subject is agentic, autonomous, rational, responsible for actively managing his health (Brijnath and Antoniadis 2016; Lorig and Holman 2003) and for calibrating his emotions within the "normal" range (see Horwitz and Wakefield 2007 on how cultural views on emotional normalcy have shifted to exclude much negative emotion). Vidal argued that brainhood gives rise to the cerebral subject: "the individual as autonomous agent of choice and initiative ... [with] emphasis on interiority at the expense of social bonds and contexts" (2009:7) and the very figure of modernity. Can a person whose performance of rationality, autonomy, and emotional control is destabilized by unpredictable outbursts of anger successfully claim a creditable self? If the discourse of brainhood is as dominant as Vidal argued, then we should expect people whose brain injuries are followed by socioemotional changes *and* their close social partners to struggle mightily with questions of identity, selfhood, brain, and mind.

Vidal's later work clarified for his critics that what he and his research partner Ortega are concerned with is the variety of ways in which the mind is believed to be reducible to the brain. Vidal and Ortega state that "the neurocentric view of the human, while powerful and pervasive, is neither hegemonic nor monolithic and serves various, sometimes incompatible interests and values ... [and] is *ultimately not* dependent on scientific knowledge about the brain" (2017:loc 72). Reductionist visions of brainhood are strongly reproduced in multiple domains today: Sebastian Seung of Princeton Neuroscience Institute asks the audience within the first two minutes of his TEDGlobal Talk to chant first "*I am more than my genes*" in a rising, triumphant tone, and then to

answer his question “What am I?” with the chant “I *am* my connectome” at a faster pace with a definitively falling intonation. Seung goes on to explain the connectome as the map of connections between neurons, and he closes his talk with a prediction that we’ll have the technology “to know ourselves by deconstructing and reconstructing our own brains,” and possibly even to cheat death through preserving the connectome (Seung 2010). Philosophers now consider the possibility of replicating a person’s brain with no loss of personal identity as a material question rather than a thought experiment (e.g. Sandberg and Bostrom 2008; Wellington 2014). Tech companies are bringing visions of mind uploading out of science fiction and into the marketplace. For example, Dmitry Itskov’s 2045 Initiative promises we’ll be able to upload our minds to material avatars by 2030 (or 2035 at the latest) and to hologram-style avatars by 2045 (2045 Strategic Social Initiative 2012), while Martine Rothblatt of Terasem offers us the promise of “mindclones”:

Mindclones are self-aware digital beings, able to think, reason, remember, and feel. A mindclone would be functionally identical to the living biological original mind simply existing now in two different substrates, one digital and one flesh. Your mindclone and you will cast the same vote, love the same children, and receive the same jury duty summons, and when your physical body dies you will live on, forever, as your mindclone. (Rothblatt 2015:“MindClone Definition”)

As visions of brain-based replication and transhuman life move from science fiction into mainstream science, humanistic study, and entrepreneurship, it seems clear that the reductionist discourse of brainhood is a dominant one.

Yet as Vidal and Ortega noted, there is variation among these manifestations of brainhood. Seung’s assertion, for instance, locates selfhood in the environmentally, experientially modifiable connectome rather than in the material substance of the brain. Wellington’s analysis of the potentials of different modes of whole brain emulation relies

on Shoemaker's distinction between "thick" and "thin" properties of a human life (Wellington 2014), which opens up the possibility of recategorizing the properties that matter to identity. And each tech company's concept for digitally uploading one's mind to a hologram or other data receptacle rather than to an emulated brain represents a different solution to the problem of substance versus essence, and a possible twist on pure brainhood. Havlík et al. (2018), having observed that prominent neuroscientists, who we might expect to take a reductionist stance on brainhood, support a dualistic view of mind and brain, surveyed attitudes on mind-brain relationships among Czech adults and revealed several interesting complications to our idea of brainhood. Only 34% of the 94 participants took a reductive materialist stance: that mind is no more than processes of the brain. Over half (56%) espoused different variations on the non-reductive materialist view that mind emerges from *and* transcends the brain. And just under 10% were dualists, holding mind and body to be completely different things. The Czech Republic is a significantly different setting from the English-speaking Western nations from which my study sample is drawn. (Intriguingly, Czech history includes correspondence between Princess Elisabeth of Bohemia and Descartes, in which she challenged him on problems in his theory of substance dualism; see Elisabeth and Descartes [1643] 2017 and Tollefsen 1999 for a discussion of the significance of Elisabeth's philosophy.) However, it is worth noting that the researchers achieved meaningfully differentiated results through a survey instrument that described 10 unique theories of mind-brain relationship; respondents seem to have been comfortable considering nuanced refinements on the question of how mind relates to brain. Furthermore, the researchers found a positive correlation between the character dimension of self-transcendence and the tendency to

take a dualist position on the mind. Personality, biography, and other factors likely intersect with our inclination toward or against a particular theory (explicit or otherwise) of the role of the brain in our selfhood.

Rose and Abi-Rached (2013), while granting the dominance of brainhood in science and scholarship, minimize its significance in popular understandings of selfhood. They claim instead that our present-day fascination with the brain offers new potentials for constructing and acting upon our selves, alongside earlier and alternative conceptions of selfhood: spiritual, psychological, instinctual. Might a brain injury leading to socioemotional change then be the impetus for creative new configurations of the brain-self relationship, if it calls attention to the material brain and therefore to a wealth of discursive resources including but not limited to neuroscientific discourses?

The way in which we navigate this discursive space in ordinary life is open to exploration. As Pitts-Taylor writes, “we cannot assume that the neoliberal construction of subjects in neuroscience, medicine, and the public sphere is wholly successful; whether or not people actually relate to their brains in the ways they are encouraged to relate to them is a matter needing ethnographic attention” (2010:640). Malabou (2008) raises the stakes of such research by suggesting that it is essential to parse the meaning of brain plasticity from the capitalist meaning of flexibility in our lived experience of our own brains. To what extent, I then ask, are our experiences of our own brains and their potentials colonized by potentially hostile discourses? I find my way into this question through the very real and pressing problem of post-brain-injury anger outbursts, and the constructions of the brain-self-society relationship that emerge from this site of experience.

## **Conclusion**

When providers familiar with brain injury are unavailable or have little guidance to offer with regard to anger, as is often the case, people experiencing post-brain-injury anger may rely especially heavily upon resources such as narrative and metaphor to construct a socially viable, valuable, comprehensible self. Somers (1994) points out that there is agency in the way individuals work within the structured bounds of conventions, cultural values, and narrative practices to tell their stories, and it is possible that the challenges of accounting for post-brain-injury anger are a fund of resources for this work rather than (or as well as) a system of obstacles. Narratives and the tropes around which they are constructed are a point of access to the poorly-understood experience of post-brain-injury anger, worth studying in its own right, and they can also give us access to this experience as a “critical situation” (Giddens 1979), which is, in Bury’s words, “precisely that kind of experience where the structures of everyday life and the forms of knowledge which underpin them are disturbed” (Bury 1982:169). I argue that interpersonal complications attendant upon socioemotional disruption force brain-injured people and their close social partners to wrestle with the relationships among brain, body, mind, and self. I take from Maines, Pierce, and Laslett (2008) the point that we too often view social actors as either victims of structure or heroic agents, and I attempt instead to view brain injury simply as a variety of experience, as a particular social and experiential location with its own challenges and its own pattern of lighting cast on widely-shared conundrums. My intent is to approach people with brain injury and their families as

theorists of their own situation, one which has relevance to broader (but often implicit) concerns about selfhood, embodiment, emotion, brain, and mind.

In studying the narratives that proliferate around the troubling topic of post-brain-injury outbursts, I have thus accessed a rich site of lay theorization on the relationships among mind, brain, self, and society. This study contributes to the debates over the neurocultural turn, a test of the extent to which neurodiscourses permeate the self-construction of people for whom the question “Is this me, or is this my brain?” is of urgent importance. The undeniably physical nature of brain injury allows me to add an important new perspective to a conversation that has been dominated by considerations of selfhood and brainhood in mental illness (e.g., Dumit 2003 and Weiner 2011).

The study also contributes to the field of narrative studies an analysis of how the narrative reconstruction of self proceeds under conditions of bodily and emotional disruption which are interpersonally experienced and perceived, in a time when the individual is expected to be the manager and narrator of his own life. It contributes to the sociology of emotion and to the neuro-rehabilitation literature—both fields with a lack of research on anger—a phenomenological portrait of post-brain-injury anger. While the study does not attempt to correlate types of narrative to types of injury or to sort harmful from beneficial self-stories, it does allow me to collect and explicate some of the most commonly used tropes in the description of post-brain-injury anger, with attention to the entailments of each for identity and social belonging. Alongside their broad theoretical importance in understanding how selfhood is constructed in the time of brainhood and the neoliberal self, these examples of close metaphorical analysis of people’s descriptions of their own post-brain-injury anger may also serve as a tool for clinicians seeking to access

clients' understandings of their condition and to frame their insights and recommendations in ways that the client is open to hearing. While metaphor might be commonly believed to be the domain of psychoanalysis or literary criticism, it also constitutes a powerful tool for treating the disruptions to identity and social belonging that problematic anger creates (see Prigatano 1991). I argue that clinicians can and should train their metaphorical sense of the conditions they treat most frequently, and I show how illness metaphors can be understood at a level between broad prescriptions about the cultural power of "quest" or "restitution" narratives over other forms on the one hand, and idiosyncratic individual schemas on the other. Awareness of the variety of metaphors commonly used to comprehend post-brain-injury anger can help an attentive provider meet a patient on her own terms, as the expert in her own experience.

### **Outline of the Dissertation**

In Chapter 2, I discuss the study procedures, background factors representing vulnerability in the population of interest, and my methods for addressing these factors practically and ethically. The second half of the chapter is an extended reflection on the role of interview research in working with informants who are likely to be experiencing a threat to their status as knowers and narrators of their own experience.

Chapter 3 begins with an overview of the intersecting forces of the clinical encounter, published narratives of illness experience, and discourses of the "new neuros" upon which we might expect people troubled by post-brain-injury anger to draw, as context for the analysis that follows. I then draw upon evidence from all phases of my study—interviews, diaries, and memoirs—to describe the most robust constructions of

the brain-self relationship that have emerged from the analysis: “the processual brain and the psychologically reactive self,” “the (un)protected brain and the layered self,” and “the flickering brain and the rational, interruptible self.” I discuss how each construction navigates the constraints theorized in Chapter 1.

I selected the trope of the self doubled in anger, a subtype of “the flickering brain” as described in Chapter 3, for further analysis in Chapter 4. The characters of Jekyll and Hyde or the Hulk appeared in accounts of post-brain-injury anger that I collected and analyze here, and these furiously doubled characters have reappeared in one after another iteration of Stevenson’s and Lee’s original stories. To situate my informants’ references more deeply in their cultural-historical context, I make extended use of *Dr Jekyll and Mr Hyde*, and *The Incredible Hulk* as two culturally salient narratives centered on the metaphor of the self doubled in anger before demonstrating how this contextual work enriches the close analysis of one post-brain-injury memoir that took the doubled self as its central theme. I introduce in this chapter an argument for the practical importance of investigating metaphorical entailments in caring for people whose narratives are of or in chaos.

Finally, I conclude in Chapter 5 by addressing each of my key questions and expanding upon the relevancies and practical applications of each: Can people in the position of finding their emotionality disrupted in a fundamental but unmeasurable way after a brain injury rely on standard stories of the agentic self when they are called to account for a troubling emotional episode, or do accounts of the neuro-emotionally disrupted self emerge in a more complex conceptual space? What roles do the various available discourses, tropes, and narrative templates play in these accounts? Is brainhood

truly dominant, and does it trouble accounts of disruption? Do sufferers' narrative movements teach us something about the experience of recovery that medical research has not yet captured, and (more broadly) do they teach us something about how it is possible to think of selfhood in an era where the brain is king? This discussion moves from the construction of self toward consideration of the social network in which the injured person is embedded. While social partners were not interviewed for this study, some memoirs were written by caregivers, and interviewees outlined a pressing need for a new, more interdependent form of sociality extending beyond the caregiver/care-recipient dyad. I bring this finding into conversation with literature on interdependence from a wide range of disciplines, toward enriching this nascent scholarly discussion.

## **Chapter 2: Methods**

### **Overview**

Since my research investigates issues of identity, embodiment, and culture, in-depth qualitative work is essential. Ethnography is impractical for studying the sporadic nature of the phenomenon in question, and surveys are too constraining for researching narrative moves and choices, thus I centered interviews at the core of my research. However, the symptoms of TBI complicate recruitment and retention for interviews. Gelech and Desjardins described part of the range of brain-injury-related difficulties that may affect subjects' participation: "communication difficulties (expressive and receptive), fatigue, lack of insight and awareness, difficulty in responding to abstract questions, a tendency toward acquiescence or limited responsiveness, lack of reflexive capacity, inability to sustain focus, and memory deficiencies" (2011:65). I therefore analyzed accounts produced in different modes and types of setting: memoirs, semi-structured interviews, and a mini-diary study associated with the interviews.<sup>1</sup>

If the self is a system of performances, then observing performances in different settings adds depth and range to the work. Further, staging these observations to minimize the intrusion into participants' lives can increase protection for subjects. Memoirs are written to a broadly public audience, and we cannot know the extent to which each author expected this audience to include their close social partners. In either case, Wajnryb argues that the act of writing, by separating the teller and the receiver in time and space, creates a zone of safety for the teller: "This way the text does not require

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<sup>1</sup> A pilot study was conducted in an online support group; findings were consistent with those presented here, but they are not reported.

an immediate response and does not collapse under its own weight” (2001:98).

Interviews occur under a different intersection of pressures: a stranger from the broader public is present for and involved in the production of the narrative. The diaries associated with the interviews offered participants some freedom to customize their approach in terms of how they chose to treat the booklet of questions I provided along a spectrum from a reflective journaling task to a pre-interview organizing device, but in all cases with the understanding that they were producing a study document. Interviews, memoirs, and diaries, thus, represent different configurations of public intimacy. To incorporate another response modality, I included prompts in both the interviews and diaries for participants to draw their experience of anger, following the technique of Emily Martin (1994) and on the advice of Joanna Kempner (personal conversation, 12/19/14).

In this chapter, I first describe the procedures of each phase of the study design. Then, as the interview phase was the most challenging on multiple fronts, I devote the second half of the chapter to a reflective analysis of the role of interview research in the study of narrative, and in particular, with members of a population hypothesized to have experienced a serious threat to their status as knowers and narrators of their own life experiences.

### **Memoir Study**

I compiled a database of nearly 300 trade- and self-published memoirs by people with brain injuries and by caregivers. A research assistant and I used jacket text, online previews, and reviews to identify those most likely to contain references to anger. I then read memoirs that we identified as having any reference to anger, fury, rage, frustration, irritation, outbursts, or other anger-related concepts and subjected the relevant passages to discursive analysis. I coded these passages for references to brainhood or neuroscientific discourse; for constructions of agency, identity, or selfhood; for ideas about causality of or solutions to anger; and for interpersonal aspects of anger. Very few of the memoirs took on anger as a central theme; one of those texts is analyzed in depth in Chapter 3. The other memoirs that referenced anger—or curiously omitted any overt mention of the anger that seemed to be brewing between the lines—offered metaphors and other “gestures toward a story” (Kirmayer 2000:155) that I incorporate with the evidence from my interviews in Chapter 4. The exact conditions of their production can’t be known, but as most of these memoirs are sole-authored short volumes published by small or “vanity” presses, they were likely written without significant influence by editing or marketing teams and therefore represent the authors’ own attempts to frame their experiences for the general public.

Memoir study allowed me to access more diversity in first-person narratives than the subsequent stage of my study was likely to capture. And in addition to the data they provided, analysis of these memoirs was an important way of collecting sensitizing concepts to refine my interview guide. This allowed me to approach the interview stage of my study with well-informed care for the protection of subjects, who may as a result of their injuries find interviews emotionally and cognitively taxing. While I could not

guarantee that I would have access to enough information about the authors to address the inclusion criteria for the interview and diary phase as outlined below, I did select only those memoirs that described brain injuries (acquired or traumatic), rather than degenerative or congenital conditions, as the primary known cause of the disruption being narrated. This helped to ensure continuity between the different phases of my study. The interview and diary portion of the study was approved by the Institutional Review Board of Rutgers.

### **Interview and Diary Study**

#### ***Interviews and Diaries: Inclusion Criteria***

My hypothesis refers to injuries having a *sudden onset that is experienced as such*. In contrast to developmental and degenerative neurological disabilities, Medved and Brockmeier argue that “individuals with neurotrauma have to deal with a brain that has been abruptly transmogrified, a brain that all of a sudden has become ‘strange’” (2008:470). I therefore included any temporally-locatable insult to the material structure of the brain, whether traumatic (TBI) or acquired through surgery, stroke, oxygen deprivation, or another non-congenital, not primarily degenerative cause (ABI), and exclude degenerative conditions such as Alzheimer’s, congenital conditions for which there is no comparative “before” period, and people who deny that they have had an injury. My hypothesis also requires *adult- or late-teen-onset* injuries, given that conditions acquired in early childhood are less reasonably viewed as disruptions (Williams 2000). The diagnosis of a brain injury sometimes sparks reflection on earlier blows to the head that may have been brain injuries, although they were never diagnosed

as such. As long as these events weren't treated as brain injuries at the time, people who have engaged in such retrospective self-diagnosis were eligible for the study even if these injuries occurred in childhood. If they were folded into a person's biography of ordinary bumps and bruises, with no one noticing a change except in retrospect, then childhood injuries would not violate this first criterion for inclusion.

The first year after a brain injury is generally recognized as a period of particularly challenging adjustment. Chamberlain reports that recovery from TBI is typically fastest in the first six months and "slows considerably" (2006:408) after twelve. The first year is also a year of potentially painful "firsts" since the brain injury. Informal observation and knowledge of the socio-psychological significance of calendar time (Zerubavel 2003) suggest that the first post-injury family Thanksgiving, birthday of a child, anniversary of a potentially strained relationship, and so on can be moments when one's awareness of being altered by brain injury may be painfully heightened. Additionally, very recently-injured subjects who are still seeing themselves and being seen as being in an unstable and temporary "recovery" stage—Howard's "temporary, progressive *expecting trajectory*" (2006:308)—may still be occupying a sick-role exemption from accounting for their dysregulated emotions. Finally, Hart et al. (2012:113) note that while other neurobehavioral symptoms may tend to subside with the passage of time, "problematic anger" may continue or increase, and Hall et al. (1994) found increased complaints by family caregivers of "temper outbursts" in the period from 6 to 12 months post-injury; this is a symptom that may become more troubling as time goes by, and there is no need to capture it in its earliest manifestation. To protect people in the sensitive first year of their recovery, I therefore took *1 year as a minimum time*

*since injury*, which also allowed me to focus on the ongoing problems of living with a brain injury rather than problems during what is believed to be the recovery stage. It is not uncommon for people with brain injuries to have had mild subsequent injuries; people with brain injuries may experience more accidents, and they may receive closer attention after even a minor bump to the head. If the injury that caused the symptoms was over one year ago, such people are eligible for inclusion, provided the subsequent injury was not severe enough to require hospitalization at the time or noticeable symptoms of undue upset or confusion in the screening process or the interview.

Since the preferred recovery narrative in America is an upward trajectory of progress marked by only minor setbacks or plateaus, it is helpful to ask what features of an anger episode are strong enough to jar that arrow into a less certain trajectory, thus heightening the call for an account. One obvious feature is that the anger must be observable if there is to be communication of multiple perspectives about it. *Clear verbal or bodily expressions of intensity* are key. I excluded people with recent episodes of physical violence or aggression, which are likely to circumvent the call for accounting in favor of an emergency response. Next, if it is to be perceived as jarring rather than to be folded into the series of successive perceptions, it must be less of a simmering irritability and more of a *sudden outburst*. Another quality likely to call forth narrative negotiation is *uncontrollability*. Anger that flares up but can be brought back under control leaves the injured individual in the driver's seat, so to speak. But anger that overpowers the individual's braking capacity, his ability to adhere to feeling rules and behavioral scripts, raises the question of who or what is really in control. For the observer if not for the injured subject, *intense and uncontrollable outbursts of anger*, if they are *new or*

*significantly worsened since the injury*, likely raise questions about the stability and identity of the “recovered self.”

Some of the most common symptoms of brain injury, such as fatigue or distractibility, could make the interview a challenge for some participants. Recruiting the person with the brain injury directly (rather than through a caregiver) helped to ensure that I selected people able to withstand the interview process, since responding to the recruitment notice indicates awareness and recall of the anger problem, communicative and organizational capacity (as required to respond to the notice), and internal motivation to participate (as opposed to pressure by a social partner). Since subjects needed to volunteer for themselves and complete the screening call without the assistance of a caregiver, participants who find communication stressful were likely filtered out by the recruitment, screening, and consenting process. Along with my research into the management of common symptoms of brain injury, I consulted with Laurie Rippon, a member of the Board of the Brain Injury Association of New York, to prepare a range of aids and protections for my participants. Since anosognosia, also known as “frontal lobe unawareness syndrome,” can block people with this particular TBI-related condition from perceiving the injury’s effects on their functioning, the possibility of unawareness among those who participated necessitated that I incorporate and then administer more protections for my subjects than they might request on their own. The resulting protections are described below in the context of the study procedures.

Joseph Fins suggested the use of the Glasgow Coma Scale (GCS) or the Rancho Los Amigos Cognitive Levels of Functioning Scale revised (RLAr) to attain a degree of homogeneity in my sample (personal conversation, 11/19/13). But both were designed for

use with people who are or were in a coma, which need not have been the case with brain injury, and while initial scores would be helpful for knowing the severity of subjects' injuries, many subjects who are otherwise eligible for my study may not have been given (or may not know that they have been given) GCS or RLAr scores. As a measure of consciousness rather than finer degrees of cognitive function, the GCS is unhelpful for recruitment: the only level that could be used to qualify a person for my study (a verbal score of 5), states simply that a person is oriented and able to converse normally, "respond[ing] coherently and appropriately" (Imhof and Lenzlinger 2011:5) to questions about name, age, year, etc. Coherence and orientation to reality are essential criteria for participation, but the GCS score is hardly necessary to ascertain these. Measures such as lowest recorded GCS score, length of inpatient rehabilitation, and recorded duration of post-traumatic amnesia (Anson and Ponsford 2006) could be useful approximators of the severity of the injury. However, these measures are less useful for my purposes than they may seem, given that none is specifically a measure of emotional difficulties, and that recovery from "severe" or "moderate" injuries may in some areas outpace recovery from "mild" injury.

While the RLAr continues to be used throughout a person's rehabilitation, its usefulness in this particular study is similarly limited. In her qualitative research among people with brain injuries, Lorenz (2010a) reports requiring a minimum score of Level VII on this ten-level scale to help ensure that subjects can remain oriented to time and place and manage a 30-minute task with minimal assistance. However, Level VII is also marked by "unaware[ness] of specific impairment," "lack of insight," and "decreased judgment" (Lin and Wroten 2019), all of which might prevent a person from recognizing

or recalling episodes of anger and from being disturbed by social partners' disagreement with their assessment of themselves as emotionally and expressively normal. Subsequent levels on the RLAr describe components of increasing awareness, recall, independence, and capacity for completing complex tasks. I used the categories of higher functioning evident in these higher levels as I developed my baseline inclusion criteria. I was clear about the time commitment of the interview (along with the possibility of ending or suspending it if it became too taxing) so that volunteers could use their own judgment to determine whether to participate, and I was attentive as we spoke to factors including the extent to which the person was able to attend to our conversation, the detail with which they recalled past events, and any signs of emotional lability in the brief, fact-oriented screening interview.

In sum, potential subjects are screened for the following characteristics, which were selected to maximize the protection of subjects and their potential for successfully completing the interview process: (1) adult- or late-teen-onset brain injuries that occurred at least one year in the past, (2) intense and uncontrollable outbursts of anger that are new or worse since the injury and stop short of recent physical violence, and (3) ability and willingness to undergo interviews.

### ***Interviews and Diaries: Recruitment and Screening***

Brain injuries pose multiple, intersecting problems for accessing and retaining people as research subjects. Studies of people with brain injuries therefore tend to have a very small sample size, with little opportunity to select subjects for maximum diversity.

As small-*n* qualitative research, the study cannot pretend to achieve full external validity; it can only be suggestive. I acknowledge the need for further research into areas of diversity not yet addressed, both in general demographics and brain-injury-related variables, and with a larger sample. Here, I follow Small's (2009) argument that some qualitative research is better undertaken as a series of case studies than as a single representative study. The heart of this approach is the adoption of "case study logic": the sequential collection of subjects, with the results of each subject's interviews informing the approach to the next, and so on toward saturation, with each interview serving to test the theory as it develops.

I investigated various possibilities for maximizing my chance of selecting participants who would be able to complete the interview. As my study is not directly focused on diagnosis or treatment, and as I had no prior research relationship in the healthcare fields, the chances of finding a healthcare provider willing to devote time to collaborating on the project were low. Furthermore, Lorenz (2010a) reports that her partnership with the outpatient department of a rehabilitation hospital hindered as well as helped her qualitative investigation into the lived experience of brain injury. The hospital she approached required that she recruit a member of their staff as her co-investigator, and that she revise her research protocol for submission to the hospital's IRB. In the current study, such requirements would have complicated an already complex set of aims and procedures. The speech pathologist with whom Lorenz collaborated selected and recommended for inclusion only those patients who he believed to be "intelligent, creative, and articulate" (2010:38), thereby restricting the sample. Her subsequent collaboration with the leader of a support group involved "wrestl[ing] over power and

control issues” (2010:44), which threatened the open-ended nature of her research design. I met with a member of the neurology faculty at Robert Wood Johnson, and when his referral to a colleague ran into a dead end, I chose to move forward without a collaborator.

I approached potential subjects through multiple avenues. I began with informants who had already publicized their injury-related experiences. As experienced narrators who were comfortable with disclosure, these informants were likely at the lowest risk of suffering emotional distress from the interview, and so it was important to begin with this group to help me calibrate my approach. These informants then assisted me with snowball recruitment, Laurie Rippon and Tom Grady of the Brain Injury Association each shared my recruitment notice with a listserv of the Association in their respective state chapters, and I posted notices on the web pages of support groups related to brain injury. Of the 12 online support communities/boards whose administrators I contacted about posting a recruitment message and the study flyer, nine groups’ administrators granted permission. Online recruitment has two key advantages: it expands the pool of potential subjects to number in the tens of thousands, and it reaches more diverse subjects, including those who are not actively seeking care, than I might by flyering physical locations such as medical practices. I attended a presentation on online safety for people with brain injuries (MossRehab, 11/8/2014) in order to develop a better sense of vulnerabilities that might emerge in online interaction with interested respondents.

The recruitment notice outlined the core inclusion criteria and noted that there would be compensation for completed interviews. I compensated participants at \$30 (roughly \$15/hour); this seemed fair without being high enough to invite disingenuous

participation. Some respondents contacted me through a direct message on the online platform on which they had seen the notice; in these cases, I set up a time at which I could call them for screening. If the potential volunteer was not available to take the call, I tried up to three times to reach them, in an effort to maximally accommodate possible difficulties in executive function without intruding on people who no longer wished to participate. In completed phone calls, I screened volunteers for the inclusion criteria described above. (See screening instrument in the Appendix.) I asked volunteers who did not meet study criteria if I could retain their information and contact them again if eligibility criteria changed. When a volunteer was screened in, I explained the study with special emphasis on features that may pose a challenge for common symptoms of brain injury, such as the length of the interview, and on accommodations I could make available from the outset or offer later if difficulties arose. After answering any questions, we discussed times when the participant might be less likely to feel rushed or fatigued, and we determined whether the interview would be in person, by phone, or by Skype. Phone and Skype interviews allowed me to include people who otherwise would not be able to attend an in-person interview, they allowed us to avoid the effects of an unfamiliar setting on fatigue and distractibility, and they made the option of pausing the interview for a break easier to enact, as participants were at home with various possibilities for a few moments of restorative time within reach. Study documents were then transmitted by mail or by email, as the participant preferred, and reminders of our appointment were provided by phone or by email, as the participant preferred. Consent was obtained again at the beginning of each interview, and any questions from the respondent were answered.

Recruitment was challenging, and attrition, as predicted, was high. Of 66 people who responded to recruitment efforts, 21 successfully screened in to the study, and 11 of these completed the interview: 4 in person, 3 by phone, and 4 by Skype with audio/video communication. Of the 11 interviewees, six completed the booklet. After describing the study procedures in further detail, I will discuss the practical and ethical concerns related to exclusion and inclusion in a study such as this.

### *Interviews and Diaries: Study Procedures*

Participants agreed to receive by mail or email a mini-diary (hereafter called the “booklet”) with selected questions from the interview guide. (See Appendix for both study documents.) This technique was based on the work of Hatala et al. (2013), who presented their participants with copies of the interview guide to take home and complete in writing over the month following the completion of oral interviews. Their intention was to accommodate different expressive capabilities among their participants, each of whom had had a hemispherectomy in childhood as a treatment for refractory epilepsy. They found that the participants’ journal work reinforced and expanded on what had emerged in the interviews, and I reasoned further that it could fulfill additional functions if presented before the interview. I therefore selected 10 key questions from my interview guide, including one drawing prompt, and organized them into a booklet, with one question per page to minimize visual clutter for the reader and to leave ample room for a response on the front and back of each page. The cover asked the participant to use the booklet to record their experience of an anger episode as soon as possible after it

happened or, if no episode occurred between the time of the screening call and the interview, to use the booklet to reflect upon a recent, memorable episode instead.

The booklets proved to be a useful device in several key ways. Logistically, a relatively thick booklet backed with cardstock and covered with a bright orange cover sheet was a tangible reminder of the study, and I used the cover of the booklet to remind the participant of the upcoming interview time, date, and location as well as the instructions for using the booklet. For the accommodation of possible memory deficits, it may have been helpful for people to reflect upon an anger episode in an experience-near manner, without the pressures of the interview situation; the booklet then became a resource we could both call upon in the interview to support and stimulate recollection. It also served to orient participants to the topic of interest before the interview, and it was available during the interview for me to call upon as a re-orienting device when the discussion strayed from the core topics. It provided an “iconic story” (Shopes 2002) to help focus the conversation, and when people chose to describe different episodes of anger in the booklet and in the interview, this resulted in greater depth as we discussed the variation between the episodes. As well as nine questions intended to elicit narrative, the booklet included a drawing prompt to which we returned in the interview for elaboration. One participant requested a copy of a drawing he made for our interview so he could incorporate it in a presentation on brain injury that he was preparing, and other participants seemed pleased at what they were able to produce and the discussion we had about it.

The study certainly benefited by having data that participants generated soon after they experienced anger in real time, and some participants may have appreciated the

opportunity to clarify and organize their thoughts at their own pace and then use the booklet to support their memory of their experiences during the interview. Others found the booklet a challenge to their attention span or organizational skill, and so I emphasized at each contact that they could spend as much or as little time as they wished on the booklet; non-completion did not affect interview eligibility or compensation. Interviews were scheduled with enough lead time to allow the participant to complete and return the booklet beforehand. Along with the booklet, participants whose interviews would be held over phone or Skype received drawing sheets they would be asked to save and use during the interview.

In interviews, I asked questions about the subject's life, injury, and experience of anger. The first section of the interview provided an opportunity for the interviewee to self-select life course benchmarks and aspects of identity. This was not only to establish comfort and rapport, but to get the narrative wheels turning and to capture any data I could about themes such as agency and continuity as they emerged between the lines of this biographical self-portrait, before I drew attention to brain injury as a benchmark or anger as a significant problem. As prompts, I adapted the outline used in NYU Rusk's world-renowned brain injury treatment program (Ben-Yishay and Diller 2011) to help participants present their life stories. The second section of my interview guide opened up the question of anger. For this part, I adapted Kleinman's (1980) list of questions designed to access subjects' understandings of their condition, and interspersed these with more specific questions about anger. First, I asked the subject to recall and describe a recent episode of anger, with prompts about the precursors, experience, and response of others as well as reflection on causes. Next, I asked the participant to answer questions

about their anger in general. I used the participant's completed diary, if it had been provided to me, for support in this section. When asked to draw their understanding of how their anger proceeds, participants chose to use either a blank page or a page showing an outline of a body and brain that I had provided. (See Appendix.) I commissioned Jessie Bennett, a graphic artist, to create the body/brain template with white space in and around the outline of a body in an open pose, off-center on the page, to encourage drawing in, on, and/or around the body's outline. The brain was included to encourage thought on how the brain relates to the participant's anger, but the drawing is otherwise minimal, and participants did not seem to feel compelled to use it; some chose to work on a blank page that I provided instead. Some participants also provided additional material—images, poems, blog posts—with permission to include them in my analysis.

Interviews were predicted to last 60-90 minutes, and I reminded subjects at several points that the interview could be shortened, paused, or ended if at any point they wanted to stop. Most interviews reached the 90-minute mark, and I quickly learned that no matter how energetic and willing interviewees were, it was best to extend the time no further than this; fatigue is a common consequence of brain injury, and its progress may not be noticeable until after a fatiguing event has ended. If I detected distress during the interview, I offered the possibility of pausing or stopping the interview, and afterward, I provided a list of resources for support (generally a list of therapists, support groups, etc. published by the Brain Injury Alliance or Brain Injury Association) and the option of receiving a follow-up call from me to check in. Interviews generally closed with a few minutes of conversation, and I remained in touch with several participants who either requested a friendly call on a later day or who were already in contact with me before

their enrollment in the study. People who completed the interview were compensated \$30 for their participation, either in person, by mail, or by online payment.

### ***A Note on My Own Background and Position***

I am a caregiver for a person with a brain injury. While this affords me the insights of over 15 years of lived experience, I also recognize potential limitations of my position and the need to address these in practice. First, because my own caregiving experience was like that of many of my participants in terms of urgently trying to get to “the truth” of what was going on, I had to guard against allowing this kind of approach into my interviewing style. I took constant care to remain agnostic as to the cause of the anger during the interviews and data analysis. Second, participants engaged in conflict with their own caregivers might expect me to take sides against them; I had to be more than usually attentive to conveying a non-critical attitude. I chose to disclose my caregiver status to interviewees for two reasons: First, some asked directly what my experience of brain injury was, and to provide as consistent an experience as possible across all interviews, it made sense to disclose my experience regardless of whether I was asked. Second, while a number of people with brain injury would certainly say that caregivers don’t understand brain injury as well as we think we do, I believe an even greater number would say that those without *any* personal experience of brain injury—including medical practitioners and researchers—don’t understand brain injury at all. Knowing that I have some experience of brain injury outside of my study may have helped participants trust me more than if they had believed I was approaching the topic as an experientially blank slate.

### *Data Analysis*

Using the themes that have emerged from the ongoing work, I analyzed the recordings, transcripts, written responses, drawings, and other artifacts provided to me and coded them for references to brainhood or neuroscientific discourse; for constructions of agency, identity, or selfhood; for ideas about causality of or solutions to anger; and for interpersonal aspects of anger. From the constructions that emerged, I identified attitudes toward brainhood, toward neuroscientific artifacts and discourse, and toward the neoliberal mandates of autonomy, personal responsibility, and emotional control. Following Timmermans and Tavory's (2012) model of abductive analysis, I sought contradiction by constantly revisiting the data in context to consider alternative frames for coded material. My endpoint was saturation, that is, when no additional themes emerged from further analysis. The intent in any case was not to conduct an exhaustive study, but rather a deep interpretive analysis exposing patterns and diversity in approaches to the problem of selfhood after a brain injury.

A challenge throughout the analysis was to focus on narratives as social action "reflect[ing] specific cultural forms" or "intrinsic indigenous modes of organization" (Atkinson 2005:3). Notwithstanding my training, this clashed with my acculturated tendency to engage with narratives as authentic reports of life experience, especially when my interview participants in particular were so generous and reflective in responding to my questions and probes over the course of a lengthy interview. To help the reader resist any tendency toward reading what follows as journalistic reportage of

the life stories shared with me, I include here only those elements of life history that emerged in interviews that are needed for contextualizing the data.

### **Problems of Exclusion and Inclusion in Interview Research**

As the interview was fairly labor-intensive for participants from the very beginning of the screening call, I chose to limit my collection of demographic information to what was immediately relevant to the study's eligibility criteria, outlined above. My participants were five women and six men, ranging in age from their 40s through their 70s. All were North American, with one living in Canada and ten in the United States. Each had a brain injury that had occurred more than one year in the past, followed by intense, new, or worsened episodes of anger that the participant has experienced as difficult to control. All participants were articulate, friendly, intelligent adults with the capacity to participate in the lengthy conversational interview. As full external validity is not a manageable concern in such a small-*n* study, I focus my discussion here first on the problems raised by how features of potential volunteers' anger could have influenced their self-selection out of the study, and then on problems of self-selection into the study.

Regarding the study's limitations, we must consider the absence of those who decided against responding, who passed by the flyer without any interest at all, or who never would have encountered it given the sites at which I chose to recruit. This could include people whose anger is very much or very little on their minds: family contention over post-brain-injury anger, for example, can be vigorously contested or simply ignored by a person whose own awareness or interpretation of their emotions differs from family

members'. Other routes through the experience that are unlikely to lead to interview participation include voluntary de-labeling (Howard 2006), or the total rejection of an identity linked to impairment. These are vital stories that cannot be told within the scope of this project, and to the extent that participation offered benefits, these narrators could not access those benefits. Here, I am able to address the stories of those with a particular cluster of abilities, awareness, and concern about their anger and their brain injuries. While I disclose this as a limitation on the study's generalizability, I nonetheless risk contributing to the crowding-out of stories that are potentially more chaotic, intersubjective, contrary to social expectations, or even untellable. This problem may trouble most open-ended interview research; considerations for addressing it will be discussed below.

The problems of inclusion and exclusion in interview research extend still further beyond concerns of validity and reliability when we broaden our scope to consider the way in which the research interview is situated in a field of similar practices. The roles of the interviewee and interviewer are institutionalized across media, criminal justice, the labor market, the educational system, medicine, and numerous other sites in Western societies. According to Gubrium and Holstein, the model of the interview that emerges across these sites of practice constructs the interview subject as a "vessel of answers" (2001:11); the interviewer, while striving to exert minimal influence on the interviewee's responses, taps the vessel and then captures the flow. Whether through the interviewer's self-control or the interviewee's reticence that necessitates drawing out, the self is enacted in an interview setting as something interior, completely containable within an individual. The interview enters homes daily through news and entertainment media, with

an upswing in the past few decades in interview-formatted segments in sitcoms like *The Office* and *Modern Family*, in “reality” TV, and in true crime shows along with its persistence as a journalistic technique. As members of an “interview society” (Atkinson and Silverman 1997), we take for granted that probing questions asked one-on-one get behind the façade and to the authentic truth of a matter, depending on the interviewer’s skill at eliciting and interpreting the interviewee’s statements.

Yet the interview has not always been with us. As the asymmetrical, semiformal conversational probing of an individual’s experiences, feelings, thoughts, attitudes and identity, the interview took shape in the late 19<sup>th</sup> century. The politicization and commercialization of the news media in post-Revolutionary America gave rise to the *New York Sun*, a tabloid-style paper directed at a mass readership. The “penny press” that grew up around the *Sun*’s success depended on daily sales to individual readers, rather than the sharing over time of the more durable and less frequently printed six-penny papers preceding them (Nerone 1987). Building on the popularity of engaging and sensational reports of criminal trials—including testimony—in previous newspapers, publishers of penny papers adopted and shaped the interview as a journalistic technique producing the engagingly readable, “authentic” human interest stories that helped sell the paper to “the new public of the ‘common man’” (Nilsson 1971:712). According to Nilsson, the journalistic interview thus took its form from criminal-court methods of inquiry, with the interviewer taking the role of the judge. By the early twentieth century, the interview would be taken up in the newly forming social sciences in the form of the large-scale questionnaires favored by sociologists, the ethnographic interviews of anthropologists, and, later, the interviewing techniques of the Chicago school of

sociology (Masschelein et al. 2014). These developments were consistent with the truth-extraction ethos of the journalistic interview even as they echoed the tension Fontana and Frey (2003) observed in the contemporaneous adoption of interviewing in medicine, between quality of response on the one hand, and representation and measurement on the other. It may be this very tension that empowers the interview as a Foucauldian technology of the self: its structured probing for insight, depth, and personal revelation occurs against a backdrop of statistical distributions against which individuals are situated under the normalizing ethos that has been centuries in the making (Foucault 1995). While tracing the intersections of these different developments in our path toward today's interview society would be an undertaking for a larger project (à la Davis' [2017] close study of the complex entanglements among turn-of-the-century developments in statistics, eugenics, the concept of normality, and identity), this brief history suggests the need for a very close look at the interview as a research technique for working with people whose selfhood is hypothesized to be rather urgently at stake.

Experienced qualitative sociological researchers have, of course, been quite reflective in considering the ways in which the interview is a constructed encounter, rather than a window to lever open on the authentic experience of an individual (see Atkinson and Silverman 1997; Fontana and Frey 2003; Gubrium and Holstein 2001). The interview forum, artificial though it may be, still offers benefits to participants. From a Goffmanian perspective, for instance, collaboratively generating a tellable, socially valid account of a disruptive, disrupting experience has potential benefit for the interviewee and for the social networks to which she can return with her newly constructed account, while it provides data for the interviewer on the kinds of faces, lines, and narrative moves

that are socioculturally practicable in identity work on such a topic. But here I suggest that interview researchers might engage in a minor sleight of hand in the way we commonly offer potential informants *the chance to tell your story* as part of our recruitment. Having observed references to this potential benefit over and over in interview-based studies, I described it in my documentation to the Institutional Review Board and to participants as part of the informed-consent process. I continue to believe that the chance to tell a story of a complicated or unbearable experience to someone who listens with care and respect is a benefit of this study and others like it, and my interview participants overall did seem to regard their completed interviews with positive emotions. But whatever we might mean by the common phrasing of *the chance to tell your story*, if recruited participants read it through the dominant lens of the “basic model” of the interview described above, they may not be opting in as the self-aware Goffmanian performers we imagine them to be, and which we get to play relatively comfortably when we take up the pen, recording device, and neutral-to-encouraging persona of the interviewer (see Weiss 1994). This possible mismatch in the interviewer’s and interviewee’s perceptions of the interview setting is an ethical problem for the researcher.

Here, I agree with Atkinson and Silverman (1997) that our potential complicity in the construction of particular kinds of selves and particular forms of narrative (see Wertsch 2008 and DeGloma 2010 on narrative templates structuring the stories we are likely to tell) remains undertheorized. We demand and participate in the work, Atkinson and Silverman point out, of “integrat[ing] the selves of memory into an essential and timeless self” (1997:313). The essential, timeless, unitary self reproduced in the interview is not a universal or a neutral option; instead it is a key underpinning of the neoliberal

self. Callon and Rabeharisoa argue that the interview situation is a “model” (2004:6) or “mock-up” (2004:5) of the public arena. As such, it operates in sync with broader mechanisms of inclusion and exclusion in the body politic; it demands rational, self-justifying accounting of participants’ choices; and it creates a boundary between public and private spheres. In analyzing the “passive resistance” of a subject to their attempt to interview him in his home, Callon and Rabeharisoa theorize that, according to the universalizing principles of neoliberal selfhood as they are enacted in the social scientific interview:

The price to pay for being a free (and responsible) individual, capable of making his or her own choices, is a) agreeing to enter into a public world where options have patiently been constructed and made visible for all to see; and b) being able, at all times, to discuss one’s private choices, that is, the options one has selected, publicly. ... The actor, simply because he or she is formatted as an actor-making-decisions, is caught in a (public) space of choices, and consequently of deliberation and justification, imposed on him from the outside. And it is out of that space that the private realm ... is cut. Make your own choice, but provided that you respect the terms of the choice as defined by the medico-social network ... and provided you can explain your choice. (2004:13)

The subject’s public and private selves—and all the commitments, relations, temporalities and expectations associated with these—are at stake when an individual opts into the interview setting. Callon and Rabeharisoa concluded that opting out of participation can be a refusal of all the “attachments and entanglement” (2004:18) of the particular form of identity that the interview enacts, and that this refusal is more than a negation (see Daghighaleh 2018 on refusal as political choice). It signals the enactment of a different form of “humanity and solidarity” (22) grounded in something other than the universal principles of the interview. Opting in, then, signals the entry of the subject into a public sphere in which they must effectively split themselves into that which can

and that which cannot be spoken in the public arena, and their entanglements into those that matter in the larger world and those that are private concerns.

While a savvy Goffmanian actor may be equipped to perceive and navigate this demand as well as the researcher does, I suspect it's more likely that people drawn to *the chance to tell their story* come to us with a somewhat less cynical, perhaps Meadian desire to express the spontaneous, flexible "I" in a setting thinned out of the "me"s that might overpower it in daily life. And while Mead (1934) described this "I" as socially responsive and thus socially constructed, participants may be likely to perceive it as the authentic self pressing forward for expression through the narrative compromises and concessions that social life has imposed. There are many directions that a fractured, strained, or otherwise threatened identity could conceivably take, from Marriott's (1989) fluid, socially constituted "dividual self" to Strawson's treatment of the self as a "basketful of understandings" (2004:448) to Malabou's (2008) subversive celebration of a plasticity that destroys as well as gives form to the self. But when an interviewer, as a representative of the "medico-social network" and of the imagined public, offers *the chance to tell one's story*, we may draw our participants into a situation structured—according to the "basic model" of the interview described above—in a way that reinforces the unitariness of the self, the narratability of a life, and the individuality of that narrative against the backdrop of broader trends. And these may be exactly the narrative pressures that my informants, who I hypothesized to live under conditions of challenge or threat to their social and moral standing as knowers and narrators of their own experience, are already burdened with in their daily lives, as they are called again and again to account for their disruptive and disrupting anger.

Yet this isn't a demand that the interview can—or necessarily should—lift. Westerners share a deeply embedded sense that identity requires, or life somehow generates, a narrative. Of course, we do narrative work because it is demanded of us as part of our public self-presentation. I sit here sorting what I've learned about brains and emotions and identity among my different selves, and while the teacher-self and the caregiver-self can each keep their share of knowledge in their respective rummage bags without any particular narrative thread running through or between them, the doctoral self is required to produce a narrative that meets professional sociological conventions for continuity and order. Yet I don't perceive this as just an artificial, externally-imposed burden: producing this narrative is an exciting thing, and perhaps that relates to Pennebaker's (2000) suggestion that the work of creating a narrative integrated by causal relationships and statements of insight might satisfy a profoundly human need for storytelling, possibly through simplifying the cognitive work of managing discordant bits of knowledge. An interview that guides a participant to engage in the reflective integration of memories, feelings, perceptions, and symbols could thus offer potential benefit to participants who live in our narrative-oriented society. To say that the demand for narrative is socially constructed is not to say that it is external to us; rather, because we are in and of our sociocultural environments, we internalize some narrative structures so deeply that they become our own. In this sense, the interview offers a backstage of sorts in which to work out the threads of a story, even for the Meadian actor who is struggling to integrate the voices of the "I" and the "me" into something that feels like an authentic, self-authored narrative. So the question for the interview researcher becomes how to provide such a potentially beneficial space for participants, without imposing the

narrative template associated with the “basic model” of the interview too strongly on the one hand, or providing unlicensed therapy on the other.

Although at the time of the interviews I considered my commitment to attending to chaos, fragmentation, and contradiction in participants’ narratives only as a matter of capturing good raw data, I have realized upon reflection that this particular orientation also helped me resist the urge to demand or impose order on participants’ narration. Good and Good (1994) theorized a “subjunctive mode” of storytelling about causality, in the case of epilepsy. While Good and Good were initially frustrated by their informants’ refusal to braid the incompatible narrative lines they opened up into a single, internally consistent narrative, they eventually realized that this was a way for “sufferers and their families to justify continued care-seeking and to maintain hope for positive, even ‘miraculous,’ outcomes” (1994:837). Some narratives kept open multiple plotlines pointing back to different origins of the seizures and forward to different courses of future action and outcomes. Some told of encounters with the supernatural and mysterious—visions, jinns, dreams—in a way that Good and Good recognized as representing alternative sources of power and possibility (Good and Good 1994). “Only in the case of the most severe illnesses, hopeless cases in which the seizures seemed certainly to result from brain damage, was there little sense of subjunctivity” (Good 2000), and this supports the possibility that narrative certainty might at times be a foreclosure of options rather than an achievement. Riessman (2000) argues for another function of a narrative that is less than airtight: ambiguity invites the audience into a story, which then becomes an intersubjective space for working on a meaning other than that prescribed by dominant templates and structures. Kirmayer claims that “...where

narratives are most coherent, they also may be formulaic and distant from sufferers' experience" (2000:153). This is an argument for the power of indeterminacy and multiplicity to prevent an alienating gap from opening up between experience and its narrative, social presentation; to keep the narrative project and the self-concept open for negotiation rather than "misprisoned" (2000:153) by a largely *received* narrative. Chaotic narratives or hodgepodge accounts can perhaps even represent "counternormative projects of defining the self" (Maines, Pierce, and Laslett 2008:21) or resistance to the expectation of a heroic narrator who drives causality forward. The repeated call for accounts in the case of post-brain-injury anger, and the uneasy fit of any standard account of untoward emotional display, may create a space in which exploration and play with concepts emerges. Within this space, multiple voices, fragmented narration, metaphors as "gestures toward a story" (Kirmayer 2000:155) represent potentials of the narrative project rather than failures to generate a coherent story. In his analysis of stories recollecting 9/11, Brockmeier discovered some accounts "rejecting syntax and storyline altogether" (2008:25). One informant, for instance, moved in her writing from a standard subject-verb first-person account to a staccato list of the elements of the terrifying scene: "I am petrified, tired + not myself. I feel like I have been through a twilight zone episode. *Masks Military Police State Troopers Scary*" (2008:25). Brockmeier observes of this passage that "[e]very expression ... offers a chain of metonymical and metaphorical extensions; each evokes splinters of experience, thought, feeling" (2008:26). Such chaotic narratives then stand as a kind of "kaleidoscope ... without singling out the particular impression as center or periphery, as beginning or end, and, furthermore, without qualifying it as either perception or thought or emotion" (Brockmeier 2008:26).

While Frank's classic work on illness narratives devalues the "chaos narrative" as one of defeat, fatalism, even amorality (1995), Brockmeier argues that narratives of traumatic or chaotic experience might need to reject the standard forms in order to be true to the experience. If so, then it is up to the listener to learn a different approach to hearing the story-as-kaleidoscope, in which the disorder constitutes the meaning, rather than demanding that the narrator lock the kaleidoscope in place, foreclosing other possible views of the situation and potentially misprisoning both narrator and listener in an inadequate view of the experience. Finally, Wajnryb argues that when linguistic, psychological, and social barriers together render a story of trauma incommunicable, then the silence that fills in for the unspeakable or unhearable is better understood as "a vernacular" (2001:99), taking on different meanings in different linguistic and social contexts.

In my approach to the interviews and the analysis of all data, then, I strove to observe and honor the potentially subjunctive, ambiguous, subversive, or chaotic narrative projects in which my participants might engage, to hold an exploratory space open along with them, and to probe for clarity before or instead of coherence. Following Zerubavel (2006) and Wajnryb (2001), I paid close attention to silences, "exclusions," denials, and moments of broken attention as well as to assertions. I asked my transcriptionist to transcribe verbatim, with hesitations, "um"s, and other possible signs of disruption in a narrative. In memoirs, I read between the lines for what was surely present—like the unnamed anger Trisha Meili hints that she felt against her mother for demanding Trisha's public silence, in spite of a narrative that a *New York Times Book Review* blurb placed on the book's back cover alleges to be "told without anger or

resentment” (Meili 2003). Working between the lines in these ways is risky, but so would it be to insist on reading narratives as complete and contained.

In future research, heightening the exploratory, experimental qualities of the interview setting while minimizing the structures and commitments imposed by the “basic interview” model might begin with small changes in the language by which we recruit and consent our subjects: from *the chance to tell your story* to, perhaps, *the chance to talk about your experiences*, or *the chance to think through your story in a new way*. These rephrasings, however, still incorporate the idea of life as a story, owned by an individual who is responsible for accounting for their life. Transitioning from the one-on-one interview setting to a focus group could partially address these concerns, but would carry in the new connotations and narrative expectations of the support group or encounter group (e.g. “awakening”; see DeGloma [2010], and Taylor’s *Stroke of Insight* [2008] as an instance of a high-profile account of brain injury as an awakening), as well as a larger section of the public. Lorenz’s (2010a) use of Photovoice methodology invited participants to photograph their responses to prompts as well as participate in interviews and group discussions with other participants on the topic of living with and healing from a brain injury. I did not adopt a similar method for this study, as it seemed likely to merge the conventional templates structuring our idea of a “good” photograph with the narrative templates noted above *and* with the templates typical to support groups, thus complicating the pressures of the interview situation. However, I noticed that the drawing prompt in my booklets and interviews seemed to shift the conversation into the exploratory, experimental mode, and Harper (2002) argues that our longer evolutionarily history of processing visual images as compared to speech positions us differently vis-à-

vis images, which may expand the space respondents have to negotiate with and around narrative templates. In future research, I might draw from Lorenz's technique the cross-viewing of narratives or artworks, such that interviewees would speak with me about another informant's story and/or art alongside producing their own, or (if problems arose in the approval of such a study design) about a publicly available story or artwork. I can also envision a focus group organized like a book club around a passage from a brain injury memoir, vignettes based on this research, or even a few passages from works of literature describing explosive anger having nothing to do with brain injury. In each of these potential study designs, the focus on another person's story, metaphor, imagery, or other artifact could minimize the risk of a subject experiencing the research situation as a spokesperson's platform, or as a confessional in which to unburden oneself of an otherwise unheard story. The *platform* model of the interview's benefits carries the risk of misprisonment described above, as the interviewee's focus on a broad public audience could easily increase commitment to widely-shared narrative templates that may not be a good fit for experience, and the *confessional* model may result in temporary relief for the subject without actually changing the problem of a social network in which the members lack important context for understanding the subject's actions (Pennebaker [2000]; see also Goffman on support groups as "collect[ing] a new set of skeletons for a newly shared closet" [1956:130]), in addition to being somewhat deceptive in presenting the setting of the research interview as a private confessional space.

Restructuring the interview as a literal exploration of physical space could also help set a different tone and trigger different schemas. In van der Vaart, van Hoven, and Huigen's study of village life, walking interviews yielded "personal, in-place accounts of

people's ... experiences" (2018:section 5). Most of my informants narrated anger episodes that had happened at home; might home visits where the story of an episode could be told in situ mitigate the public arena aspect of the interview? Could drawing an anger map where episodes had occurred, or hotspots in one's daily round where episodes were likely to occur, stand in for this when touring the actual sites isn't feasible? Simply providing a fuller kit of drawing tools for working with the body outline or offering sculpting materials as well (see Bat Or 2015) could integrate bodily memory and the embodied act of drawing more thoroughly into the interview process, so that it doesn't become dominated by oral narration.

I designed this study's interview guide to have an order of questions that would structure a narrative if followed verbatim, as insurance against dead air in the interview, to ease the cognitive transitions I was asking my respondents to make, and to ensure what consistency I could across participants. To the latter point, however, Small (2009) is correct in noting that since an in-depth interview study is rarely if ever going to reach the number of subjects required for statistical power, we do the method an injustice to treat it as if it is a form of second-rate quantitative work. In designing future research, then, I would consider structuring the interaction for disruption or disjuncture in a way that leaves the making or unmaking of order to the respondent. Masschelein et al. (2014) mention the *abécédaire* format that Parnet and Boutang developed for interviewing Deleuze; the interviewing team chose 26 key words related to Deleuze's work as the themes of the interview, from the A of *animal* to the Z of *zigzag*, notified him in advance, and then proceeded to introduce and discuss them in order, disrupting the basic model of the interview. The method is one of random constraints imposed upon the creative

process of narration. I do not suggest that we set aside our sensitizing concepts in favor of aardwolves, baboons, coelacanth, and other Oulipean innovations in interviewing, and certainly not with research subjects who may be prone to cognitive fatigue and frustration. What I draw from this example is a structure designed for playfulness and improvisation, and a role for the interviewer as a turner of the kaleidoscope rather than its documentarian. Cognitive load remains a concern, but the reflections above suggest that the demand for a structured narrative can add to this load, and the guardrails that we set up to guide the respondent might ultimately guide them into a narrative untrue to their experience. In a future study, I would consider being less concerned with consistency of the interview experience across participants, perhaps grounding my interview guide in key concepts rather than carefully-formed questions, and breaking up the interview period into activity-related chunks (e.g. a drawing exercise, a narrative exercise, a consideration of an anger-related artifact exercise), carefully staged and monitored in order not to become an obstacle course for the participant. My contributions to the discussion would then require analysis along with the respondent's, which is in any case truer to the social emergence of narrative. Such methods would still address the question of the kinds of moves that are possible in accounting for the phenomenon of interest, and I propose that they can help a respondent to unpack and explore their narrative toolkit, without being as likely as a traditional interview to generate an overdetermined and potentially misrepresenting narrative. Including non-traditional methods in our research could also help to recruit participants who are, in Callon and Rabeharisoa's formulation, "engaged in other forms of entanglement, where public justification and articulation are no longer playing a key role" (2004:22).

## **Conclusion**

Each strand of the study analyzed narratives produced in different settings and for different audiences. Yet narrative in each of these forms—interviews, diaries, memoirs—is potentially troubled in the ways described above, as each is being produced for eventual communication to a public audience. This raises problems for the interpretation of findings and for the benefits or risks to participants, and I have addressed each of those problems to the extent possible, as described above. With so many pitfalls, is a narrative study of post-brain-injury anger worth doing? I agree with scholars like Strawson (2004) that narrativity may have a different hold on or potential for each of us, and certainly among different groups of us, but I would argue that this is true of any form of expression or communication, from the psychoneuroimmunological production of stress-linked pheromones to the sociocultural shaping of bodily experience (see Davis 1983). Mixed methods and triangulation offer too thin an answer; each method carries its own weaknesses and risks, and triangulation shouldn't come before the need to match the method to the research question, which is what I have done here in hearing, reading, and closely analyzing the narrative moves within the stories of people whose status as knowers, narrators, and self-managers is at risk. The answer I practiced in this study was to carry a constant meta-awareness of what we are actually doing when we collect, elicit, participate in, or otherwise co-construct narratives with our subjects, and to continue working on ways of structuring this meta-awareness into future study designs.

In the next chapter, I will explore patterns of narrative moves that emerged across the interviews, memoirs, and diaries. I will shift my axis of analysis to making sense of

connections and contrasts within narratives, and between narratives and culturally salient discourses of brain injury. This speaks to the theoretical questions of whether and how people with post-brain-injury anger are incorporating discourses of brainhood and its alternatives into their self-representation, and to the practical question of how a clinician might interact with a patient on the level of narrative.

### **Chapter 3: Discursive Constructions of the Brain-Self Relationship**

Anger is a consequence of brain injury that can be especially difficult to grapple with. Sudden, unpredictable outbursts of intense rage can arise without any clear provocation. Marked by physical and verbal changes which can be frightening and which certainly disrupt the appearance of the normally recovered or recovering person, these angry outbursts demand to be accounted for: What does the anger signify? Where does it come from? Who is responsible for managing it? Does it index an external problem that needs to be addressed, or an internal one, or is the anger itself the problem? Injured people and their families may turn to medical providers for help, but when the medical definition of the problem is unclear, the cause is difficult to isolate, and treatment protocols for post-brain-injury anger are rare (Hart et al. 2012), clinicians have no clear path to follow: should a particular case be dismissed as a normal and temporary reaction to trauma, discussed as a matter of family dynamics, addressed by treating a more fundamental deficit, referred to individual psychotherapy, medicated, or something else?

The analysis driving this chapter focuses on the kinds of selves that people with post-brain-injury anger construct in their narratives, and, in particular, on the kinds or qualities of selves that emerge in the cracks in narrative frames. A written memoir, for instance, may follow an overall arc of awakening or of acceptance through learning to appreciate compensations for the harmful aspects of the injury. But when anger breaks onto the scene, the story often has to take a different turn. Attention to narrative frames and structures that have already been described in the literature was an essential part of

identifying places where a narrative's frame cracks or chaos bubbles up: what cultural tensions are being addressed, what kinds of selves are being forged in those spaces?

This is, of course, not a simple matter of coming to the analysis with a reference list of dominant narrative forms. Illness narratives take shape in sites as diverse as the primary-care clinical encounter with its checklists and rigid time frames, and the TED Talk stage on which Jill Bolte Taylor delivered her narrative of enlightenment through brain trauma. As people move through the different settings in which they author, co-create, or serve as an audience for illness narratives, it's unlikely that they keep the narrative norms and toolkits associated with each neatly compartmentalized. Moreover, the sites themselves intersect in different ways, with each other and with broader social forces. Here, I first briefly discuss three major intersecting social forces that, in addition to the pressures of the interview situation theorized in chapter 2, likely influence the ways in which people construct their illness narratives: the norms and structure of the clinical encounter, the genre of published biographies and autobiographies of illness experience, and the discourses of the "new neuros" (see Pykett 2013). I then use findings from the memoirs, diaries, and interviews I analyzed to show how the narrative moves that people with post-brain-injury anger make at the intersection of hegemonic cultural practices and discourses of the "medical history," the "pathography," and the "neuro-" generate particular kinds of selves.

### **Clinical Encounters**

People dealing with chronic illness or disablement have abundant opportunities to come into contact with a range of healthcare practitioners, from primary care physicians coordinating care within a network of doctors to providers of alternative therapies. As the power differential is likely greatest in the encounters between a patient and the biomedical doctor, it is worth considering the ways in which narrative may be structured by (or contrarily, as the spillover from or complement to) these encounters. Mishler's conversational analysis of doctor-patient interactions found that the clinical encounter takes shape around a cycle of the doctor initiating a question or request, the patient responding, and the doctor acknowledging and/or moving to the next cycle (2009). More recently, Good and Good (2000) demonstrated Habermas' "colonization of the life-world" by expert knowledge by showing that in the process of their training, doctors learn to convert patients' subjective, messy "fiction" to objective, actionable "history." The patient is guided through the encounter by the doctor's pattern of attention and inattention to what they deem relevant.

While models of patient-centered care and narrative medicine now call for attention to patients' values, interpretations, and capacity to engage in a more symmetrical encounter, Heritage and Maynard (2011) note that research on the forms the doctor-patient interaction is taking at the nexus of the countervailing powers (see Light 2000) of market forces, changes in social welfare, and developments in the technology driving evidence-based medicine forward, to name only a few. And some research that does exist suggests that old forms of paternalism persist beneath the rhetoric of the empowered healthcare consumer. In Roberts' (2006) analysis of the rhetoric of the responsible individual who actively chooses her healthcare vis-à-vis actual practice in

clinical encounters, she finds that opportunities for choice are denied to patients. This may be especially the case for people coming to the clinic as brain trauma patients, if the doctor presumes that the cognitive or emotional aftermath of the injury limits the injured person's ability to make sensible healthcare choices.

It is likely, then, that my research subjects have had experiences of cycling through questions determined by the doctor, waiting between speaking turns as the doctor interacts with the electronic patient database, and perhaps experiencing the anxiety of watching their body inscribed in bits and pieces into the multiple forms of medical record produced in such encounters (see Shildrick 2005; Mol 2002). The ideal patient, then, might be one who communicates active engagement in the process while being docile to the doctor's lead; one who responds to questions with morsels of information corresponding to the various records the doctor must produce; one who minimizes the voice of the lifeworld without appearing to appropriate the voice of medicine; one who presents an interesting case without challenging a doctor's training in managing uncertainty (see Fox 1980). None of these expectations are explicit, and a patient's ability to intuit and navigate them with skill is of course dependent on axes of social inequality intersecting with the doctor-patient asymmetry, as Lareau showed for the influence of social class on clinical encounters (2002). The self who narrates an illness experience successfully in a clinical interview is classed, raced, gendered, responsive, goal-oriented, and docile to the larger interests demanding particular narrative elements or structures.

### **Illness Narratives as a Genre**

Outside the clinic, stories of illness and disablement told in book-length form from the perspective of the suffering person or a close witness to their suffering, began to emerge as a genre around the mid-20<sup>th</sup> century (Hawkins 1999; Jurecic 2012). Since that time, subgenres have developed. In my own sample, for instance, cartoonist Suzy Becker's *I Had Brain Surgery, What's Your Excuse?* (2005), written on a Bunting Fellowship at Harvard and published in the mainstream press, stands as an instance of the comedic subgenre that was perhaps pioneered by Gilda Radner's cancer narrative *It's Always Something* in 1989. By contrast, J.J. Virgin's narrative of her son's brain injury is organized as a testimony to the particular style of nutritional self-help she markets; she heightened the self-help aspect when she changed the name of the book from *Miracle Mindset: A Mother, Her Son, and Life's Hardest Lessons* to *Warrior Mom: 7 Secrets to Bold, Brave Resilience* shortly after its 2017 publication. Some memoirs, like those of Becker, Virgin, Trisha Meili (the "Central Park jogger"), and the well-connected British writer and editor Robert McCrum (1999), capitalize on the author's standing as a public figure, while others are written—and often self-published—by first-time writers who are otherwise not widely known. Across subgenres, however, themes of inspiration for the reader and the therapeutic value of writing for the author predominate. Jurecic raised the question of how we are to study narratives strongly marked by themes that are "overtly cathartic, therapeutic, or personal" and that "provoke affective and intimate engagement" (2012:10)? Without taking them at face value as unmediated testimony, how can we avoid categorizing them according to some standard of complexity or productivity, or crushing them under the weight of our scholarly "suspicion" (2012:3) of the author's moves?

While the literature on the therapeutic value of writing about trauma tends to center on journaling, there seemed to be something particularly meaningful for authors in my sample about completing the project of writing a book for publication. Lori Purdy Faitel, for instance, writes on the back cover of her self-published memoir: “With the publication of this book I have conquered my Closed Head Injury!” (2009). In completing and publishing her book, Faitel seems to triumph in the feeling of mastering a culturally valued, comprehensible narrative form. The culturally salient narrative templates structuring published illness narratives are likely to shape the stories people tell, particularly when they’re aware of a public audience for those stories. While the analytic literature on illness narratives has increased along with the number of published illness narratives, I find two of the earliest analyses useful here, as the author of each balanced their critical approach with a fairly new exploration of illness narrative as something with the potential to do more than simply convey the facts of a medical case. Neither Hawkins’ *Reconstructing Illness: Studies in Pathography* (1999) nor Frank’s *The Wounded Storyteller: Body, Illness, and Ethics* (1995) forms part of my theoretical framework, as both are shot through with assumptions about proper embodiment, sociality, and productivity, all areas that my research opens up for examination. However, the authors’ observations of trends in published memoirs of illness are useful here, as guides to the kinds of narrative templates that had come to dominate the genre by the end of the 20<sup>th</sup> century.

Hawkins contrasted her work to Kleinman’s on explanatory models by calling attention to the mythic aspects of narrative, which open stories up to interpretation rather than asserting one explanation. She describes the “mythic authority” (1999:188) of illness

narratives as deriving from three aspects of the “myth of narrativity” (1999:186): the insistence on the truth-value of personal narrative, the belief that personal narration empowers the narrator, and the belief that narrating is part of healing. In the Western contexts in which these beliefs predominate, certain mythic paradigms recur in illness narratives. Some she claims to be “archetypal...transcultural” (1999:xv); these include narratives of illness experience as a battle, as a journey, or as a rebirth. Others are culture-bound; those she identifies include the “Gaia myth” (1999:182) constructing the ill individual as part of a larger environmental sickness, and a combination of optimism, a belief in the body’s power for healing itself, and an active role for the ill person that together she calls “healthy-mindedness.” While Hawkins praises “healthy-minded” narratives as a therapeutic and meaningful counterweight to the dehumanizing tendencies of the medical system, she does explore what happens when illness doesn’t give way to the hopeful pursuit of healing. The hope that is fetishized in the paradigm of “healthy-mindedness” becomes “problematic or even disabling” (1999:156), and it can feed a cycle of hope for decreasingly likely outcomes each followed by new disappointment. When Hawkins views narrative as equal to mastery over disorder and the culmination of a disruptive experience, her acknowledgment that powerful narrative templates can ensnare a narrator in an ill-fitting story is noteworthy. I do not intend to test her categorization of pathographies; instead, I consider her identification of themes of battle, journey, rebirth, healthy-mindedness, the Gaia myth, and the overarching myth of narrativity in this genre to be representative of what a reader of illness narratives might observe, and thus potential influences on my research subjects.

Frank's (1995) assessment of the state of the genre overlaps with Hawkins' in terms of the categories he identified. In his triad, we have the highly socially valued quest narrative, in which narrators describe illness as a journey to an unknown destination and tell how they made of that journey a quest; they narrate in order to bear witness to the journey and share the wisdom they have gained through it. There is also the restitution story, in which the narrator travels full circle and is restored to normalcy and health after the troubles of illness. Finally, there are chaos narratives, where no clear structure really emerges, where events are disordered, unpredictable, and the narrator is not in control. Frank's theory also corresponds to Hawkins' in his preference for narratives that signal mastery and the communication of meaning that transcends the suffering of illness; he prioritizes the quest structure as the most successful and considers chaos barely a story at all. Where he differs most significantly from Hawkins is in examining these stories at the level of the body, and theorizing four general problems of embodiment that illness forces a person to face, a spectrum of responses to each, and four ideal types of self that emerge from how a person handles the problems of the body. Of these ideal types, he holds up as exemplary the communicative type, the suffering body that expresses itself in storytelling for the sake of others. What was groundbreaking at the time was how he explored the possibility of constructing a valid or even transcendent form of self *through* rather than in spite of the sufferings of illness, and how he connected narrative and embodiment. While his is a classic and much-cited typology, I find a problem in Frank's moral motive in privileging a certain kind of productive body. The strong preference for narrators who generate particular kinds of meaning for their readers, rather than, say, narrators who expose their experience in whatever form it may take for an audience to actively witness

and engage with, is a culturally constructed imperative rather than something we can assume to be universal. I argue that this comes to be an oppressive analytical framework, and yet he has captured something in the expectations the reading public has come to hold for this fairly new genre of writing: the provision of order, the construction of meaning, the demonstration of overcoming in some capacity. The self who writes an illness narrative “should” be one who understands, overcomes, attains wisdom, and inspires.

### **The New Neuros**

Neurodiscourses and neurotechnologies are all around us, in both macro- and micro-ways. In her exploration of how neuroscience is shaping public policies and institutional practices in the United Kingdom, Pykett (2015) investigates manifestations of “brain culture” in architecture, education, and the promotion of positive psychology in workplace training. In each setting, brain-based rhetoric assists in the governance of those to whom it is directed or applied, while appearing to be universal, value-neutral, and respectful of individual agency. Brenninkmeijer and Zwart (2017) analyze the appearance on the market of an increasing range of “soft” neuroenhancement devices, including wearable plush cat ears that respond to the user’s attentional states as interpreted by an EEG device and over-the-counter devices using different forms of cranial electrical stimulation to alter one’s mood or mental state. These “neuro-toys,” Brenninkmeijer and Zwart argue, are parasitic in how smoothly they infiltrate our lives and how subtly they can shift our sense of the normal, through making mental states (or the limited set of states as they are defined and operationalized by the maker of a neuro-toy like

Necomimi-brand cat ears) visible to others and manageable in new ways toward states suggested to be optimal. In these toys, “brainwaves” are presumed to offer the most direct access to inner experience, and to be unproblematically legible with the assistance of technology. “With a very simple gadget, a new type of knowledge, namely brainwave knowledge, is distributed, communicated and interpreted” (2017:343). The marketing of the devices encourages us to open our interior lives up to our own and others’ scrutiny, not to mention surveillance by those with access the data we upload to some of the devices now or in future iterations. Transcranial direct stimulation, neurofeedback, and other “brainwave” technologies are becoming more commonplace, and carrying with them the discourse of brainwave knowledge.

The discourse of plastic brains underlies or intersects with many of these manifestations of the neuro-. Made popular in trade-press books like Norman Doidge’s *The Brain That Changes Itself* (first published in 2007) and Daniel Amen’s *Change Your Brain, Change Your Life* (first published in 1996, and part of a network of programs Amen markets for this purpose, both on- and off-site of the Amen Clinics), “brain plasticity” appears in public-oriented discourses as a “limitless and largely untapped” (Pitts-Taylor 2010:641) resource, that we have both the power and the responsibility to improve upon toward more adaptive ways of being. Malabou describes how this discourse of plasticity allows us to think about the brain as both object and process, but she notes that this “neuronal ideology” (2008:11) is so closely interwoven with the new “spirit of capitalism” that our understanding of plasticity is confounded by the capitalist ideology of flexibility. The problem, she notes, is that flexibility entails a docile reception of form whereas plasticity, in her reformulation, is both a making and an unmaking:

“disobedience to every constituted form, a refusal to submit to a model” (2008:6). Moreover, our brains are being made over into a justification of “flexibility without limits” (2008:6), an ethos which neatly justifies economic and social discourses of flexibility that construct individuals as endlessly movable nodes in a network that shifts according to its own needs. Malabou calls for us to liberate ourselves and our plastic potential from the ideology of flexibility, while Pitts-Taylor argues that we are already constructed in its image. In either case, the discourse of brain plasticity is a sticky one both in the concurrent work it does for hegemonic social structures and in offering hope to individuals of changing their fortunes.

More broadly, Rose and Novas (2005) remind us that our bodies are both economically and politically valued, and in the present era, managed. Biological citizenship at present in the West entails a view of biology as “knowable, mutable, improvable, eminently manipulable” (2005:442), coupled with a moral mandate to become informed about the science of bodily matters, maintain hope for a more normal or ideal body, and take action toward bodily optimization. As biological citizens, our productive value—or that of our illness, or the data our bodies generate—is of central concern. We describe ourselves and our prospects in scientized, biological terms, and we take on the responsibility of active choice-making on these terms. And there are further specifications, demanding perhaps more intrusive self-fashioning, when attention is called to mood, cognition, or anything we could associate with the brain or mind: Rose’s theorized “neurochemical self” (2004) or LeDoux’s proposed “synaptic self” (2003) are two prime examples.

While all of these neurodiscourses might seem to offer very attractive, validating pursuits for people with post-brain-injury anger to pursue, there are various ways in which this population might find themselves disconnected from these ways of thinking about and constructing the self. Biomedical information about the condition is scant, choices to be taken with regard to it are contradictory, and the construction of the flexible, productive body that emerges from each of these may be at odds with what it means to live a good life after a serious brain injury. The lack of research on and therapies for post-brain-injury anger also suggests that the condition is not perceived as one that generates biovalue for corporations or the state (see Rose and Novas 2005); the overarching discourse of biocitizenship may be one from which they are—for better or worse—excluded. In this, Malabou might see opportunity to engage in a more truly transformative undertaking than the mere reproduction of neoliberal flexibility and of mind-brain-body ideals that are ultimately attainable by no one.

## **Findings**

Here, I discuss the three most robust of constructions of the brain-self relationship that have emerged from the studied accounts of post-brain-injury anger: “the processual brain and the psychologically reactive self,” “the (un)protected brain and the layered self,” and “the flickering brain and the rational, interruptible self.” Using narrative excerpts from interviewees and authors of memoirs, I illustrate each construction. I conclude with a discussion of what these findings reveal more broadly about the

construction of a livable, creditable self amid the “expanding constellation of neurocultural discourses and practices” (Vidal 2009:5) theorized above.

### 1. The Processual Brain/The Psychologically Reactive Self

In this construction of the brain-self relationship, narrators focus on *processes* of the injured brain and frame them as continuous with those of the non-injured brain. Referring to intersubjectively unknowable processes of mind, these accounts attribute anger to psychiatric diagnoses such as depression, and/or position anger as the secondary emotional response to stress. To be depressed after a brain injury or frustrated at goals blocked by brain injury symptoms is reactive rather than a primary change, and in that sense, extreme anger is positioned as a *normal* response to extremely stressful circumstances. Narrators of these accounts elude (or simply disregard) the problems of brainhood in taking a *processual* rather than material approach to the brain.

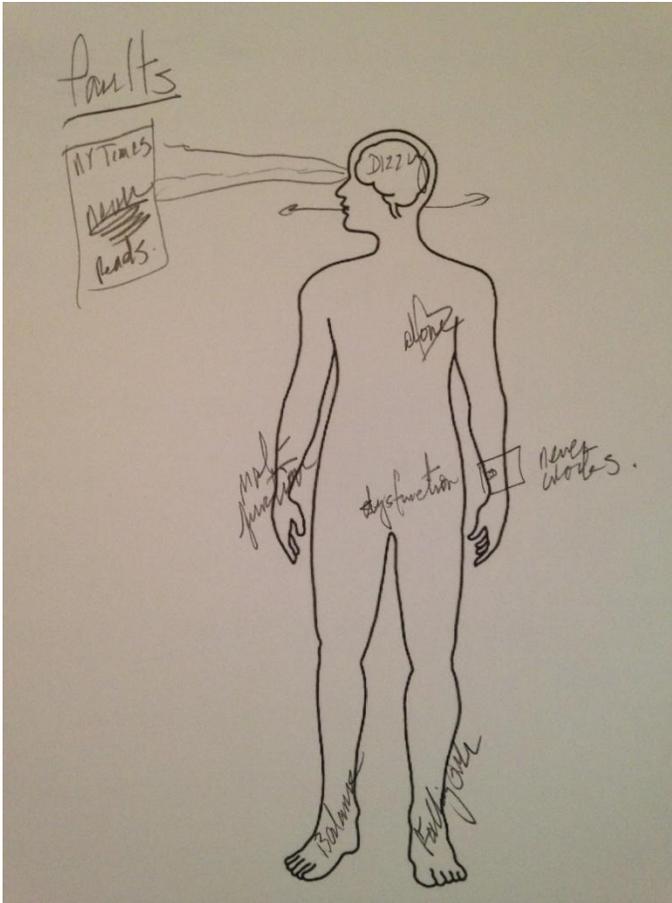
First, people cited psychological mechanisms prominent in the popular imagination, like frustration, resentment, and moving past denial to come to terms with changed circumstances. Mark’s<sup>2</sup> story exemplifies the cascade of frustrations to which some subjects attributed their anger. He drew the picture below to show the “faults” and frustrations brought about by his brain injury: loneliness, dizziness, imbalance, difficulty with dressing, decreased sexual function, and difficulty reading. He described how a series of irritants—needing to sleep late and falling behind in the routine that structures his days, dealing with a now-necessary roommate’s untidiness, and struggling to button a cuff with his weakened hand—lead to “overload” and anger. Whereas in the past he kept

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<sup>2</sup> Interview subjects are represented by pseudonyms; memoir authors are represented by the names under which they published their work.

anger in, constructing his emotional life as a foil to the anger he witnessed in his father and brother in his youth, he now vocalizes his anger and says he hopes someone will hear and acknowledge how difficult his circumstances have become. Mark has created a routine of exercise and support-group attendance that structures his days and keeps him focused on recovery, but he describes a background of deep frustration at the suspension of the film projects he had been immersed in at the time of his injury, and which he can no longer easily complete without the judgment and technical assistance of a friend, whose time is scarce. His tone as he described leaving the gym in the morning asking, “What am I gonna do today? Who am I gonna *be* today?” conveyed the sense of a man unmoored from the projects, relationships, and potentials that had ordered his pre-injury life. His self is seriously threatened, but not fundamentally altered; he expects to master his physical difficulties and return to work, and he asserted that his anger will subside when he has been able to accomplish more highly valued tasks. In his narrative, we see an understandable series of frustrations leading up to anger that, while it is more “severe” than he had experienced in the past, is still constructed as a psychologically comprehensible outcome of unusually difficult circumstances.

[Fig. 1: Mark’s drawing of the cause of his anger (body/brain template provided).]



Geo Gosling, author of “TBI Purgatory,” described his anger with himself for his role in the accident in which he was injured, and with “anyone who I perceived as happy and ‘successful’ because I was certainly not happy and ‘successful’ and wanted to be.” Asking, “Who doesn’t want to be happy and successful?” (p.23), he normalized his anger as something arising from ordinary frustration over unfavorable comparisons to his past self and to others. He later described how adopting a kitten “gave me a sense of worth, and that improved my self-esteem, and that decreased my depression, and that made life better, and that made me slightly less angry” (p.32). Resentment, depression, and low self-esteem are understandable secondary outcomes of life with a brain injury and potentially remediable (in Geo’s narrative) by changes as simple as adopting a pet. To

construct anger as the outcome of such a chain of psychological processes is to distance it from the identity of the narrator.

The idea of a chain of frustrations also creates a number of points of intervention at variable distances from the self: in Geo's case, the sense of uselessness brought on by the changes in his roles was alleviated through caring for a kitten. Mark pointed similarly toward blocked role performance and public self-presentation as key sites of intervention. While he notes physical and personal troubles in this chain of frustrations as well, note, in Figure 1, the heavy underlining that emphasizes the word *never* in the image of the *New York Times* that he "never reads." In the drawing, the newspaper and its heavily marked label are the focus of three beams of ocular attention from his head, which is labeled "dizzy" and marked by an arrow from the mouth, reflecting the harsh words he recalls using, and a rotational arrow at the back of the head suggesting dizziness or even disorientation. This arrow points in the opposite direction of the *Times*, suggesting that his symptoms pull him away from the world represented by the newspaper. Mark struck me, during our interview, as humorous, intelligent, creative, and kind. He was poised and elegantly dressed. He spoke of taking on meaningful work through caring for his family's home and working toward his next creative project. And yet he feels alienated from the world of the urban intelligentsia symbolized by the *Times*, and the drawing suggests his view that he could choose work to remediate his anger through any one of the problems the drawing lists, perhaps most directly through problems of attention and concentration that hinder his reading.

Others positioned their anger as a stage in a continuum of psychological healing. Chris Lee, author of *From Frustration to Fulfillment*, attributed his anger to being "not

yet aware of the need for self-acceptance” (2012:27). After describing how the “clutter” he was “having trouble clearing” from his head caused his emotions to range widely, he narrates how, in the process of preparing for a sale of the “clutter” around his home, he cleared away hospital gowns, old medications, and other relics of his accident, and in the process became “ready to begin releasing all the resentment, blame and general overall negativity associated with this life-changing incident. That is when true healing began” (2012:90). He thus constructed the cause of his anger and other moods as psychological baggage he had been carrying, which stalled him on the road to recovery. In *Living with a Brain Injury: What Helped Me To Stop Being My Enemy and Create a Life for Myself*, Craig J. Phillips positioned his anger among the five stages of grief; it is part of the process of tracing his feelings to their roots in “past hurt, anger, disappointment and resentment” (2015:89) with the help of journaling, consultation with his mentor, and meditation. Chris<sup>3</sup> and Craig’s narratives each focus on the narrator’s reactions and expectations, and each is clearly marked by self-help and psychotherapeutic language, language of the mind rather than of the material brain. While their lives have changed and the journey through recovery can be expected to change who these men are (as any therapeutic journey would), they do not represent themselves as having been fundamentally altered by the injury itself. They are simply in a normal, if undesirable, spot on their psychological journeys.

Some narratives separate psychology from physiology/materiality by general reference to the “mental.” Geo detached the emotional experience of anger from the

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<sup>3</sup> From this point, I use the first names of memoir authors as well as the first-name pseudonyms of interviewees. This is to avoid suggesting a difference in respect due to those who I spoke with on a first-name basis and those I have met only through their publications.

material injury to the brain when he wrote: “The actual physical injury to the brain is permanent [...] However the emotional, psychological or mental aspect of a TBI can be temporary” (p.146). And in dismissing people who talk about the “new me” post-injury, James argued that there is no limit to “mental recovery.” He implies that brain injury is not a unique disruption, that the self cannot be changed or lost, and that one is always in the process of *becoming*. This in spite of his casual description of how, when he looks at imaging of his brain, “I can see damage that’s never gonna repair.” Narrating a distinction between brain and mind, James protects his selfhood from being defined by the damage to his brain. Similarly, Lori Purdy Faitel, whose memoir “Am I Brain Damaged?” ends with the emphatic statement “Yes, I AM BRAIN DAMAGED” (p.156), wrote of how hard she “worked every minute of every day not to be mentally sick” (p.66). While the injury to the structure of the brain is seen as permanent, treating the mind as a separate and recoverable phenomenon is one way of negotiating the stigma potential of a permanent brain injury with emotional symptoms. While scholars attending to neurocultural production often point out how our new conception of the mind is that it *is* what brain *does*, I saw no such link in these accounts. They are emphatically dualist, and the individual’s work of remediating problematic symptoms like anger can occur at the level of mind in a way that is unlimited.

Others accounted for their anger as a downstream consequence of one or more symptoms of brain injury. Some described how outbursts happen when they are overwhelmed by stimulation or by problem-solving tasks that tax their cognitive ability. The fatigue that characterizes life after a brain injury was frequently cited as a factor leading to anger. “When I become extremely tired, and ‘hit the wall,’” wrote Geo, “I am

always in a rotten mood” (p.116). Even while calling attention to the injured brain, these accounts positioned anger as secondary response to a less-interpersonal and often less-explosive symptom such as fatigue or speed of cognition. Breaking anger down into known brain-injury symptoms may help anger seem like the end of a complex chain of psychological events with one or two missing links, with the person holding the end of the chain more or less unchanged. Pinpointing contributing symptoms may also allow injured people to focus their efforts on managing symptoms more tractable than anger. Alternatively, in isolating one particular chain of processes that has been compromised, these narratives resonate with philosopher Derek Parfit’s idea of identity as composed of “overlapping chains of connectedness” (1984:205), which allows for some chains to be broken while others persist and thus emerge as the core of identity.

In the psychologically-based accounts of all these narrators, anger results from a (theoretically) manageable *process of the mind* that is continuous with those of uninjured people. Constructing anger as a temporary feature of a difficult psychological position they are caught in until they achieve acceptance, process their trauma, or manage to reduce their internal and external stressors, these narrators fashion a continuous sense of self based not exactly on individual psychological continuity (as philosophers of identity often posit), but on general psychological *comprehensibility* with regard to circumstances.

## **2. The (Un)protected Brain/The Layered Self**

These strategies construct the brain as composed of layers of protections and socialized learning. The injury, having compromised one of these layers, exposes a more

vulnerable, raw, or primal self; sometimes it exposes or facilitates the expression of a more *authentic* self. I identified two variants of this category: anger that emerges from a brain stripped of its layers of learned knowledge and restraint, and anger that emerges to protect a person whose brain has been stripped of other self-protective capacities.

***Anger from the de-socialized brain:*** Some spoke of the injury as having rewound them to an earlier developmental stage. According to Geo, “A person who has suffered a severe TBI, like I did, is essentially a full-grown, extremely upset infant that needs a lot of care” (p.9); he describes himself learning skills and establishing his “disposition” over time, as an infant might. Lori wrote of her recovery as “redevelopment” (135), likening the post-injury “age of learning” to the period “from birth to 24,” and referring to “Lori in limbo, the one in the cocoon, soon to emerge in my new form” (87) in explaining a series of actions that she later regretted performing. She discusses her “new form” as an improvement on the old. Two-thirds of the way through her book, she reveals that she had explosive anger outbursts *before* her injury as well, and it is the “redevelopment” process following the injury that motivates her to work on strategies for reducing her anger. She thus treats her injury as having wound her back along the developmental trajectory to an earlier stage, and this period of redevelopment as an opportunity to more mindfully create her character, even as she insists she should not be held fully accountable for the actions and reactions she manifested along the way.

Sue traces her anger back even further. Although she was angry in her pre-injury youth, it was an anger she used “to keep myself and my people safe.” It was a “spark,” a “surge,” motivation to act without fear. By the time of her injury, she had “mellowed” and “evolved,” having found an outlet for that anger in sports. Her injury not only

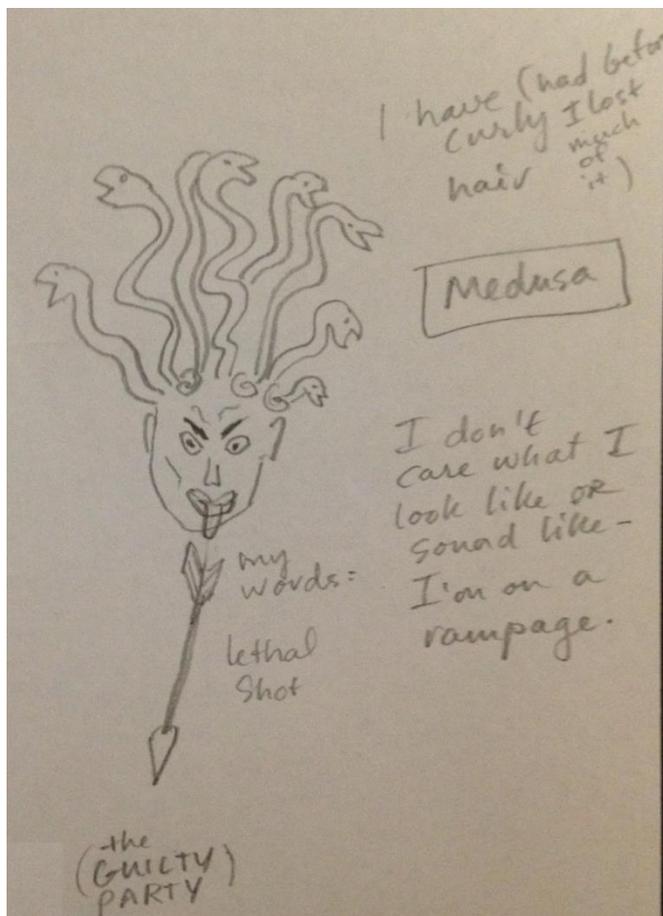
reversed that process of evolution, but brought out in her a “primal rage.” This post-injury anger offers her no more than a moment of confidence, strength, or protection, as it is a desire to destroy and “show my dominance of the world.” She misses the anger of her youth, and wishes she could still call upon it and manage it for protective purposes, but she feels that injury has diminished her in two ways: she has a less “energetic armor” or life force to “push out energy” and keep negativity from coming in, and she has a smaller “toolbox” of coping skills—higher-level cognitive skills of articulation, reframing, complex understanding, and perception—for managing anger when it arises. I will return to an equally important theme of Sue’s narrative below; for now, I note that she called her post-injury anger a “classic fight response” to things from which the capacities she developed over a lifetime previously protected her. James also spoke of having no more “flight” reaction after his injury, only “fight.” He related his “hypersensitivity” and “startle reflex” to a defensive feeling that “they’re out to get me.” For both Sue and James, the injury stripped away a layer of earned knowledge and socialization, leaving them at the mercy of primal, reflexive, instinctive emotion. Yet both are actively engaged in reversing this process. James “disconnects,” a flight reaction that is partly under his control and sometimes suggested by a friend who may tell him to take a walk. Even though he describes this as “go[ing] into my little box,” he goes outside and walks in the woods, where movement, solitude, and the free rein he gives his imagination can bring him back into connection with those by whom he felt disrespected or attacked. He is adding a “flight” response to his “fight” reflex. Sue senses growth in her awareness and ability to respond to negativity or complexity in others’ emotions, and her relationship with her partner is becoming more nurturing and interdependent with regard to helping

Sue stay rested and nourished so she isn't raw and vulnerable to angry outbursts. Sue takes concrete steps as well: she stocked her garage with unwanted pottery from her studio to give her an outlet for her destructive anger when it arises, and she was pleased to report that her pottery-smashing strategy was a success. Narratives of a brain that has regressed to a younger or more primal stage do not imply that the person is arrested in that stage. They convey potential for redevelopment, and sometimes for a very intentional refashioning of the self. The themes of animal-ness are mild but present in these narratives: in James traveling the woods until he is ready to return to society (and speaking of it metaphorically in terms suggesting a dog being crated for calming purposes), and in Sue drawing the wild animal image of her anger that is shown as Figure 5 in the section below. There may be a warning here, against parenting, disciplining, or otherwise attempting to control the narrator: they may have regressed, but they are not to be viewed or treated as a child.

***Anger as protection of a vulnerable brain-self:*** Some accounts valorized anger as something that protects a newly vulnerable self. Marie spoke of how her bodily experience of anger will warn her that she has been “slighted” before she can cognitively process what has happened, and how it will motivate her to take self-protective action. She also described how she can “use” Medusa (see Fig. 2), a self-protective mode of anger she developed as a child in dealing with her verbally abusive mother. Her caption about Medusa’s curly hair reflects her identification with—even idealization of—this character or mode, and she normalizes this mode of anger by rooting it in her pre-injury past. She described using Medusa recently to end a long-term abusive relationship in which she came to realize—with a slowness she attributes to the cognitive-processing

delays associated with her injury—that her symptoms were being used against her. When she realized there was nothing important to lose, and after several days of her anger simmering to a “boiling point,” she said Medusa came out: “I slice[d] and dice[d] him with my words.” Medusa targets “the guilty party;” thus, Marie locates the cause of this kind of anger in others’ actions and slights, against which Medusa is her last resort for self-defense. While there appears to be some element of will in Medusa’s emergence, Marie also described anger beyond her control and spoke of it positively as a general motivational force. When I asked what bothers her most about the anger, she replied, “I’m glad I get angry, because if I wasn’t, I wouldn’t be doing anything. It’s up to me to find something constructive to do with that.” Other motivations for action may have been stripped away by the injury, but the rise of anger taps into a deep well of energy that she can then channel by her own will and choice to accomplish things of value. (Whether she is able to harness and channel that anger makes a difference; I will discuss other constructions she produced below.) Marie thus constructs anger as compensating for capabilities weakened by the injury. In her narrative, this intensely disruptive phenomenon is not a sign of pathology but rather a protective response to other symptoms or deficits caused by her brain injury.

[Fig. 2: Marie’s Medusa drawing]



Lori described how anger restored her motivation to continue working on her recovery. After describing her horror and despair at realizing she had unknowingly defecated in the shower, Lori reported:

Mom always cleaned up my messes patiently, which just made me angrier. She didn't mind cleaning, because I was sick. I extensively worked every minute of every day not to be mentally sick. Mom's patience with my inability made my blood boil. If my mom could accept and handle the disgusting messes I created, she must have accepted I had reached the end of my recuperation. Maybe I should accept it also. Maybe I was not "normal." Maybe I would forever be unable to be an independent woman again. I cried harder, stomped my feet, and ground my teeth together until I felt pain. I will not be mentally sick...No...I won't accept that! (p.66)

Lori took great care in her book's introductory chapters to establish herself as an independent young woman striving for a normatively successful life. In the context of that identity, the anger she attributes (in this passage and many others) to her exclusion

from normal activity, achievement, and independence expresses an enduring character trait. In her narrative, anger is more than frustration; it is a motivational force and a reflection of her character as a worker and striver.

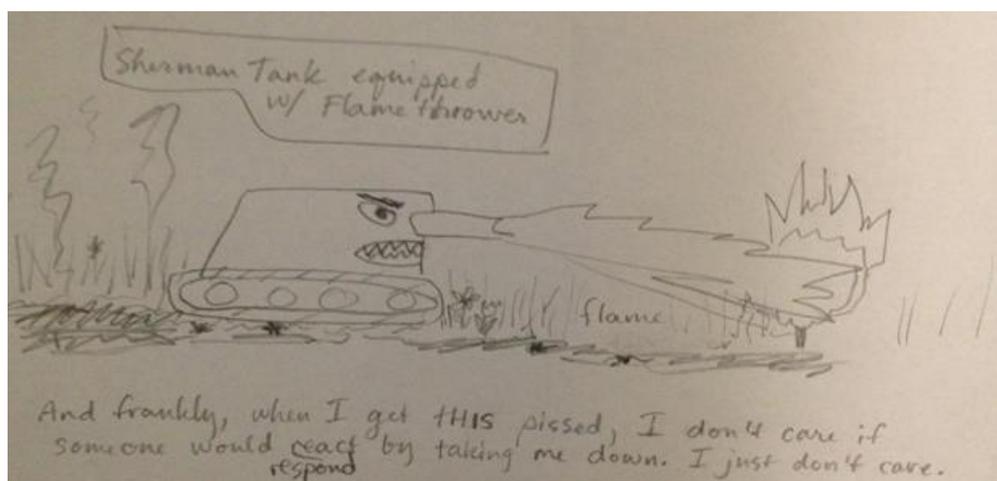
In accounts that value anger positively, anger is valuable in what it signifies about the self, in the power it bestows on the self to protect, or as energy to be channeled by the will of the self. In these narratives, the brain injury has not diminished the self, but rather exposed something essential and authentic at the core of the self. Whether that exposed element is the anger itself, or something vulnerable that anger projects itself into the world in order to protect, what these narratives have in common is a newly vulnerable person who is still able to accomplish self-protection in some way.

### **3. The Flickering Brain/The Rational, Interruptible Self**

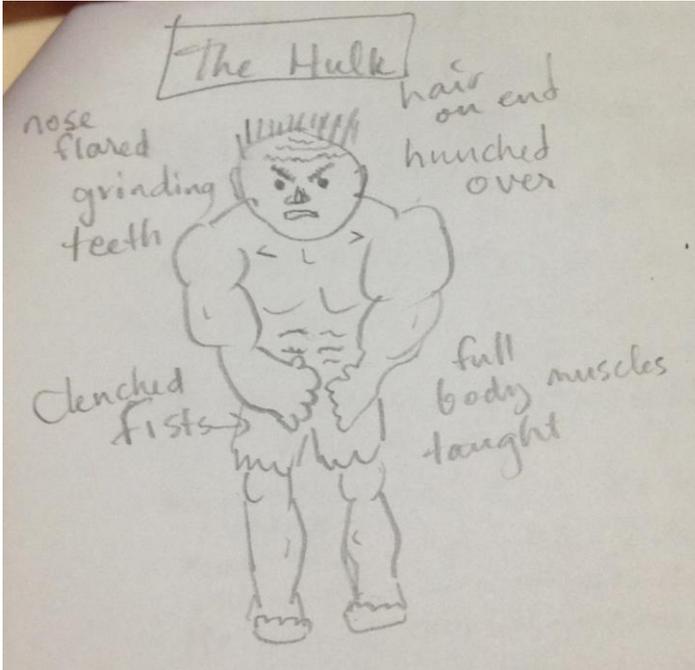
These strategies construct the injured person as a rational being who is at times eclipsed or engulfed by an irrational force that they are working to master. Marie and Sue each use an eclipsing construction and developed it further in the ways they constructed the anonymous other by whom they were eclipsed. Each woman drew a representation of her anger as something other than herself. In addition to the Medusa image above, Marie drew herself as a personified tank crushing flowers, setting a tree ablaze, and putting her at risk of being “taken down” (Fig. 3). She identifies the tank as “I,” but it is also something other than herself, and a way of being beside herself, entirely unconcerned with her own safety. Marie also drew the Hulk. While he is a superhero with a pro-social storyline, he is also bestial and hypermasculine, and these are the traits she emphasized in her depiction (Fig. 4). He is more common in her experience than Medusa and, by

contrast, he is not something she developed in the way she recounts Medusa's genesis; the Hulk did not precede her injury, nor does he do anything useful for her. Instead, he engulfs her and exceeds her control. Sue drew a three-stage process (Fig. 5) in which she moves from unhappiness in a situation through "starting to lose my ability to hold on to rational feeling" to explosive rage. The sharp teeth of the final image convey that she is "no longer a domestic animal" at that point; she has become wild, something else, something out of her control. "I'm in the pool of anger," she said, describing the anger as something outside her, engulfing her, rather than something she manifests from within. While the emergence of the "other" in Marie's and Sue's narratives is more episodic than in Randal Flutur's (2013) narrative of the other as his constant companion, they similarly project the anger onto a character who is not-quite the narrator herself, and whom the narrator *struggles against* rather than *acting through*.

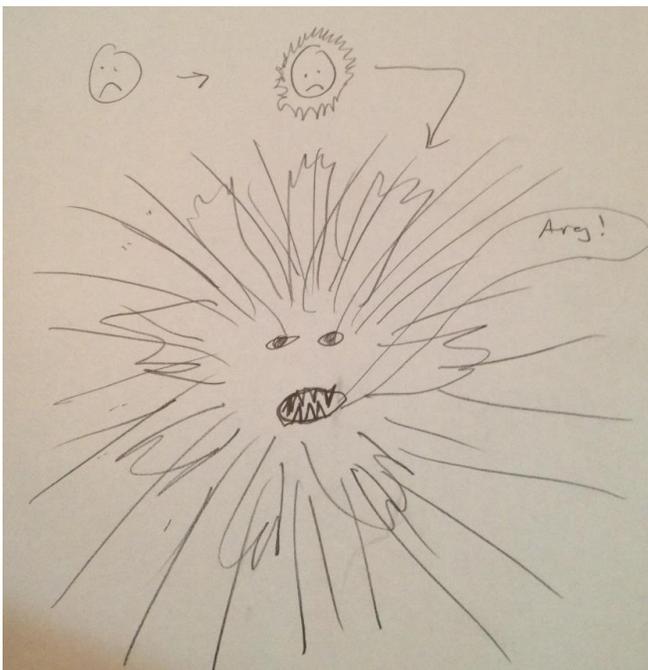
[Fig. 3: Marie's tank drawing. Captions: "Sherman Tank equipped w/ Flame thrower", "flame", and "And frankly, when I get THIS pissed, I don't care if someone would react respond by taking me down. I just don't care."]



[Fig. 4: Marie's Hulk drawing. Captions: "The Hulk" [from top left to bottom right]:  
 "nose flared", "hair on end", "grinding teeth", "hunched over", "clenched fists", "full  
 body muscles [taut]".]



[Fig. 5: Sue's drawing. Caption: "Arg!"]



Both women are scientists by pre-injury training and trade, so it was not surprising to find that logic and reason figured strongly in their narratives of how they work toward managing their anger. Marie described her anger trajectory as a mathematical curve and spoke about how different “catalysts” like anger or stress will put her at a higher or lower point on the curve, thus affecting the “amplitude” of the anger that emerges. She spoke of how important it is to her when speaking to others to avoid sounding “biased...emotional”; this priority and wanting to be a good example for her son help her make the choice to compartmentalize her anger. She described a rational strategy of listing pros and cons of acting on anger versus compartmentalizing it. While she said she does not find time to use this strategy, she put it forward as the ideal response. Her drawing of the Sherman tank also illustrates compartmentalization in her correction of “react” to “respond” in the commentary on others’ actions below the picture: she added the word “respond” without quite striking through the word “react.” I interpret this as Marie’s care to indicate that she is sensible of a difference between rational response and instinctive reaction.

Marie explained that upon reflection, she can always discover a reason why her body reacted with anger; she exerts rationality retrospectively to explain why her scalp tingled and her face became hot in an interaction. The story she chose to tell me in greatest detail was a clear-cut story of an abusive relationship in which she had given a boyfriend a great deal of care and understanding only to be mistreated in return. It took her some time to realize what was happening in that relationship, and while this is not unusual in abusive situations, she attributes the delay in her realization and her anger to her cognitive processing delay. It was her anger that helped her locate and defend herself

against “the guilty party.” In her narrative, she is still fully reasonable, just on a longer timeline than previously, and in retrospect, her anger is actually a part of the process of perception; it motivates the reasoning she will use as she looks back to figure out what it was that made her angry.

While Sue’s narrative was a fascinating pairing of spiritual and rational ideas, she focused here on her effort to identify the moment at which she could choose to disengage from the process of becoming angry. She described the second of the three stages she drew as “a shimmering moment of choice...a moment of possibility.” Even if she is not yet able to take advantage of it, she holds on to the belief that there is a moment in which she can catch herself becoming irrational and turn herself back. And she is careful to observe the symptoms and conditions, particularly hunger and fatigue, that make the emergence of anger more likely. She described how she is learning to disengage and talk about the topic that angered her later, when she is fed and rested. She, like Marie, has researched her cognitive symptoms quite thoroughly; she can easily call them by name, describe how they contribute to her explosive anger, and track her progress in those areas of function. Her account centered her commitment to try to *restore* reason by logical and orderly means whenever she is able. In a twist upon Locke’s “sameness of a rational being” (1689:II.xxvii.9), it may be this *will* toward reason, whether successful or not, upon which she founds a viable selfhood.

Vickie said of her anger, “I turn into the antichrist.” She cited her education and her previous career in social work as evidence that “I am not that type of a person,” and she likened the anger to “becom[ing] someone else, because it is so out of control.” She drew an episode for me, as a head with an open mouth, “lightning” zig-zagging through

the forehead, and no other features than the storm and yelling mouth. She said that the storm originates from her brain injury, it “all happens in my head,” and “to get out of it, I have to think.” Her “head” is not the same as her sense of “I”; she makes a dualistic narrative move here that situates the anger as something that doesn’t come from her *self*. In explaining that it isn’t part of who she was in the past nor who she wanted to be, she thus situated *desire*—commitment to becoming a desired version of oneself—at the foundation of her selfhood.

[Fig. 6. Vickie’s drawing.]



Jeanette described herself not as doubled, but as becoming *engulfed* by anger. In phrasings such as “I just lost it – frustration, plus pain and the rage exploded,” she referred to “the” anger in a way that distanced it from the narrating I. While this may seem to be a chain-of-frustrations explanation, Jeanette also described the rage as “like standing under a Niagara Falls of raw emotion with no way to turn it off” and the feeling of “surging energy – I felt like I was short circuiting – energy surging everywhere with

no control.” It’s “neurological gridlock...more traffic than I have lanes to process the traffic.” She was, in short, engulfed. In her booklet, she qualified her response to “How would you describe your emotions during the outburst?” by writing: “Part of my problem is that I don’t have good fine points about what I feel. I essentially lost my body and what different signals from my body meant when my brain swole up 11 days post op [approximately 20 years ago].” While she wasn’t speaking directly to the etiology of her anger, connecting this to her description of the Niagara Falls of rage suggests a link, as if her severed connection to her body is what allows her “whole body [to become] charged with rage.”

She spoke in our interview in terms of severed connections, specifically, of her brain surgery as an amputation. In a tone that reminded me of a solemn naming of the dead, she recited for me: “My brain stem is damaged on both sides. The limbic emotional center of brain is partially amputated, it has been cut through by scalpels. The pons cut through by scalpels. The cerebellum has been cut through by scalpels. The hypothalamus has been cut through by scalpels, and the left amygdala has been damaged by post-op swelling. And all those areas that were cut were also damaged by the swelling.” Less literally but still significantly, she described how a spiritual teacher had given her a name that she was meant to grow into, but “brain tumor surgery ended that.” After her tumor excision, she was unable to seek further training or attend gatherings of her spiritual group in person. However, she told me that she was still in metaphysical communication with the others in her spiritual network; she would sense that one had helped her, or someone would respond to the guidance she offered in an email before she had even sent it. This seemed to relate to her particular variant of dualism: “My mind and my brain are

NOT the same things. My mind knows what it wants to do—how it wants to be in the world and uses my brain to actually carry out its intentions—the problems happen when my brain is unable to do what my mind wants done,” she wrote. “Windows is fine,” she joked at another point, “but the CPU is screwed.” Among the many agile narrative moves she made, from medical narration to spiritual testimony, the image that emerged was of a balky brain that can’t carry out the intentions of her mind-spirit-self, which allows negative emotions such as anger to flood the body from which her mind has also been severed.

While the experiences Jeanette described sounded truly overwhelming, she reframed them in terms of “timeline therapy” after describing the various mainstream, alternative, and spiritual practices that hadn’t helped her: “If you need to learn a thing, emotion gets your attention.” This intersects with the strategy described in the previous section, of the anger protecting a newly vulnerable self, and it led to her setting herself some introspective tasks for tracing the anger back to an original hurt. She had described to me over the course of the interview a life marked by trauma and adventure, and we laughed together over her description of herself as a “tough little bitch”; resilience was part of her identity, and I had a sense during our interview that she was actively constructing new understandings of her anger and generating ideas from her spiritual studies for working toward the source of the anger. While her rationality was perhaps even more strongly entwined with spirituality than Sue’s, and while she was moving in the direction of locating her anger in her difficult childhood with abusive parents, she was nonetheless taking a student’s orientation toward her anger: identifying learning needs, setting herself tasks, and reporting on progress toward goals.

Externalizing anger as a besieging or engulfing force assigns the stigma potential of anger away from the personhood of the narrator, and it provides the narrator with a problem that they can objectify and work on by rational means once an episode has passed. The challenge of trying to rationally manage one's own irrational outbursts may be paradoxical, as Weiner (2011) noted in her study of people self-managing bipolar disorder, but it may be the *process* of rational self-surveillance (with or without a fully successful outcome) that allows people to assert their validity as a rational, self-managing subject. As I will discuss in the following chapter, however, the extent to which an individual or their social partners center and internalize the belief that anger and rationality are opposing forces could affect the degree of distress they experience from their anger.

### **Conclusion**

I hypothesized that in a cultural context in which brainhood is taken as background knowledge, people would avoid claiming an emotively damaged brain in order to avoid claiming a compromised, emotionally untrustworthy self. Indeed, “damage” has been far from central in the narratives I have studied to date. Even Lori Faitel, who began and ended her book with the idea of damage, managed the stigma threat in a variety of ways that keep the “damage” away from the identity she constructs for herself. And the ideas Jeanette generated for herself in the course of her interview, in spite of taking a severe stance on her brain “damage” as “amputation,” speak to the complexity and creativity she brought to bear in narrating her post-brain-injury anger. Vickie, similarly, made a variety of narrative moves that we might call subjunctive in the

sense of Good and Good. She described, for instance, a shared “epiphany” with her husband, as they realized that he had to “honor it [the anger] and know that it comes from a place of injury, where the brain injury happened.” The two uses of *injury* here represent different distancing techniques: “a place of injury” is language rarely used for physical damage and suggests instead a metaphysical or psychological wound, while “where the brain injury happened” situates the injury in the past. My narrators’ moves around the concept of “damage” suggest that it does carry stigma potential, but that it is being managed subjunctively in ways that produce constellations of selfhood rather than single selves orbiting the heavy concept of “damage.”

We might expect neuroplasticity to be a powerful discourse to call upon in this context. However, those who did mention it did so in ways that deviated from the mainstream discourse of “brain training.” Jeanette named Norman Doidge, cited neuroplasticity by name, and made several comments about her hope that “there is a healing that the brain can do even in the primitive areas where my brain is damaged.” Yet she framed this as a sort of side effect of her own efforts, or even the brain’s own business that would proceed with or without her input, rather than specifying any particular way she hoped to engage it. Geo calls up the discourse of neuroplasticity when he writes about how his “brain was ‘re-wiring’ itself to make up for the injured areas” (p.93), in some cases falling short and in others, getting “a little carried away,” such that “certain areas of my brain are connected in their auxiliary configurations and as a result my feelings of sympathy, empathy, sadness, etc. have been amplified” (102). It was a process both healing and pathological. And Randal spoke of rewiring as a purely pathological process by which his injured brain created “the stranger” (Flutur 2013). All

of my subjects had a sense of recovery, but beyond these references, none specified any process or mechanism by which recovery happened in the material brain.

Nor has there been any appearance of Rose's "neurochemical self" (2004), constituted through chemical flows that may require pharmaceutical rebalancing. Medical treatment for the anger was not a priority for my interviewees and memoirists, and mention of neurons, neurochemicals, synapses, networks, connections, or any such mechanism or metaphor was rare. Furthermore, my questions about medical images of their brains evoked no special interest from my interview subjects overall, although Xavier found them "beautiful" and pulled up a file of his scan images to show me, and James found them a picture of "death" at which he refused to look. Between these emotionally-charged poles, these were not of narrative use to my informants. The last few decades of developments in neuroscience seem to have affected these subjects' relationships to their brains modestly if at all.

Yet brainhood is an older construction, pre-dating the recent neurocultural turn, and still a prominent discourse with which to contend. The styles of attribution I observed—"the processual brain and the psychologically reactive self," "the (un)protected brain and the layered self," and "the flickering brain and the rational, interruptible self"—represent different ways to navigate the problem of having an injured brain in a time of brainhood. The first style focuses on the brain's processual rather than material nature, which draws attention away from the material injury to the brain and to the altered circumstances of the person who suffered the injury. This situates anger as a reaction to rather than a direct result of the brain injury. The second style centers selfhood in a sort of core generator of identity that persists and powers the person's recovery and

development after layers of knowledge and ability built up over the years have been torn away by the injury. Responses are raw, reactions are juvenile, but there is potential for development from the untouched core of the self. And the third style takes the extreme position of locating the troublesome phenomenon of anger in an “other” or outside force who at times overpowers or manipulates the self, leading the person to struggle with this other rather than within their own self.

The range of attributions I observed—from internal processes to external influence to postulation of a second being—signifies a wealth of alternative discourses. Not only does each represent a different notion of causality, significance, and responsibility for anger, but the *different kind of brain-self relationship* that emerged in association with each style of accounting reveals many subjects’ understanding that their selves are constituted biographically, processually, by mind and spirit as well as by materiality, by action as well as by material substance. I heard very little evidence of “brainwave knowledge,” neurochemical selfhood, or other forms of neurodiscourses. Moreover, I heard of repeated disappointments with mainstream practitioners who might be the most direct sources of neurodiscourse, but who had failed to assist with my informants’ problems, or who seemed only to have made things worse. Neuro-discourses have not come to dominate the narratives of the people whose accounts I analyzed, yet the mandates of neoliberal selfhood more generally—that the self be engaged in projects of self-surveillance and self-improvement—were strongly in evidence.

I turn next to a close analysis of a particular trope that recurs in narratives of post-brain-injury anger: the doubled self. The memoir that I center in Chapter 4, Randal H. Flutur’s *The Stranger Inside of Me*, is fragmented in multiple ways: it is organized as a

collection of poetry rather than a sequence of chapters, each poem incorporates irregular line breaks and indentations, and the story it narrates is one of major recurrent disruptions to Flutur's life post-brain-injury. Rather than attempting to draw these fragments into a unified narrative, I show how the tracing of one recurring metaphor through his text and across texts from other memoirs and other narrative domains yields insight into a latent but powerful cultural schema structuring Flutur's storytelling.

## Chapter 4:

### Beside Oneself with Rage: The Doubled Self as Metaphor in a Narrative of Brain

#### Injury with Emotional Dysregulation

At the intersection of the urgency of post-brain-injury anger and the demand for accounts that attribute the anger to a source and point the way toward its management, the stories people tell of the disruptive experience of dysregulated anger may emerge in ways that are fractured, chaotic, or contradictory. They may resist incorporation into a biography, particularly into the kind of biography centered on the self-managing individual that is privileged in neoliberal Western societies. How then are we to study this experience and the narrative moves that people make under conditions of severe disruption that cannot be definitively attributed to a particular source, and which carry strong stigma potential if attributed to the self? One way is to treat a narrative as a collection of narrative moves and to take a meaningful move rather than the entire narrative as the object of analysis. Here I demonstrate the process of deep, interpretive study of specific moves encountered within narratives of chaos, fragmentation, disruption, or dysregulation which may otherwise resist our engagement.

One metaphor that recurs with some frequency in the narratives of people with post-brain-injury anger is that of *the doubled self*: the person with the brain injury is said to become someone else, in what some people describe as a Jekyll-and-Hyde change, or turning into the Hulk. These cultural references are threads in the web of meaning from which the metaphor of the doubled self is plucked. I therefore ask: What has the construct

of the self doubled in anger meant in recent cultural history, and what does it mean when people with brain injuries use the metaphor now?

Metaphor is more than just a literary flourish, even more than an aid to communication; it is constitutive of how we experience reality. As Kirmayer writes, “Even the few words of an isolated trope invoke a whole conceptual space or world” (2000:155). Exploring that conceptual space in order to understand more fully the meaning and implications of the metaphors by which people describe their post-brain-injury anger can facilitate communication between injured people, families, and professional care providers, and it may ultimately help us develop and communicate better interventions for injured people and their families.

I therefore selected for analysis a published memoir of brain injury that makes extended use of the metaphor of the doubled self in its narration of the author’s experience of post-brain-injury anger: Randall H. Flutur’s *The Stranger Inside of Me* (2013), which I situate among other narratives by caregivers and injured people calling upon this trope. To explore the cultural and historical context of Flutur’s use of the metaphor, I also analyzed the meaning of the self doubled in rage in Robert Louis Stevenson’s *Dr Jekyll and Mr Hyde* (1886) and the first issue of Stan Lee and Jack Kirby’s *The Incredible Hulk* (1962). While neither Dr. Jekyll nor the Hulk is explicitly said to have a brain injury, the brain is nevertheless the site of the change in each story, and specific references to these tales of monstrous doubling certainly recur in descriptions of post-brain-injury anger as told by injured people and their caregivers. Present-day references to these works likely draw additional meaning from any of the dozens if not hundreds of reimaginings produced over the years, but the very quantity of

subsequent work inspired by these stories speaks to the place they secured in the cultural imagination; thus, the original texts are worth analyzing as landmark moments in the development of the metaphor of the doubled self. Reading these texts against Flutur's present-day memoir, I was struck by remarkable similarity in the way the metaphor of the self monstrously doubled in anger is deployed in each. Most significantly, I note the recurrence in these three different texts of a 2,000-year-old philosophy of anger, a construct I call the Senecan triad, first described in the Roman philosopher Seneca's treatise *De Ira* ("On Anger"). I argue that this pattern of recurrence reflects a cultural preoccupation with Seneca's severe perspective on the management of anger, and clinicians treating people with brain injuries should recognize the structure and implications of the Senecan triad when it is reflected in the narratives of their patients or patients' families, and even in their own manner of addressing post-brain-injury anger. While the metaphor of the self doubled in anger may be consistent with a clinical view of post-brain-injury anger as a failure of the brain's inhibitory systems that allows another kind of self to escape the boundaries of the injured person's socialization, it may not be an emotionally helpful metaphor to use or to validate.<sup>4</sup>

In this chapter, I first review selected literature on metaphors of illness and emotion and then outline a short cultural history of anger's conceptualization in the 19<sup>th</sup> through 21<sup>st</sup> century West. I discuss Flutur's memoir *The Stranger Inside of Me* as an exemplar of one significant way in which people with problematic post-brain-injury anger may conceptualize and communicate what happens to them: through the metaphor

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<sup>4</sup> Future research might inquire into the possibility that certain prototypical metaphors correspond with brain-injury-related variables, and that these correspondences might have diagnostic value. The metaphors most commonly used to describe anger resulting from disinhibition, for instance, might differ from those most commonly used to describe anger resulting from the frustrations of recovery.

of the doubled self. I then analyze Stevenson's *Jekyll and Hyde* and Lee and Kirby's *Hulk* as two highly culturally salient representations of anger and the metaphor of the monstrously doubled self. Finally, I show that situating the present-day use of this metaphor in its cultural history can inform our understanding of what the metaphor can mean, practically and socially, for those who use it, and I expand the analytic lens to include attention to what the metaphor might mean in a Western context of late capitalism. This can in turn inform our understanding of the meanings and potentials that intersect in the case of problematic anger after a brain injury.

### ***Metaphorical conceptualizations of anger***

Drawing upon the work of Kleinman and Harrington, Jurecic writes of illness narratives as potential “acts of resistance to the medical establishment and as necessary complements to modern medicine” (2012:10). Illness metaphors, as “gestures toward a story” (Kirmayer 2000:155) can be similarly understood, and they offer us a way of entering a narrative that resists the expected forms. However they come to be in a narrative, metaphors are always freighted with cultural meanings, and metaphor is thus a site for working out the problems of telling a socially comprehensible, viable story, both for the narrator and for attentive interlocutors (see Prigatano 1991 on metaphor's therapeutic use in brain injury rehabilitation). Metaphor is more than just a poetic device; it's at the heart of how we comprehend and communicate our experiences.

The particular metaphors we use—not only as we speak, but as we make sense of the world around us—affect our understanding of the phenomena we experience and our behavior toward those phenomena. “The essence of metaphor,” according to Lakoff and

Johnson, “is understanding and experiencing one kind of thing in terms of another” (1980:5). Some instances of metaphorical thought or communication are fairly easy to recognize as such. If we say, for example, “she’s such a bear in the morning,” the comparison of the person’s manner to that of a growling animal is clear. Other metaphors rely on a less patent transfer of meaning from a different conceptual domain. The ideas of “spending” or “saving” time represent time as a valuable, commodifiable resource, saying that a prosecutor “builds a case” invites the listener to understand the profession of law in terms of construction, and referring to a leader as the “head” of an organization taps into a broad conceptual field in which that which is “up” is associated with power and control. These metaphorical mappings entail particular ways of experiencing and treating the target phenomena and make alternative ways somewhat less thinkable. We could expect, for instance, that a language in which arguments are primarily conceptualized in terms of partnered dancing or meal-sharing would correspond with a very different set of norms regarding the conduct of a disagreement from a language in which the metaphor of argument as war predominates.

Inquiring into the metaphors that structure our conceptions of disease and disability is therefore important to understanding the experience of a particular condition and interrogating our attitudes toward and treatment of people affected by it. In her essays on the use of metaphor to comprehend illness and the reciprocal use of illness as a metaphor for a variety of moral or social concerns, Sontag (2001) held that metaphor has the potential to stigmatize and demoralize those who suffer from illness. One target of her analysis was cancer as portrayed in literature, news items, and popular discourse of the 1970s. She found that views of cancer as a condition of repressed energy attributed a

blameworthy personality to the sufferer; militaristic metaphors of the disease as an invasion have lent themselves to a model of aggressive, counter-attacking treatment that may have made other approaches less thinkable; and the use of cancer as a metaphor for something of extreme social or political danger that must be eradicated has imbued the experience of the disease itself with additional terrors and stigma. Cancer is certainly not the only condition so shot through with metaphor: “Any important disease whose causality is murky, and for which treatment is ineffectual, tends to be awash in [social and moral] significance” (Sontag 2001:58). Dysregulated anger following a brain injury meets both of these conditions, and it is therefore important to investigate the metaphors commonly in use for describing post-brain-injury anger to assess whether they invest it with any kind of harmful significance.

Metaphor is as unavoidable in medicine as in any other domain. The very process of diagnosis, Hanne (2015) contends, is a process of working with metaphor, not only in the sense of interpreting the figurative language of a patient’s report, but in the more fundamental sense of matching observations to a prototypical illness or family of illnesses. Metaphor is, after all, a “device for playing with classifications” (Hanne 2015:35), which is the diagnostician’s work. Any effort a physician makes to develop her own metaphorical sense can therefore help her perform diagnostic work more reflectively, critically, and effectively. In Hanne’s words,

“It is crucial for medical professionals and laypeople to become more aware of the significance and effects of the metaphors they use, to critique their own and each other’s metaphors, and to acknowledge the value of multiple metaphors, capable of illuminating the many facets of any situation” (2015:49).

While metaphors can be limiting or damaging in the ways Sontag described, they are integral to the pattern-matching process of diagnosis.

Attention to metaphor is also essential to a doctor's ability to communicate with a patient. A person describing anger as a wild animal, for instance, might be receptive to ideas for taming or slaying the beast of anger, while a person describing anger as a turbulent sea might respond more willingly to ideas for riding its waves. Against Sontag's call to "de-mythicize" health conditions by resisting metaphorical thinking about illness (2001:7), Hanne and Hawken recommend that we develop "a richer fund of metaphors" (2007:97) for use in public discourse about illness as well as in the clinic. Just as a family member's or clinician's poor choice of metaphor could confuse, misdirect, or emotionally harm a patient, metaphors chosen carefully from a range of available tropes can help reorient a patient toward coping strategies, treatments, and greater acceptance of their condition. Kirmayer (2000) writes of the importance of "poetic truth" as accessed through metaphor in defining a clinical problem, and even when a problem is clear, attending to metaphor is a way for clinicians to access patients' understandings of their conditions and to frame their insights and recommendations in ways that patients are open to hearing. It may also be the case that some metaphors are more compatible with clinical guidelines for emotion management, while others may lead the patient in counterproductive, even dangerous directions. While clinical encounters are certainly co-constructed in real time (see Mattingly 2000), the clinician's ability to enter the conceptual space of the patient and work with him there on the level of poetic truth would be enhanced by time spent outside the clinic studying and reflecting on commonly-used metaphors for the problem to aid in the recognition, interpretation, and selection of metaphor in conversation with patients and families. This chapter demonstrates the close analysis of one such metaphor.

Before we turn to the metaphor of the self doubled in anger, let us consider metaphorical conceptualizations of anger more broadly. A full cultural history of anger is beyond the scope of this chapter, and what follows should not be taken as comprehensive. I first address some key developments in the past century as they have been documented by other scholars, and I then build upon that history by framing those developments in terms of a longer-standing tension between Aristotelian and Senecan philosophies of anger. While I do not claim that the philosophy of anger began or reached its fullest development in classical antiquity, I find the Aristotelian-Senecan opposition a useful tool to think with regarding the history of anger in the West.

Kövecses (2010), calling upon Stearns' (1994) history of emotion, presents the dominant view of anger held in the United States today as the culmination of a shift occurring over several centuries, from demonic and then humoral notions of anger toward an increasingly mechanized view. According to Stearns, one particularly significant shift occurred in the middle of the twentieth century. Victorian-era Americans had viewed anger as dangerous in private life, but potentially valuable if drawn upon and directed toward righteous, pro-social ends in public life. This view began to shift in the 1930s, as the Scientific Management movement to improve efficiency in workplaces promoted a view of anger as something entirely negative which should *always* be controlled. If necessary, it could be released through venting to a professional counselor set apart from both public/work and private/family life. Tracing the slower permeation of this concept into childrearing manuals, Stearns discovered that by the 1950s, experts were advising parents to remain impassive while children "drained off" (130) their anger in tantrums, thus allowing more positive emotions to fill the child-as-container in its place.

Kövecses (2010) finds that through this particular history, anger has come to be conceptualized in our time as the *contents of a container under pressure*. The mapping of a target—in this case, a particular situation of anger—to a source domain such as the pressurized container through metaphor carries over certain inferences or entailments from the body of knowledge that exists about the source. This mapping highlights certain aspects of the target situation while occluding others and freighting the target with connotations. The primary entailments of metaphors drawn from the domain of the pressurized container—having an outburst, venting, boiling over, erupting, and so on—are that anger escapes suddenly, violently, and unintentionally as a result of the physical build-up of pressure within a person. Without necessarily being conscious we are doing so, we invoke the forcefulness of anger and the relative helplessness of the person-container to hold it in when we call upon this metaphor.

Does the source domain of the pressurized container fully explain the self doubled in rage? Kövecses (2010) interprets the development of the pressurized container metaphor as a mechanization and abstraction of anger from the self, in a way that opposes it to the rational self. This conceptual opposition of destructive anger to rationality and identity certainly serves as groundwork for the metaphor of the doubled self, in which a malevolent force explodes onto the scene in an episode of uncontrollable anger and overpowers all reason, but the doubled self also exceeds the metaphor of the pressurized container in several ways: it is more of a binary switch or gestalt shift than a building of pressure toward a release, and it is a genesis or a splitting rather than a dispersive eruption. The metaphor requires its own exploration and elucidation because the

dominant metaphor of an angry person as a pressurized container is not sufficient to understand the metaphor of the self doubled in rage.

Situating this brief history of anger in a broader history of Western thought, I propose that the movement from Victorian valuation of anger to twentieth-century efforts to eradicate anger also represents a move from an Aristotelian view of anger as a force to be managed for positive ends to a Senecan view of anger as an unmanageable force once unleashed and the enemy of rational humanity. Contrary to Aristotelian thinkers who believed anger arises from human nature and can be not only appropriate but virtuous, given the proper management of intensity, timing, targeting, and other variables, Seneca held that anger is an “utterly inhuman” (1928 [trans.]:1) product of worldly attachments, that it serves no purpose which could not be better served by some virtue, and that anger cannot be mastered once it is allowed any kind of expression (see Nussbaum 1994). The pressurized container metaphor represents a new twist on Seneca’s view, in that venting (in a separate space or to a minimally-responsive audience such as a therapist) is now thinkable, but our overall view of anger as something to be quenched before it can do harm certainly resonates with Seneca’s severe view of anger. This shift may now be in the process of reversing, after decades of treating anger as anathema. For instance, the 2015 film *Inside Out*—popular with the public and lauded by psychologists—took a more Aristotelian stance in representing anger as an important emotion that is functional if tempered or channeled by other emotions and attachments. Even if such a shift is occurring, my point that the Senecan and Aristotelian views on anger are good tools to think with as we consider how cultural attitudes toward anger shift over time still stands, and when it comes to the clinical treatment of anger, our focus is still closer to Senecan

eradication rather than to Aristotelian identification of uses for anger. I will return to this point in the analysis that follows.

***Three cases of the self doubled in anger: The Stranger, Mr. Hyde, and the Hulk***

People with brain injuries and their caregivers call upon the trope of the self doubled in anger in various ways as they narrate their experiences with post-brain-injury anger. Before delving into a close analysis of Randal H. Flutur's memoir, *The Stranger Inside of Me*, I briefly address the use of this metaphor in selected memoirs—three by caregivers and one by a person with a brain injury—to illuminate the range of forms the self doubled in anger may take. While these writers call upon a variety of metaphors in the course of their narratives, their use of the trope of the self doubled in rage is consistent in representing post-brain-injury anger as severe, disruptive, and pathological, beyond the mere venting of pressure.

The anger described by reference to doubling is extreme. In her memoir of life after her husband Alan Cromer's anoxic brain injury, for instance, Janet M. Cromer writes of Alan's "wild" outbursts (2010:83, 91, 189) as a disruptive force in the midst of the couple's joint efforts to rebuild Alan's identity. She identifies her husband's rage episodes as the "toughest and most frightening problem" they faced (63) and describes the height of the anger episodes as Alan's "'Jekyll and Hyde' mode" (122). Another caregiver, Terry Ann Johnson, writes of the mood swings her husband Lynn experiences after a blow to his head from the falling tailgate of a farm truck. Johnson characterizes Lynn's mood states as different "personalities" and has named a handful of them. Among this cast of doubles, "the Asshole"—the personification of Lynn's rage episodes—is

unique, easily recognizable, and “the worst of all” the personalities: “When the Asshole makes his presence known everyone shudders. The air can make him screaming furious mad, everything and nothing makes him uncontrollably angry” (2011:chapter 15). In fact, “the Asshole” seems the polar opposite of her “beloved Lynn,” who Johnson says is often the first personality to emerge and make amends after the retreat of his angry double (chapter 15). Johnson doesn’t categorize all Lynn’s anger as the actions of “the Asshole”; for instance, she described a time when Lynn was angry on behalf of his small daughters as a socially and morally sensible response to an injustice. By contrast, there is no provocation or any observable buildup to the appearance of “the Asshole.” It is a sudden, frightening, and total switch from the person himself to an alternate personality.

Other accounts calling upon the metaphor of doubling specify singularity of the self as a crucial sign of recovery. In John Kennedy Rizzo’s account of his experience of a brain injury sustained in a motorcycle accident, themes of duality are prominent, from the right-sided bodily weakness that he likens to “two different individuals ... walking alongside of each other in the same body” (2016:chapter 7), to his recurring sense that his injury is “pulling half of me into another place, into some strange and scary dimension, while the other half is stuck in this world, in this body and in this place” (chapter 7). He raises the possibility of a Hulk- or Hyde-like transformation by saying he and his fellow patients awaited a recovery that Rizzo hoped “wouldn’t turn us all into monsters” (chapter 10). He describes himself as a field upon which forces of good and evil battle, and speaks specifically of his severe anger outbursts as one of the “bestly behaviors” that emerged as his “ability to control [his] lesser nature was grossly out of order” (chapter 12). He thus constructs his recovering self as two natures at odds within one

body. He describes his recovery in terms of spiritual growth that resolves conflicting dualities through a conquering singularity: the triumph of good over evil, and the achievement of control over the monstrous or animal nature to which he attributed his anger. J.J. Virgin's memoir of caring for her teenage son Grant after he sustained a brain hemorrhage and other severe injuries in a hit-and-run reaches a similar narrative resolution. Before his injury, Grant had already experienced outbursts of anger serious enough to lead to expulsion from multiple schools. The severity of these outbursts increased after the injury, and Virgin writes, "It was as if there were two Grants—the sweet, smiley Grant who repeated, 'I love you, I love you,' and the angry, volatile Grant whom John [his father] and I referred to as the Incredible Hulk" (2017:77). While she attributed his pre-injury outbursts to bipolar disorder exacerbated by exposure to certain foods, she writes of struggling to disentangle the causality of his post-brain-injury anger and wondering "*What if we've awakened a monster?*" (88). Although Grant's outbursts subsided as he moved beyond the early period of his recovery, they remained problematic. The climax of the story is a shared meal at which Virgin realizes, "I had to stop asking myself which parts of Grant's personality were him, what was the brain injury, and what was his bipolar disorder. I had to accept Grant for Grant. The way he was now was Grant—all of it" (214). In spite of Grant's continuing outbursts, his mother finds peace with the difficulties of the situation by symbolically restoring Grant to a single entity rather than a former unity problematically doubled in anger.

Randal H. Flutur's intricate and extended exploration of this trope makes his memoir, *The Stranger Inside of Me*, an ideal choice for close analysis. Anger is a powerfully disruptive presence in this memoir of life after brain injury, and Flutur centers

the metaphor of the doubled self as he narrates his struggle to master the anger that engulfs him. Injured in an accident that took the life of his best friend, Flutur describes problems with balance, attention, concentration, vision, stamina, and increased anger; anger is the central theme of the poetry that comprises the book. He opens with a poem apologizing “for angry words / or the rage that makes me strike out / in ways that make me feel ashamed and estranged” (2013:chapter 1). As Flutur writes of how ordinary provocations build up anger within him that will then “explode” (chapter 15) over an innocent person, and his fear that he could kill or harm someone with “a termination response” (chapter 35, section 2), it quickly becomes clear that his anger is beyond what we consider normal, and consistent with the kinds of post-brain-injury anger described in the rehabilitation literature. While the build-up of provocations to the point of explosion is an instance of the metaphor of the self as a pressurized container, Flutur’s more central metaphor attributes the anger to “THE STRANGER” who was “born” (chapter 31) at the accident and who drives out all rationality, forces him into uncharacteristic outbursts of rage against his wife and children, and “pounds me into ruthless submission— / He rips out my heart / and tears at my soul” (chapter 6). In Flutur’s narrative, his mind and body have been taken over by an unpredictable, relentless, malevolent force; he is in a sense beside himself, doubled in being. He flickers in his own view between being himself and being eclipsed by the Stranger, and he vows to fight the Stranger “till we both die, / And I will not know / whether I won or lost— / nor will I care. / For THE STRANGER inside of me / is me” (chapter 5). The struggle with his double will never end, except in death.

The doubled self mingles with other metaphors, as in one poem he writes of himself as the “fuse” and the Stranger as a “hidden bomb” (chapter 15). While it’s

common to speak of anger in terms of a short fuse or blowing up, and the bomb metaphor is certainly consistent with the pressurized container, it's interesting to see that Flutur *is* rather than *has* a fuse. Contrary to expressions like "he's a ticking time bomb" or "she's gonna go off," he assigns the parts of the bomb to separate aspects of himself; thus, he is the part which is consumed, and it is the Stranger—not an insentient force—who explodes onto the scene when he has burned too low. The force of his anger is not vented; rather, it issues a new and malicious actor. Flutur also uses the metaphor of rewiring to describe how his mind has become dangerously strange to himself: "I am out of control— / my head has been rewired / so that my body is pawn to its next / thought / emotion / action / reaction / or distorted command or any or all of them" (chapter 22). The language of rewiring is often used in reference to neuroplasticity and potential for healing, but Flutur uses it to reinforce the distinction between his bodily self as the pawn and the Stranger as his own "head," producing twisted impulses that his body cannot help but carry out. The theme of duality permeates his writing, especially in how he is plagued by the constant, lurking presence of the Stranger who can without warning overpower him.

Throughout the memoir, the cost that anger exacts from Flutur and from every member of his family is clear. He is under pressure both internal and external to make sense of this profoundly disruptive phenomenon, yet the metaphor of the doubled self seems to complicate rather than simplify his narrative: he alternately claims helplessness against the Stranger who produces the anger, articulates a struggle between the Stranger and his true self, and identifies himself with the Stranger. What can this perpetual inversion and eversion of himself mean for his identity and his rehabilitation? Is the metaphor of the doubled self a dangerous foray into dissociation? Does it represent the

abdication of responsibility? Or, as a narrative technique, might the strategy of extracting, projecting, and dualizing allow Flutur to tell a story of himself as a normal and virtuous person periodically visited by a stranger who is fundamentally not him, and against whom he struggles mightily? Does it protect him from the social consequences of exhibiting problematic anger? Clinicians treating people with anger might ask, can it be constructive to externalize anger in this way as something to combat, or does it lead to an energy-draining battle of the injured person against himself? To more fully understand the implications of this metaphor, it is important to situate it in its cultural history.

I therefore turn next to Stevenson's *Strange Case of Dr Jekyll and Mr Hyde* as a landmark in the development of the doubled self as a metaphor for anger. I do not claim that anyone using the Jekyll-and-Hyde metaphor to describe their anger intends to reference the themes of the story or could necessarily outline the plot. All that most of us likely know of the thematic content of the story is the idea of duality, two very different characters in one, and the horrifying suddenness of the change between them. People using the Jekyll-and-Hyde metaphor to describe anger outbursts may mean no more than that, but the *persistence* of this trope from 1886 to today is meaningful, and it is worth investigating what it may have been in the original story that captured and held our attention for so long. I analyze Stevenson's work in order to outline some of the intricacies and entailments of the metaphor as it was developed in this culturally significant novella.

In the orderly form of a case study, Dr. Jekyll describes how it all began: he was caught between a dispositional mischievousness and the desire to be a grave, dignified, upstanding doctor in the public eye. He feels that he wasn't such a bad man, but his strict

“aspirations” for himself led him to recognize “the thorough and primitive duality of man” (Stevenson 1886:107). Neither of the “two natures that contended in the field of [his] consciousness” (108) seems more himself than the other, but rather than working to integrate both into his identity, he tries to extract and objectify the “lower elements in [his] soul” (110), and to retain only virtue in his conscience and his public persona as Dr. Henry Jekyll. While readers commonly interpret this as a tale of Victorian repression and the conflict between conscious and unconscious forces, Stiles (2006) contends that Stevenson was far more likely to have been influenced by contemporary physiological theory than by later Freudian theory of unconscious drives. According to Stiles, Victorian theories of the “double brain” held that the left hemisphere (associated with civilization, reason, masculinity) and the right (associated with primitive irrationality, emotion, femininity) constituted a pair of brains that could operate independently of each other. As we see in Victorian studies of insanity and criminality, imbalance between the hemispheres was believed to lead to personality disorder. Stevenson carried this concept to an extreme by a “fictional corpus callosotomy” (Stiles 2006:885), severing and isolating the functions of the two hemispheres and creating an oscillating imbalance between two opposite aspects of the self. The structure of the story, Stiles argues, also oscillates between the clinical case study and gothic horror, underlining the novella’s central theme of “the doctor’s struggle to maintain scientific objectivity in the face of a terrifying subjective reality that threatens to overwhelm him” (881), or the struggle between reason and the passions. Problematic anger is prominent among these passions, and while Hyde personifies many of Jekyll’s antisocial drives and emotions, he is very much characterized by animalistic rage. Anger drives him to commit murder, beating an

old man to death “with ape-like fury” (Stevenson 1886:37), and it is certainly one of the elements that Jekyll wishes to isolate from his public and moral identity by means of the transformational drug he invented.

Jekyll thinks that by extracting and personifying his “lower elements” (110), he has found a solution to the war between freedom and restraint, between emotion and intellect, between the indulgence of the passions and honorable detachment. But Hyde seizes any opportunity to emerge, until the drug is no longer needed and the “animal within [him]” engulfs Jekyll at any momentary lapse of his “spiritual side” (131). Hyde is an emerging engulfment, coming from within to overpower and mock Jekyll, destroying beloved things—like letters and a portrait of his father—that tie him to society. But Jekyll by the end can pity Hyde, who lives in fear and clings to the body of Jekyll for protection, a clinging to life which Jekyll calls “the abjection and passion of...attachment,” and to which he contrasts his own “power to cut [Hyde] off by suicide” (139). Hyde’s dominance and Jekyll’s loss of self eventually do drive Jekyll to the “suicide” of laying down his confessional pen and resigning himself to his disappearance into the character of Hyde. This is not a willing transfer of identity, since Jekyll expects Hyde’s life to end shortly after, whether by execution for his crimes or by finding the “courage” (141) to end his own life. Both in terms of the Jekyll he believes himself to be and the body he sees himself as sharing with Hyde, he is making an end of himself.

In this story, the projection of anger into another character allows anger to indulge itself and grow. Although he embarked on his dualizing experiment with the desire to express rather than eradicate his troublesome passions, Jekyll’s belief in the total incompatibility of rationality and anger (among the other passions), and his disgust for

Hyde as a creature of attachments, reflect Senecan thought. This belief propels him along a course of action from which, ultimately, the only escape is suicide.

The Victorian-era Stevenson brings Jekyll (and the reader) to an Aristotelian epiphany that the development of spiritual strength and vigilance to master anger through continuous struggle would have been better. Jekyll's Senecan attempt to silence Hyde through "a life of such severity as I had never before attained to" (125) lasted only two months before the torture of "Hyde struggling after freedom" (126) compelled him to split himself again. The novella thus critiques the Senecan view on anger: to disallow any expression of anger in the life of the reasonable person is to unsustainably, destructively split and destabilize one's self. In other words, to oppose goodness, rationality, and normalcy to disruptive urges and emotions (including anger) so completely that they seem to belong to different people, is to allow those disruptive elements to grow unchecked, putting reason, humanity, and even survival at risk.

I argue that Jekyll's suicide is not simply an idiosyncratic plot twist, but an entailment of the Senecan view of anger, in which rationality and anger are diametrically opposed. Analyzing Seneca's *De Ira*, Nussbaum (1994) calls attention to the anecdotes of extreme grievance (such as the murder of one's child) by which Seneca explores the limits of his view on the necessity of extirpating anger from the self. In those extreme cases in which anger cannot be avoided, Seneca advises suicide. I see his philosophy as constructing a triad of choices for a person facing the problem of anger: master anger through the exertion of rationality, surrender to anger and lose all humanity, or rise above unavoidable anger by suicide. When Jekyll committed himself to the opposition of the

passions (including anger) and reason—that is, when he doubled himself—he entered this Senecan triangular construct, which ultimately led him to end his life.

The same triad emerges in 1962's inaugural issue of *The Incredible Hulk*, which I analyze here as further evidence, first of all, that the self doubled in anger is a metaphor to which we return with a troubled fascination, as evidenced by the persistent popularity of both tales analyzed here, and more significantly, that this metaphor again takes on the same Senecan entailments in a very different time and narrative medium from Stevenson's work. In Lee and Kirby's original story, atomic scientist Bruce Banner is hit by gamma rays and transformed into the Hulk, in an engulfing physical/cognitive/emotional change that then comes upon him every night. The Hulk embodies anger; in his first storyline, he's described as an animal, a monster, and a brute. He rages indiscriminately and leaves a trail of destruction for which Banner could be forced to answer; Banner fears the transformation, and the Hulk despises Banner's weakness. In the cover art from the first issue in 1962, the Hulk appears not in place of Banner but looming over, threatening to engulf him; he is Banner's doubled self, and in that image he seems to be more of a menace to Banner than to the people around him. The cover also poses a question not unlike Flutur's ambivalence about his relationship to the Stranger: "Is he **man** or **monster** or... is he **both**?" (Lee, Kirby, and Reinman [1962] 2003:49). The central theme isn't the damage the Hulk inflicts during his rampages; instead, it is the threat that he, as a projection of rage, poses to Banner's identity.

As in *Jekyll and Hyde*, the good doctor is still the real identity, or at least the captain of the self, but there is more crossover between Banner and the Hulk. The Hulk contains some of Banner's motivations and memories, directing some of the Hulk's anger

toward pro-social ends. And the Hulk even represents an improvement on Banner in some ways. The Hulk is able to identify and thwart the machinations of a Soviet spy whose duplicity Banner hadn't been able to detect while they worked side by side in the laboratory, and after the Hulk's first appearance, the socially-oblivious Banner is able to interact more personally with the woman who was clearly written to become his love interest. The experience of the Hulk's rage seems to allow Banner to grow in social value even as it rips his life away from him. Banner fears his next descent into bestial rage, but his social value is increased in some ways by some residue that the Hulk leaves behind, or by something the Hulk awakens or enlarges in him.

Where *does* Banner's anger come from? Is it a part of him, externalized like Mr. Hyde, or is it a newborn interloper like Flutur's Stranger? Given fears of nuclear destruction at the time of the writing (Regalado 2015), the Hulk and his rage quite likely represent a species regression to a more primal form, rather than to something particular in Banner himself. Yet this still resonates with the idea of Hyde as an animal spirit existing and emerging from under the higher, evolved nature of Dr. Jekyll. Interestingly, 20 years after the original issue, in a period in which psychiatric diagnoses such as PTSD proliferated, writers of the Hulk revised his backstory in a way that transforms his rage from a primal, animalistic one to a rage rooted in personal trauma. In the mid 1980s, a background of childhood abuse emerges as an explanation for the "pent-up rage" (Mantlo, Mignola and Talaoc 1985:20) that materializes in the form of the Hulk. Later, in the 1990s, his childhood is reframed as a time when his personality split and he began to externalize his feelings of anger as a character named the Hulk (David, Keown, and McLeod 1991). In more recent iterations, then, the Hulk's rage originates not on the

global stage of espionage and weapons development but on a personal, psychodynamic one; his rage is an expression not of an earlier state of man's development or of an animal spirit, but of a mind broken by social trauma. This more recent Hulk speaks to anxieties over the states of our minds, and what disorders might lurk within. Yet the theme of projecting unbearable rage onto an external other persists through all these iterations, and in them, the Senecan triad becomes even more stark. A witness to Banner's horror at realizing that he has not died after the ordeal of his first transformation narrates Banner's condition, noting that "He forsakes his intellect and even the strength of the raging beast locked inside him to embrace despair" (Mantlo, Mignola and Talaoc 1985:26). The reader leaves Banner caught between these poles of his identity—rationality and rage—and huddled on the ground, "[his] thoughts dwell[ing] upon his own death" (26).

The original Banner describes his transformation as a fire in his brain (Lee, Kirby, and Reinman [1962] 2003:60). The brain is the setting of the struggle between the consistent, virtuous self and the rageful stranger, the rational scientist against the passionate beast. It is surely as context for that struggle rather than coincidence that the series' first supervillain is also doubled in rage. The Gargoyle, a man made monstrous in mind and body by Soviet experimentation, furiously masterminds evil plans in pursuit of world domination on behalf of those who transformed him. He is still in possession of his intellect, unlike the Hulk, and able to respond when Banner offers to restore him to his human form, even though this will mean the loss of his brilliance. Once his restoration from a monster of rage to human form is complete, he turns against his Soviet captors and former allies not with rage, but with stoic dignity and noble last words about dying as a man. He presses a switch that will kill the high-ranking Soviets in the room along with

himself. We see again the Senecan triad dramatized: now aware that his reason cannot protect him from descending into monstrous rage, with the hateful specter of the Gargoyle looming in his memory as evidence of how destructive his rage has been and may be again, the former scientist takes the third way of suicide. This foreshadows the bind in which Banner's doubled nature places him. If he cannot restore himself to a single identity as the rational Dr. Banner, and if he cannot control the Hulk's explosive rage, then is self-destruction his only choice? While the moral distinction between Banner and the Hulk is somewhat less sharp than that between Jekyll and Hyde (a difference perhaps reflecting greater cultural ambivalence between Senecan and Aristotelian approaches to anger at the time *The Hulk* was written), the triad thus emerges once again.

### ***Discussion***

Insofar as it reflects a Senecan philosophy in which anger and reason cannot simultaneously reside in one body, the projection of one's anger onto an anonymous, external force through the metaphor of the doubled self seems a risky strategy, drawing one into a triad of impossible choice. To see the recurrence of this stark triangular construct in popular fiction of the past 150 years raises questions. What does it mean that we continue to return to this severe philosophy two thousand years after Seneca's time? More importantly, what does it mean for those who use the metaphor to comprehend or express their own condition? The Senecan triad was vividly present in Flutur's memoir, in which we see him caught between the impossibility of consistent rationality and the unbearability or inhumanity of unrestrained anger, and he vows to fight the Stranger to their mutual death (2013:chapter 5). In Jekyll's final note, laying down his confessional

pen represents his suicide; as long as he could write and confess, he existed. To narrate, to exercise a moral conscience over the anger even when control cannot be exerted, is to exist for others as a self. As pure narrative strategy, it's important to note that the binary opposition embodied in the dual characters of Jekyll and Hyde, Banner and the Hulk, Flutur and the Stranger makes for a gripping story. If we continue to revisit the stories of Dr. Jekyll and Dr. Banner long after they were written, then Flutur's strategy of isolating anger from his identity by narrating himself as doubled may earn him the patience, interest, and even the respect of an audience otherwise frustrated or frightened by his outbursts of anger. In giving himself a force against which to struggle, he preserves his own moral identity as the agentic protagonist of a culturally-valued "standard story" of the self (Tilly 2002) or quest narrative (Frank 1995).

But insofar as the metaphor might express—to himself or to his audience—the lived reality of his experience, we have cause for concern. If he is torn by the imperative to be a rational, stable, composed, predictable human being on the one hand, and the opposite imperative of anger that demands expression on the other, does Seneca's third choice of suicide loom over him? Narrative accounts projecting anger onto a double seem to entail the Senecan triad of a rationally composed life, a dangerously overemotional life, and a life not worth living. For a caregiver or clinician to apply this metaphor to a person or to reinforce the person's own use of it is to invite them into this triad. When anger does not subside in spite of the struggle, as research suggests is often the case with post-brain-injury anger, the consequences of engaging the view that anger and rationality cannot reside in the same body may be severe. The specter of suicide may be a dangerous entailment of accounts of the self doubled in anger. While I do not go so far as to claim

that adopting this metaphor leads to suicide, its use nonetheless reflects an underlying structure of beliefs about self and emotion that is extremely difficult to live up to once brain injury has compromised one's ability to manage emotion, and its use can indicate or perhaps even increase the emotional distress of the person caught up in this triple tension.

Taking a cue from Sontag's work and considering this metaphor in our broader cultural context, we should ask what social or moral concerns it might reflect to construct a person experiencing post-brain-injury anger as doubled. Beyond discomfort with the possibility of a monster of rage residing within each of us, could the metaphor of doubling capture even broader, culturally particular concerns with being both self and not-self? Western anxiety over the boundaries of the self is reflected in Belling's analysis of the Ebola body, for instance, as both a reminder "that our selves are contingent on a dark zone that at once contains and fails to contain the horror" (2016:64) and as a figure of our fear of a shifting global landscape without clear boundaries or "ordering codes" (62). Emily Martin (2000) similarly argues that our hyper-rational view of the brain represents an anxious retreat from the late-capitalist, corporate construction of the marketplace as an "unpredictable, spontaneous, and ever shifting" (Postrel 1998, cited in Martin 2000) site of disorder demanding that we manifest a kind of manic energy to adapt to its shifts. Perhaps the trope of the self monstrously doubled in anger reflects present-day anxieties over the multiplicity and shiftiness of postmodern identity and the self unmoored from "ordering codes," or perhaps it represents a fear of a plasticity unbound, ungoverned by the rational individual or the codes of capitalist "flexibility"

(see Malabou 2008). If so, it is a moral and social concern projected onto people who are already struggling mightily with their condition.

What does all this mean for the care and treatment of post-brain-injury anger? First, that we may be underestimating the threat that anger poses to identity. Strohminger and Nichols (2015) showed the significance of the continuity of moral identity in others' perception of a neurologically impaired person, and outbursts of anger threaten that continuity. People like Randal Flutur are struggling not only to minimize the damage anger causes, but to see and present themselves as valid people worthy of care and respect. Second, that the metaphor of the self doubled in rage is founded on an opposition between anger and right living, and if this opposition is too severe—if families, clinicians, or injured people adopt or express the view that the only way out of anger is to eradicate it—then a person experiencing post-brain-injury outbursts may be at risk of being drawn into the Senecan view on anger, with its demoralizing and potentially dangerous entailment of suicide as a serious alternative to living with anger.

Clinicians should therefore be attentive to their own use of metaphor, and it may be wisest to seek out ways of speaking about anger that do not represent the angry self as doubled. As the analysis here suggests, this metaphor—which may be expressed as a splitting, an alternation, or an engulfment by an alien other—entails a Senecan view of anger as incompatible with full selfhood, even if this view is not made explicit. Knowledge of a wider range of relevant metaphors and their entailments can enable a clinician to move more fluently from one to another in discussion with a patient, to avoid imposing any one metaphor too strongly and to help patients expand their own range of narrative resources for making sense of their experience. Reading and reflecting on

memoirs and blogs by people with brain injuries, attending online or in-person support groups, and of course giving patients the time and encouragement to describe rather than briefly report on their symptoms are all ways in which clinicians can build and diversify their fund of metaphors for common symptoms such as dysregulated anger, per Hanne and Hawken's (2007) recommendation.

Clinicians who have reflectively examined their own use of metaphor are better prepared to engage with the metaphors the patient uses and their entailments. In consultation with a patient calling upon the trope of the doubled self, it may be wise for a clinician to listen for other metaphors or gestures toward metaphor in the narrative, and to attempt to draw these alternatives out further while respecting what the patient's reference to doubling reveals about the reality and severity of their experience. This is not to say that a clinician should impose another conceptual framework on an injured person's narrative; rather, given the many threads of meaning that comprise a narrative, a clinician can be attentive for those that do not oppose the rational to the emotional self, and help the patient elaborate on them.

One rich resource for this kind of work is the source domain of the pressurized container, which Kövecses (2010) showed to be a nearly universal resource for thinking about anger. While the different cultural histories of the development of a metaphor would cast different patterns of relevance upon its many variants and entailments for members of different cultural groups, it is likely that descriptions of anger that tap into this domain will be comprehensible and acceptable to a variety of patients. Moreover, the source domain of the pressurized container can easily accommodate known strategies for venting, channeling, or otherwise *managing* anger rather than striving to eradicate it.

In addition to serving as a demonstration of how a metaphor that patients commonly use can be analyzed and to what ends, this chapter also represents a step toward a typology of common metaphors for post-brain-injury anger that clinicians may use as an aid in interacting with their clients. While constructing a thorough encyclopedia of such metaphors would be an impossible task, a resource identifying some key prototypes and giving insight into the entailments of each could sensitize clinicians to the metaphors that may lie between the lines of patients' reports (See Skelton, Wearn, and Hobbs 2002 on the value of cataloging and analyzing common metaphors in clinical practice, and Kövecses 2010 on the importance of identifying prototypical ways of speaking about anger.). Finally, this analysis of the metaphor of the self doubled in anger suggests a possible need for the development of interventions specifically guiding people with post-brain-injury anger toward a more livable Aristotelian view on the management rather than the obliteration of anger.

In the concluding chapter, I revisit selected portions of my interview data in order to outline a new kind of sociality—alternative to that of neoliberal flexibility, productivity, and self-improvement—that emerged in my informants' descriptions of what they need from others in order to manage their anger.

## **Chapter 5: Conclusion: Interdependence as Alternative to Neoliberal Selfhood**

This research project began with questions about identity, became a project about narrative, and ends as a project about my participants' gestures toward *interdependence* as an alternative to neoliberal individualism. In this concluding chapter, I readdress my findings through this lens. When I centered the neoliberal imperatives of rationality and self-management, both of which may be threatened by the realities and the stigma potentials of brain injury, in a reanalysis of my findings, four types of self emerged as viable or bidding for viability. After briefly describing these, only some of which fulfil the mandates of the neoliberal self, I sketch the outlines of the interdependent alternative that took shape as my interviewees shared their understandings of how others could interact with them in more attuned ways. Finally, I revisit my research questions to summarize results.

### **Presentations of the Post-Brain-Injury Self under Neoliberalism**

The **reasonable self** is constructed as continuously rational, although making sense of outbursts may require a caregiver's exertion of retrospective rationality, or drawing boundaries around the anger through statements of temporal limitation: that angry episodes last only as long as the provoking circumstances, or that anger will dissipate over time. Intriguingly, even when framed in psychological-therapeutic language, this presentation was not necessarily accompanied by mention of therapy or *any* particular self-management project. For caregivers and injured people, the assertion of reasonability may be sufficient to credit this self with normalcy and emotional

continence: the ability to manage emotions within a socially/situationally meaningful range with minimal intervention from others. The **reasoning self**, by contrast, locates its claim to normalcy and validity in the commitment to the *pursuit* of continuous rationality. An injured person performs (or is asked to perform) the rational labor of discussing, dissecting, even documenting the details of an outburst, and the paradoxical task of using their rational mind to monitor their brain for irrational outputs. Outbursts are sometimes projected as an external force, and other times simply isolated as exceedingly strange objects of study. This self hews closely to the biomedical model of illness and the mandate of self-management through self-surveillance. Both the *reasonable* and the *reasoning* presentation of self seem to be valued positively by caregivers and injured people alike.

The other two types of self-presentation seem to generate more contention. The **searching self** pursues balance through whole-body or chemical means, or the quest to identify triggers and other external factors disrupting balance. Many of these pursuits make use of general biomedical concepts (e.g. endorphins); some explore exercise routines; others extend beyond the boundaries of medical recommendations (e.g. taking herbal supplements). Searching selves may participate in an imagined community of non-injured others who engage in the same activities, and movement of the body through these routines may be a restorative performance of normal, agentic selfhood: a whole person making healthy choices in a functional body. There is little to no speculation as to the cause or mechanism of the outbursts, and (perhaps consequently) there is no endpoint to the practice of vigilance for triggers and imbalances. By contrast to the vigilance of the *reasoning* self, the body as a whole (rather than the inaccessible brain) is the target of

surveillance and management: a mother might check her son's forehead to see if illness has triggered an outburst, or a husband might carry sunglasses to protect his wife's sun-sensitized brain. Injured people position themselves alone or in partnership with caregivers as searchers, and caregivers position themselves as searchers on behalf of dependents, but I did not observe in my sample any cases of caregivers approving of an injured person's self-directed pursuits as a searcher. Although it has certain commonalities with the project of the reasoning self, the less-rationalized pursuit of the searcher, who does not focus on an isolable, internal cause of anger, may not be as creditable to close social partners. Finally, the **struggling self** engages in no particular project, but struggles to regain self-control. Many narratives of the struggling self echo with tragic resignation to the loss of rationality and emotional continence, even as they assert the agency of the struggling person against the injury. The struggling self acknowledges dependence and insists on forbearance. As we might expect in a neoliberal context in which dependency is anathema, caregivers and injured people seem to have difficulty accepting this presentation of the injured person's self from one another; this self struggles for social validity as well as for control of anger.

What are we to do with the problem of the necessary forms of dependence necessitated by many brain injuries? Gelech and Desjardins (2011) found that people with brain injuries tended to see their inner selves as stable and possibly changed for the better, while losses and changes for the worse were associated with their public selves. While we might theorize that this disparity is due to the social complexity and role-related obligations that increase when more than one person is in a situation, such might not be the case in every sociocultural setting. I argue that the particular demands of

neoliberal constructions of the self, which imply particular forms of relationships, might be exacerbating or even driving the distress people experience in situations like post-brain-injury anger, which challenge the ideal of the self-surveilling, self-managing, self-possessed, rational individual. What alternatives are there to a demoralizing dependence if one cannot perform the reasonable or reasoning self?

### **Visions of Interdependence**

Jeanette described how once her anger is activated, she loses access to logic and reason and acts out on her first instinctive response. When I asked what could prevent her from entering this state, which she finds scary and draining, she said she “needed a prosthetic,” and explained that she needed someone else to supply what her own brain couldn’t at the moment. I had expected to hear people tell how they need someone else to adjust their expectations or their behavior to accommodate the anger outburst, but Jeanette was asking someone to *supplement* her incapacity, to recognize that reason had fled and she was going to need to plug in to another person to get through the episode. Family members were present for the anger, and one helped her afterward with physical contact and kind words, but what was missing was for someone to recognize the absent function and not to point it out to her, or exit the situation, or cover for the episode, but to *fill in* for the absence with their own capacities until Jeanette could come back to herself. This resonates with what neuropsychologist Laurence Miller (1990) writes, when he says that family members may have to act as an injured person’s frontal lobe after a brain injury.

Vickie described how when she feels anger rising, she contacts her husband at work. They devised a “safe word” that they use to call each other’s attention to her anger, and then he talks to her in the way she would talk to herself if she were able, reminding her of what she could lose in terms of her relationships if she lets anger take hold. She doesn’t experience this as admonishment or a threat; she seemed to experience this also as a prosthetic. The responsibility, the effort, and the thought processes he’s helping her through are still hers, and when he supplements her ability to recall her values and intentions, he helps her do the work of preserving relationships. I heard no indication of diminished selfhood or frustration that she can’t do this for herself; they’ve developed a working system that allows them to preserve their relationship for mutual benefit.

Liz’s anger was tied up with extreme anxiety over whether her perceptions of situations were colored by symptoms of her injury. She relies on friends to help her distinguish symptomatic errors in perception from more socially comprehensible perceptions. She described her friendships as strong, and I received the impression that this type of interaction isn’t a one-way flow of support, but part of a mutual flow between people helping each other navigate the world. Her brain injury may be an intensified case of needing these other perspectives, but it’s still continuous with the normal flow of interactional exchanges and part of how she continues to participate in and contribute to her friendship groups, by acknowledging that her perception can be flawed and trusting others to fill in with their own perceptual capabilities.

This isn’t to say that brain injury opens the doors to a magical new world of interdependence. People definitely expressed frustration with the ways in which they were cut off from others, or reliant on others, or more susceptible to the energies of

others. And the instances of interdependence I observed required an incredible leap of faith on the part of the injured person. To trust another person to be your prosthetic even when their actions suggest the opposite of what your own emotional state is suggesting you do is no simple matter. If that trust is missing, a caregiver would simply drain themselves in trying to provide unidirectional accommodation. Interdependence also requires a high level of self-control and delicate attunement on the part of the caregiver. Charmaz wrote about an elderly couple in which the wife serves as caregiver for her ill husband; she allows time for his slow and slurred speech in their conversation, and he reports, “She knows what’s happening to me better than I know myself” (1983:183). Both said they were satisfied with their relationship, and I interpret this as saying that their intersubjective attention to and allowance for absences (to revisit Leder’s term) allowed their relationship to transcend the problems of one individual body. Similarly, I propose that the model of interdependence sketched here offers mutual satisfaction if it brings a person who might otherwise have to become a wild animal or a Sherman tank back into the flow of interaction as a vital contributor.

It shouldn’t surprise sociologists to think of our selfhood as mutually constituted in and through others, and it certainly isn’t a way of being that my research subjects invented, but it *is* very much at odds with the cultural and medical goal of achieving independence after a major injury. Rather than being crushed under the weight of brainhood and associated neoliberal ideologies of the self and its relations, at least some of my participants found ways of using even brain injury—an injury to what we tend to see as the most essential, individualized organ—as the opening to interdependence with

others. I see in these moves the potential for the experience of access intimacy, which disability activist Mia Mingus described this way:

...that elusive, hard to describe feeling when someone else “gets” your access needs. ... It could also be the way your body relaxes and opens up with someone when all your access needs are being met. ... Without it, relationships exist under a glass ceiling or split by thick frosted windows, with huge pieces of myself never being able to be reached. Without it, there is survival, but rarely true, whole connection. ... [Access intimacy] brings the people who are a part of it closer; it builds and deepens connection. (2011)

A reader oriented toward technological solutions may have read the findings of previous chapters as an indication that we need to find ways of helping people with post-brain-injury anger take better advantage of the range of neurotechnologies available to them. My participants did not ask for this. Many did, however, in some way call for interdependence, so I ask that we zoom out of our focus on the individual brain and look instead to the broader social question of how we can create a society hospitable to and encouraging of the kind of interdependence that Mingus and my participants describe. In an effort to amplify these voices and expand the conversation, I turn now to examining visions of interdependence or near-interdependence from a range of disciplines. In examining the strengths and weaknesses of each, I move closer to a theoretical framing of what an interdependence strong enough to address a problem as disruptive and recalcitrant as post-brain-injury anger would look like.

### **Configuring Interdependence: A Multidisciplinary Approach**

In the field of artificial intelligence, the prospects of mind coalescence for people with brain injuries are exciting. AI researchers Sotala and Valpola (2012) propose different hypothetical scenarios by which minds might eventually be connected through a

prosthetic “exocortex.” Might caregivers or medical providers be able to use this technology one day to enter and better understand the experience of living with a brain injury? Could we coalesce in order to share our cognitive strengths with someone whose cognitive deficits currently mask or suppress their own strengths? However, uses like these are curiously absent from the list of motivations for participating in mind coalescence that Sotala and Valpola describe. Instead, they prioritize productivity and efficiency: a physicist and an economist can coalesce so that “connections [between their disciplines] could be noticed quickly and with little effort” (2012:2), and working groups can use coalescence to identify anyone whose desires differ from collective goals. Sotala and Valpola discuss values, emotions, and experiences as packets of information to be transmitted unidirectionally and intentionally, as from a parent to a child. Their example of a “person with a weak visualization ability ... want[ing] to experience what a strong visualization ability feels like” (2012:3) could be read as a gesture toward mind-coalescence as a route to an intersubjective compensation for disability. However, their selection of a weakness that is generally considered within the range of normalcy, their language of “want[ing] to experience” (rather than, say, “needing to access”), and their positioning of the weaker party as the sole receiver of benefit all work against this interpretation. Rather, the example seems to proceed from an assumption of normalcy, a desire for superiority, and a unidirectional helper-helped relationship between ultimately separate individuals. Sotala and Valpola raise a concern that the more skilled party in that example risks “losing their own skill” (2012:18); that is to say, there is nothing to be gained, in the authors’ view, from entering the experience of a “less”-skilled person. Similarly, their example of an individual wanting to “think and do many things at once”

to overcome “attentional blindness” frames deviation from the neoliberal ideal of the flexible multitasker as an undesirable disability. More broadly, any sense of coalescence as a shared experience of reality is strangely thin. People choosing coalescence out of a “desire to better understand another person’s way of thought” are entering that other person’s discrete “way of thought” as an explorer in a pre-existing terrain that is presumed to be uninfluenced by her presence, rather than truly experiencing a new space that they have altered simply by entering it. “[L]overs or very close friends ... choos[ing] to coalesce as an expression of their loyalty to each other” would be performing a kind of surveillance on each other, rather than truly “weaken[ing] the borders of individuality” (2012:18) as the authors predict. The possibilities for mutual entrainment of attention disappear behind the authors’ focus on facilitating multitasking. Indeed, Sotala and Valpola speak of the feeling of merging with another as a matter of sharing memories, skills, and information, toward goals of progress and efficiency that are completely consonant with the figure of the idealized neoliberal individual discussed in previous chapters. And for my purposes, this vision of mind coalescence promotes a view of the self that is defined by cortical activities<sup>5</sup>, and that only strengthens the bind in which people with injured brains are caught.

Philosopher Marya Schechtman (2014) intervenes in the philosophy of identity by proposing that we’ve overemphasized an independent and continuous consciousness, even the mind altogether, and that we need to shift our focus not just to personhood, but to a personhood that is socially embedded (or entangled, in Callon and Rabeharisoa’s sense). In the case of a person in a persistent vegetative state, for instance, she argues that

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<sup>5</sup> And among cortical activities, this vision refers to only the subset of these which is presumed to represent peak performance before the brain “ages and degenerates” (Sotala and Valpola 2012:9).

as long as the person continues to hold some kind of relationships with others and some kind of place in the social life of a community, then she is still a person. Lia Lee, as described in Anne Fadiman's *The Spirit Catches You and You Fall Down* (1997), entered a persistent vegetative state as a small child. She remained in this state for over 20 more years after the book's publication, and throughout that time, her hair was brushed, her family dressed her in age-appropriate clothes, and her birthdays were celebrated with cake and a party around her bed. Schechtman would argue that although Lia was nonresponsive and to the best of our knowledge non-conscious, this is still a state of personhood, although it is diminished. We don't have to agree entirely with Schechtman in order to take her point that our personhood is composed partly of those who hold a relationship to us, and their personhood is composed partly of our relationship to them. Just existing in relationship with others is part of what makes people themselves, so we can start to rethink our ideas about caregiving and care-receiving by looking for flows in *both* directions. Horwitz, Reinhard, and Howell-White (1996), for instance, found that given a certain degree of care, people with serious mental illness maintain relationships through symbolic exchange of social support that their family members recall as valuable. This stands as an instance of interdependence: people as a system mutually supplementing each other's Lederian presences and absences. And I saw evidence of this mutual flow in James talking about how he protects his wife from reminders of the day he hit his head, Sue talking about how she "holds space" for vulnerable others, and Jeanette describing the care she provided for her husband at the end of his life and the cards she sent to family and friends on every holiday (and even to me after our interview). Valuing

people as part of the flow of a community's life, rather than in their overall measure against an idealized self, is certainly part of how interdependence would look.

What could it look like on a broader social level? Roberts (2006) argues for collective action and a social responsibility/welfare model as a corrective to the problems of somatic individuality. In analyzing how the discourses of the body and self that proliferate around particular conditions or dis/ability more generally are unequally distributed, shot through with gendered stereotypes, and unsupported by the structure of biomedical practice, Roberts strongly critiques but doesn't dismiss the possibility of somatic individuality as a form of patient empowerment. Without a robust connection to politics, communal ethics, and to the collectivity of patients, however, it becomes merely a force for shaping a subject. I would argue that the case is more severe for people with brain injury (by comparison to Roberts' focus on perimenopausal women), who are likely further disenfranchised in the medical system due to their pattern of real and perceived deficits, and who may have difficulty organizing as a collective of patients due to the wide range of possible symptoms and disabilities that can follow a brain injury. Roberts, then, misses an opportunity to address interdependence as a level between the shaping of independent subjects and the communion of similarly positioned sufferers. When care at the level of the social network does arise in her article, it's only partially addressed in the way in which it poses an inequitable burden of responsibility on women. The need for interdependence intersects with a need to equalize such responsibilities, rather than to shed them. How can this be done without simply spreading around the work of neoliberal subjectification, particularly when a circumstance like post-brain-injury anger seems to demand rational management?

Purcell (2017) offers one way of rethinking social relations toward greater interdependence in his analysis of Nahua (Aztec) philosophy. Whereas Aristotelian philosophy positioned reason as the highest virtue of human life, the Nahua were less concerned with human nature, and more with our circumstances in a world that is uncertain, transitory, and not necessarily amenable to human happiness. Since the world is perceived as “slippery,” allowing people to “f[a]ll into wrong” (2017:12), slips aren’t something that can be avoided by reason or virtue, only managed. Moreover, our lives and the world we live in are transitory. Rather than seeking happiness, or Aristotle’s *eudaimonia*, Nahua people sought to be “rooted” on earth as the full expression of their personhood. One key way through which this rootedness could be achieved was through allowing others to help you attain a certain kind of character. Character was deeply intertwined with one’s social role, and no role was necessarily a more direct path to rootedness than any other. What I take from this analysis is the possibility of a cultural ethos that honors caregiving roles as vital in holding each other onto an uncertain earth, that values caregiving for the character it develops in the caregiver as well as the aid it provides to the receiver of care, and that doesn’t categorize the roles of caregivers *or* receivers as separate from the “productive” roles of society.

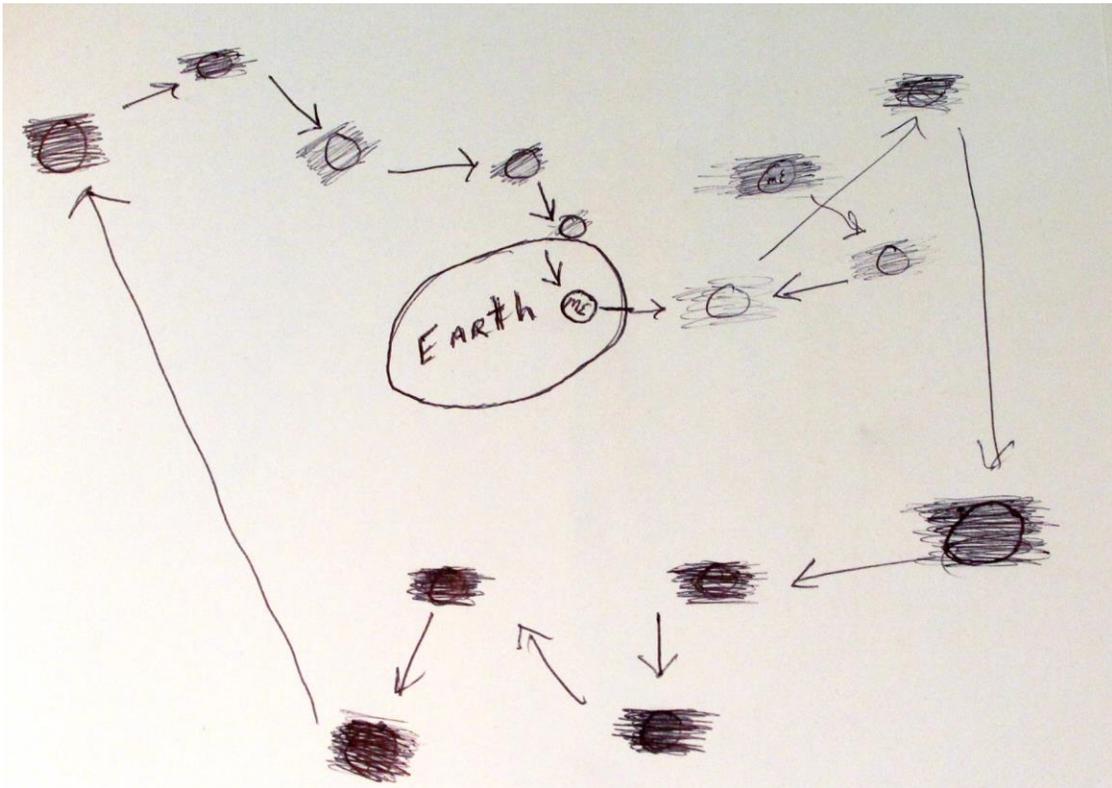
On material and symbolic levels, Western society is a long way from valuing rootedness in the Nahua sense, and perhaps our cosmology is incompatible with such a value. Yet there is value in “thinking with” this concept. For instance, the highly regarded Rusk Brain Injury Day Treatment Program, one of only a few programs like it in the world, operates through different configurations of group therapy for neuropsychological symptoms of cognition, mood, and motivation. One way of seeing these group

experiences is as practice in entrainment of attention. Since learning what to attend and to disattend to as relevant or irrelevant is a “sociomental act” (Zerubavel 2015), it is key to becoming a full person in any culture or social group, and shared training in attentiveness is a way to practice this skill. Moreover, sharing a focus is a vital part of face-to-face interaction, and the group work likely thus builds each person’s capacity for relating with others outside the program. Rootedness offers us another lens through which to view this aspect of Rusk’s program and perhaps a richer metaphorical repertoire for talking with participants about the value of the work. If caregivers and participants alike are at risk of unrootedness on the shifting earth, the work that participants do in the group and for themselves becomes essential to their community, and not simply a means of self-improvement.

I think now of James, who drew this image of his journey through a rage so strong that he metaphorically left earth (Fig. 7). He called it a disconnect, and he narrated through this picture how the path he takes is erratic, out of his control, and how he becomes more and more disconnected from others—represented by the extent of the dark lines occluding the circle that represents him—until somehow he is able to return. He slowly roots himself through a walk in the woods or by listening to music, but a close look at the drawing shows a moment of circling just after he leaves earth. Like Sue’s “shimmering moment of...possibility,” is this the point at which the injured person feels intervention is possible? And if so, then how can we become more troubled by this missed opportunity and the lonely journey of rage that ensues, so that we can share the work of rooting James as he leaves earth, Sue as she begins her transformation to a wild animal, Jeanette as she starts to hear the rushing of the waterfall? I argue that it will not

be through methods that align with neoliberal ideologies: reasoning, charting, self-objectifying, and demanding or providing accounts of cause and effect.

[Fig. 7: James' drawing. Text: "EARth" "ME". James specified that this drawing is not to be reproduced in other publications or presentations without permission.]



### Revisiting the Research Questions

In sum, narrators of post-brain-injury anger invoke different constructions of the brain-self-society relationship in the stories they tell. Notable among these were the figure of the psychologically reactive self, the layered self, and the rational but interruptible self. While I anticipated that these narratives would draw upon a number of cultural discourses in navigating the stigma threat of brainhood, I was struck by the dominance of the general neoliberal ideal of the rational self among these, both as an

ideal and a problem to navigate. If the demand for self-explanatory accounts of disruptive behavior is heightened or even created by this ethos, then this is not surprising, and it may in part reflect a self-selection bias into the study. However, it also raises the question of the extent to which we—as healthcare providers, social partners, and interested others—might be exacerbating the suffering of people who experience the disruption at the site of their own body, for calling them to account for the way the disruption reverberates in the social fabric. This is not, however, to say that unidirectional accommodation of disruption is the better response. Rather, I propose a more intense focus on interdependence in the way we address the chronicity of brain injury symptoms.

**Appendix**

**Study Documents:**

**Recruitment Notice, Screening Instrument, Diary/Booklet,**

**Interview Guide, and Drawing Template**



**Screening Instrument**

<i>Question</i>	<i>Acceptable answer for inclusion in the study*</i>
How old are you?	(21to 79)
Do you have a brain injury?	(Yes)
When did your injury happen?	(After the age of 16, AND more than 1 year ago**)
Since your injury, have you had intense episodes*** of anger?	(Yes)
Is the anger difficult to control?	(Yes)
Have you ever been violent when you're angry?	(No; or yes but only in the first two years post-injury, AND 5+ years ago)
Will you be able to complete an interview that will last an hour or an hour and a half?	(Yes, or yes with breaks, or yes in more than one meeting)
Can you think of a person who cares about you, who knew you before the injury, and who has seen your anger episodes?	(Yes. But see below; this person does not have to be nominated for an interview.)
I am looking for different perspectives on anger. Do you think that person would be willing to meet me for an interview?	(Yes; obtain contact info. But I will waive this if I judge the subject to be a good fit for the study, and if they state that

	they are unwilling or unable to nominate a social partner.)
<p><i>*If at any point the volunteer appears to be disturbed or unduly confused by the process, I will screen that person out for their own protection.</i></p>	
<p><i>**It is not uncommon for people with brain injuries to have had mild subsequent injuries; people with brain injuries may experience more accidents, and they may receive closer attention after even a minor bump to the head. If the injury that caused the symptoms was over one year ago, such people will be eligible for inclusion, but I will exclude them if the subsequent injury was severe enough to require hospitalization, or if I notice symptoms of undue upset or confusion in the screening process or the interview.</i></p> <p><i>If injuries in childhood are noted, ask whether they were diagnosed at the time; what they were called at the time; how they were treated at the time (by medical providers and/or family); whether anyone identified lasting effects around that time, and/or any other questions to determine whether this is a retrospective diagnosis (include) or something that was believed to be a brain injury at the time (exclude).</i></p>	
<p><i>***If the subject uses another word for “episodes,” I will begin using that word here and in subsequent communications.</i></p>	

**Diary/Booklet**

**This diary was provided as an 11-page booklet, with the instructions on the first page and the questions spaced out as marked across the next 10 pages, with room to write or draw below each question.**

**[Page 1]**

**Please wait to begin this booklet**

**until *after* you have signed, dated, and mailed your consent form.**

**Then, after you have an outburst of anger,**

**please start the booklet as soon as possible.**

- Please answer the questions as completely as you can, to the best of your ability.
- Please try to set aside 30 minutes to complete the booklet, although you may spend more or less time on it.
- Please complete this booklet alone, without consulting anyone. I am interested in learning *your* perspective.
- If there is a question you can't or don't want to answer, you may leave it blank.
- [Instructions for returning the booklet and a reminder of the interview's date and time were printed here.]

**[Page 2]**

What was happening before the outburst?

**[Page 3]**

How would you describe your emotions during the outburst?

**[Page 4]**

How did you feel, bodily, during this outburst?

**[Page 5]**

What did you say?

**[space]**

What did you do?

**[space]**

What thoughts were going through your mind?

**[Page 6]**

How did the other person react?

**[Page 7]**

What happened after?

**[Page 8]**

What might have prevented the outburst, if anything?

**[space]**

Is there anything that would have helped you?

**[Page 9]**

Is there any song, movie, character, or image that tells what your outbursts are like?

**[Page 10]**

Can you draw what your outbursts are like?

**[Page 11]**

Is there anything else you can tell me, to help me understand?

## Interview Guide

**PART I:** First I want to learn a little bit about you, and your life.

### **1. What is a typical day like for you?**

Education (How far did you go in school? What did you study?)

Occupation (What kind of jobs have you had?)

Hobbies (What kinds of things did you do for fun? What's your favorite thing to do now?)

People (Who are the main people in your life?) [Probe for relationship to social partner]

### **2. Has any of that changed over time? How?**

### **3. Now tell me about your brain injury**

-When did it happen? Where? How?

-How long were you in the hospital?

-What kinds of treatment did you have?

-Which (kinds of) doctors have you seen since your brain injury?

Therapists?

-What else has been done to help you recover?

-What are the results of the injury?

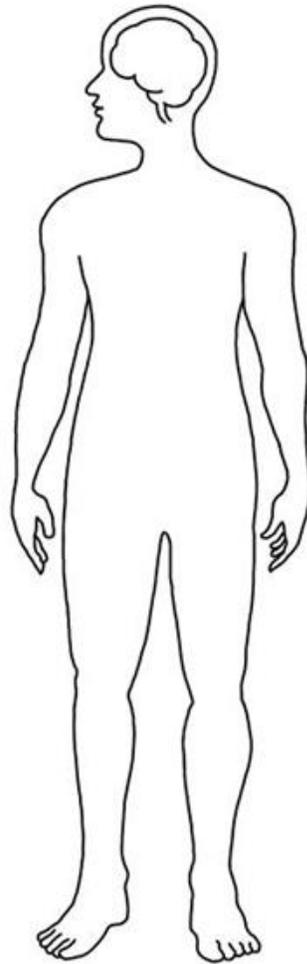
-Have you seen images of your brain injury? What do they tell you?

**PART II:** You volunteered for this study because you said there are times when you get very angry.

1. Do you have any special name for these times when you get angry? [Substitute that name for “outbursts” in subsequent questions.]
  - a. Why is that a good name?
  - b. Does anyone else (like a family member) have a different name for it?
2. Can you tell me about the last outburst you remember? [Elicit detail. If the booklet is available, use the booklet as support and use these questions to fill in gaps.]
  - a. Precursors—what was happening beforehand?
  - b. How would you describe your emotions during the outburst?
  - c. How did you feel, bodily, during this outburst?
  - d. What did you say? What did you do? What thoughts were going through your mind?
  - e. How did the other person react?
  - f. What happened after?
  - g. What might have prevented the outburst, if anything? Is there anything that would have helped you?
3. Is that a typical outburst? (If not, can you describe one that’s different?)
4. Is there a song, a movie, a character, or an image that tells what your outbursts are like?

5. When did you start having them? Why do you think they started when they did?
6. In the booklet, you drew what an outburst is like, here, I want you to think, where do they come from? [Offer paper—blank, and body/brain—and writing tools for in-person interviews; request by mail or email if not.] [Further probe if needed: How do they start?]
7. [If not answered by drawing.] How do they work? What makes them happen? Do you think your brain injury was involved?
8. Are they different from anger that you used to have before the injury? From other people's anger? How?
9. Is there anything you do to help yourself? (...to prevent, get through, or recover)
10. Is there anything your [social partner] does to help you? (...to prevent, get through, or recover)
11. How long do you think this problem is going to last? Why?
12. What bothers you most about the outbursts?
13. What problems have the outbursts caused?
14. Is there anything good about your outbursts?
15. Who else have you told about your outbursts? What did/do they tell you? What do you think of that explanation? [May probe for doctors, therapists, neuropsychologists...]

**Fig. 8: Drawing Template**



## References

- 2045 Strategic Social Initiative. 2012. "About Us: Future Prospects of '2045' Initiative for Society." Retrieved February 15, 2020 (<http://2045.com/about/>).
- Anson, Katie and Jennie Ponsford. 2006. "Coping and Emotional Adjustment Following Traumatic Brain Injury." *Journal of Head Trauma Rehabilitation* 21(3):248-259.
- Atkinson, Paul and David Silverman. 1997. "Kundera's *Immortality*: The Interview Society and the Invention of the Self." *Qualitative Inquiry* 3(3):304-325.
- Atkinson, Paul. 2005. "Qualitative Research—Unity and Diversity." *Forum Qualitative Sozialforschung / Forum: Qualitative Social Research*, 6(3), Art. 26. Retrieved March 29, 2020 (<http://www.qualitative-research.net/index.php/fqs/article/view/4/9>).
- Bat Or, Michael. 2015. "Separateness Representations in a Sculpting Task: Revealing Maternal Subjective Experience." *Art Therapy* 32(2):70-77.
- Beard, Renee L. 2016. *Living with Alzheimer's: Managing Memory Loss, Identity, and Illness*. New York: NYU Press.
- Becker, Suzy. 2005. *I Had Brain Surgery, What's Your Excuse?* New York: Workman Publishing Company, Inc.
- Belling, Catherine. 2016. "Dark Zones: The Ebola Body as a Configuration of Horror." Pp. 43-66 in *Endemic: Essays in Contagion Theory*, edited by Kari Nixon and Lorenzo Servitje. London: Palgrave Macmillan UK.
- Benjamin, Walter. [1936] 1968. "The Storyteller: Reflections on the Works of Nikolai Leskov." Pp. 83-109 in *Illuminations: Essays and Reflections*, edited by Hannah Arendt and translated by Harry Zohn. New York: Harcourt Brace Jovanovich.
- Ben-Yishay, Yehuda and Leonard Diller. 2011. *Handbook of Holistic Neuropsychological Rehabilitation: Outpatient Rehabilitation of Traumatic Brain Injury*. New York, NY: Oxford University Press.
- Elisabeth and Descartes, René. [1643] 2017. "Correspondence between Descartes and Princess Elisabeth," translated by Jonathan Bennett. Retrieved March 29, 2020 ([https://www.earlymoderntexts.com/assets/pdfs/descartes1643\\_1.pdf](https://www.earlymoderntexts.com/assets/pdfs/descartes1643_1.pdf)).
- Biderman, David, Ellen Daniels-Zide, A. Reyes, and B. Marks. 2006. "Ego-identity: Can It Be Reconstituted after a Brain Injury?" *International Journal of Psychology* 41(5):355-361.
- Brekhus, Wayne H. 2003. *Peacocks, Chameleons, and Centaurs: Gay Suburbia and the Grammar of Social Identity*. Chicago: University of Chicago Press.
- , 1998. "A Sociology of the Unmarked: Redirecting Our Focus." *Sociological Theory* 16:34-49.
- Brenninkmeijer, Jonna and Hub Zwart. 2017. "From 'Hard' Neuro-Tools to 'Soft' Neuro-Toys? Refocussing the Neuro-Enhancement Debate." *Neuroethics* 10:337-348.
- Brijnath, B. and Antoniadou, J. 2016. "'I'm Running My Depression': Self-management of Depression in Neoliberal Australia." *Social Science & Medicine* 152:1-8.
- Brockmeier, Jens. 2008. "Language, Experience, and the 'Traumatic Gap': How to Talk About 9/11?" Pp. 16-35 in *Health, Illness and Culture: Broken Narratives*, edited by Lars-Christer Hydén and Jens Brockmeier. New York: Taylor & Francis.
- Brumberg, Joan Jacobs. 1997. *The Body Project*. New York: Random House.
- Bury, Michael. 1982. "Chronic Illness as Biographical Disruption." *Sociology of Health & Illness* 4(2):167-182.

- Callon, Michel and Vololona Rabeharisoa. 2004. "Gino's Lesson on Humanity: Genetics, Mutual Entanglements and the Sociologist's Role." *Economy and Society* 33(1):1-27.
- Carricaburu, Danièle and Janine Pierret. 1995. "From Biographical Disruption to Biographical Reinforcement: The Case of HIV-Positive Men." *Sociology of Health & Illness* 17(1):65-88.
- Chamberlain, Diane J. 2006. "The Experience of Surviving Traumatic Brain Injury." *Journal of Advanced Nursing* 54(4):407-417.
- Charmaz, Kathy. 1999. "Stories of Suffering: Subjective Tales and Research Narratives." *Qualitative Health Research* 9(3):362-382.
- , 1991. *Good Days, Bad Days: The Self in Chronic Illness and Time*. New Brunswick, NJ: Rutgers University Press.
- , 1983. "Loss of Self: A Fundamental Form of Suffering in the Chronically Ill." *Sociology of Health & Illness* 5(2):168-95.
- Clark, Candace. 1987. "Sympathy Biography and Sympathy Margin." *American Journal of Sociology* 93(2):290-321.
- Cooley, Charles H. 1902. *Human Nature and the Social Order*. New York: Scribner's.
- Corbin, Juliet and Anselm Strauss. 1985. "Managing Chronic Illness at Home: Three Lines of Work." *Qualitative Sociology* 8(3):224-247.
- Corrigan, John D., Gale Whiteneck, and Dave Mellick. 2004. "Perceived Needs Following Traumatic Brain Injury." *Journal of Head Trauma Rehabilitation* 19(3):205-216.
- Cromer, Janet M. 2010. *Professor Cromer Learns to Read: A Couple's New Life after Brain Injury*. Bloomington, IN: AuthorHouse. Kindle edition.
- Daghagheleh, Aghil. 2018. "Ambivalent Voting Behavior: Ideology, Efficacy, and the Socioeconomic Dynamic of Voter Turnout in Iran, 1997-2005." *Sociological Forum* 33(4):1023-1044.
- David, Peter (w), Dale Keown (p), and Bob McLeod (i). 1991. "Honey, I Shrunk the Hulk." *The New Incredible Hulk* Vol. 1, No. 377, January 1991. New York: Marvel Comics. Retrieved July 30, 2017 (<http://readcomiconline.to/Comic/The-Incredible-Hulk-1968/Issue-377>).
- Davis, Lennard J. 2013. "Constructing Normalcy: The Bell Curve, the Novel, and the Invention of the Disabled Body in the Nineteenth Century." Pp. 1-16 in *The Disability Studies Reader*, 4<sup>th</sup> ed., edited by Lennard J. Davis. New York and London: Routledge.
- Davis, Murray S. 1983. *Smut: Erotic Reality/Obscene Ideology*. Chicago: University of Chicago Press.
- DeGloma, Thomas. 2010. "Awakenings: Autobiography, Memory, and the Social Logic of Personal Discovery." *Sociological Forum* 25(3):519-540.
- Demark, Jenny and Monica Gemeinhardt. 2002. "Anger and Its Management for Survivors of Acquired Brain Injury." *Brain Injury* 16 (2):91-108.
- Dikmen, Sureyya, Joan Machamer, Jesse R. Fann, and Nancy R. Temkin. 2010. "Rates of Symptom Reporting Following Traumatic Brain Injury." *Journal of the International Neuropsychological Society* 16:401-411.
- Docter, Pete, Ronnie del Carmen, Meg LeFauve, Josh Cooley, Jonas Rivera, Amy Poehler, Phyllis Smith, et al. 2015. *Inside Out*.

- Dumit, Joseph. 2003. "Is It Me or My Brain? Depression and Neuroscientific Facts." *Journal of Medical Humanities* 24(1/2):35-47.
- Erikson, Kai T. 1976. "Trauma at Buffalo Creek." *Society* 13(6):58-65.
- Fadiman, Anne. 1997. *The Spirit Catches You and You Fall Down: A Hmong Child, Her American Doctors, and the Collision of Two Cultures*. New York: Farrar, Straus, and Giroux.
- Faircloth, Christopher A., Craig Boylstein, Maude Rittman, Mary Ellen Young, and Jaber Gubrium. 2004. "Sudden Illness and Biographical Flow in Narratives of Stroke Recovery." *Sociology of Health & Illness* 26(2):242-61.
- Faitel, Lori Purdy. 2009. *Am I Brain Damaged? Memoir of Return to Life after My Head Injury*. Parker, CO: Outskirts Press.
- Flutur, Randal H. 2013. *The Stranger Inside of Me*. Bloomington, IN: AuthorHouse. Kindle edition.
- Fontana, Andrea and James H. Frey. 2003. "The Interview: From Structured Questions to Negotiated Text." Pp. 61-106 in *Collecting and Interpreting Qualitative Materials*, edited by N.K. Denzin and Y.S. Lincoln. Thousand Oaks, CA: Sage.
- Foucault, Michel. 1995. *Discipline and Punish: The Birth of the Prison*. New York: Vintage Books.
- Fox, Renée C. 1980. "The Evolution of Medical Uncertainty." *Health and Society* 58(1):1-49.
- Frank, Arthur. 1995. *The Wounded Storyteller: Body, Illness, and Ethics*. Chicago: University of Chicago Press.
- Garro, Linda C. 2000. "Cultural Knowledge as Resource in Illness Narratives: Remembering through Accounts of Illness." Pp. 70-87 in *Narrative and the Cultural Construction of Illness and Healing*, edited by Cheryl Mattingly and Linda C. Garro. Berkeley and Los Angeles: University of California Press.
- Gelech, Jan M. and Michel Desjardins. 2011. "I am Many: the Reconstruction of Self Following Acquired Brain Injury." *Qualitative Health Research* 21(1):62-74.
- Giddens, Anthony. 1979. *Central Problems in Social Theory: Action, Structure, and Contradiction in Social Analysis*. Berkeley and Los Angeles: University of California Press.
- Goffman, Erving. 1956. *The Presentation of Self in Everyday Life*. Edinburgh: University of Edinburgh.
- Good, Byron J. 2000. "Ethnography—In the Subjunctive Mode." Paper prepared for "Cultural Psychology Meets Anthropology: Papers in Honor of Jerome Bruner." AAA Annual Meetings, November 18, 2000, San Francisco. Retrieved online May 4, 2014 (<http://www.english.ubc.ca/PROJECTS/PAIN/DGOOD.HTM>).
- Good, Byron J. and Mary-Jo DelVecchio Good. 2000. "'Fiction' and 'Historicity' in Doctors' Stories: Social and Narrative Dimensions of Learning Medicine." Pp. 50-69 in *Narrative and the Cultural Construction of Illness and Healing*, edited by Cheryl Mattingly and Linda C. Garro. Berkeley and Los Angeles: University of California Press.
- 1994. "In the Subjunctive Mode: Epilepsy Narratives in Turkey." *Social Science and Medicine* 38(6):835-842.
- Gosling, Geo. 2010. *TBI Purgatory: Comes After Being in TBI Hell*. Parker, CO: Outskirts Press, Inc.. Kindle Edition.

- Gubrium, Jaber F. and James A. Holstein. 2001. "From the Individual Interview to the Interview Society." Pp. 2-32 in *Handbook of Interview Research*, edited by Jaber F. Gubrium and James A. Holstein. CITYXXXX: Sage.
- Gubrium, Jaber F. and James A. Holstein. 1998. "Narrative Practice and the Coherence of Personal Stories." *The Sociological Quarterly* 39:163-87.
- Hall, Karyl M., Peter Karzmark, Marie Stevens, Jeffrey Englander, Patricia O'Hare, and Jerry Wright. 1994. "Family Stressors in Traumatic Brain Injury: A Two-Year Follow-Up." *Archives of Physical Medicine and Rehabilitation* 75:876-884.
- Hanne, Michael and Susan J. Hawken. 2007. "Metaphors for Illness in Contemporary Media." *Medical Humanities* 33:93-99.
- Hanne, Michael. 2015. "Diagnosis and Metaphor." *Perspectives in Biology and Medicine* 58(1):35-52.
- Harper, Douglas. 2002. "Talking about Pictures: A Case for Photo Elicitation." *Visual Studies* 17(1):13-26.
- Hart, Tessa, Monica J. Vaccaro, Christina Hays, and Roland D. Maiuro. 2012. "Anger Self-Management Training for People with Traumatic Brain Injury: A Preliminary Investigation." *Journal of Head Trauma Rehabilitation* 27(2):113-122.
- Hatala, Andrew R., James B. Waldram, and Margaret Crossley. 2013. "Doing Resilience with 'Half a Brain': Navigating Moral Sensibilities 35 Years after Hemispherectomy." *Culture, Medicine, and Psychiatry* 37:148-178.
- Havlík, Marek, Karolína Mladá, Iveta Fajnerová, and Jiří Horáček. 2018. "Do Personality Features Influence Our Intuitions of the Mind-Body Problem? A Pilot Study." *Frontiers in Psychology* 9:1219.
- Hawkins, Anne Hunsaker. 1999. *Reconstructing Illness: Studies in Pathography*. West Lafayette, Indiana: Purdue University Press.
- Heritage, John and Douglas W. Maynard. 2011. "After 30 Years, Problems and Prospects in the Study of Doctor-Patient Interaction." Pp. 323-342 in *Handbook of the Sociology of Health, Illness, and Healing: A Blueprint for the 21<sup>st</sup> Century*, edited by Bernice A. Pescosolido, Jack K. Martin, Jane D. McLeod, and Anne Rogers. New York: Springer.
- Hochschild, Arlie Russell. 1983. *The Managed Heart*. Berkeley: University of California Press.
- Hofstra, Jorie. 2019. "Beside Oneself with Rage: The Doubled Self as Metaphor in a Narrative of Brain Injury with Emotional Dysregulation." *Journal of Medical Humanities*: [forthcoming; online first]. (<https://doi.org/10.1007/s10912-018-9546-9>)
- Horwitz, Allan V., Susan Reinhard, and Sandra Howell-White. 1996. "Caregiving as Reciprocal Exchange in Families with Seriously Mentally Ill Members." *Journal of Health and Social Behavior* 37:149-162.
- Horwitz, Allan V. and Jerome Wakefield. 2007. *The Loss of Sadness*. New York: Oxford University Press.
- Howard, Jenna. 2006. "Expecting and Accepting: The Temporal Ambiguity of Recovery Identities." *Social Psychology Quarterly* 69(4):307-324.
- Hunt, Linda M. 2000. "Strategic Suffering: Illness Narratives as Social Empowerment among Mexican Cancer Patients." Pp. 88-107 in *Narrative and the Cultural*

- Construction of Illness and Healing*, edited by Cheryl Mattingly and Linda C. Garro. Berkeley and Los Angeles: University of California Press.
- Imhof, H.-G. and P. Lenzlinger. 2011. "Traumatic Brain Injury." Pp. 1-91 in *Head, Thoracic, Abdominal, and Vascular Injuries: Trauma Surgery I*, edited by Hans-Jörg Oestern, Otmar Trentz, and Selman Uranues. Heidelberg: Springer Science & Business Media.
- Johnson, Terry Ann. 2011. *The Unbearable Truth of Reality: Life after Head Injury*. Self-Published, CreateSpace Independent Publishing. Kindle edition.
- Jurecic, Ann. 2012. *Illness as Narrative*. Pittsburgh: University of Pittsburgh Press.
- Karp, David A. 2006. *Is It Me Or My Meds? Living With Antidepressants*. Cambridge: Harvard University Press.
- Kempner, Joanna. 2014. *Not Tonight: Migraine and the Politics of Gender and Health*. Chicago: University of Chicago Press.
- Kirmayer, Laurence J. 2000. "Broken Narratives: Clinical Encounters and the Poetics of Experience." Pp. 153-180 in *Narrative and the Cultural Construction of Illness and Healing*, edited by Cheryl Mattingly and Linda C. Garro. Berkeley and Los Angeles: University of California Press.
- Kleinman, Arthur. 1980. *Patients and Healers in the Context of Culture*. Berkeley, CA: University of California Press.
- Kövecses, Zoltán. 2010. "Cross-Cultural Experience of Anger: A Psycholinguistic Analysis." Pp. 157-174 in *International Handbook of Anger*, edited by Michael Potegal, Gerhard Stemmler, and Charles Spielberger. New York: Springer Science & Business Media.
- Lakoff, George and Mark Johnson. 1980. *Metaphors We Live By*. Chicago: University of Chicago Press.
- Lareau, Annette. 2002. "Invisible Inequality: Social Class and Childrearing in Black Families and White Families." *American Sociological Review* 67(5):747-776.
- Leder, Drew. 1990. *The Absent Body*. Chicago: University of Chicago Press.
- LeDoux, Joseph. 2003. *Synaptic Self: How Our Brains Become Who We Are*. New York: Penguin Books.
- Lee, Chris. 2012. *From Frustration to Fulfillment: How a Traumatic Brain Injury Changed My Life*. The Literary Loft.
- Lee, Stan (w), Jack Kirby (p), and Paul Reinman (i). [1962] 2003. "The Incredible Hulk: #1." Pp. 49-73 in *Marvel Encyclopedia Vol. 3: The Incredible Hulk*, edited by Kit Kiefer. New York: Marvel Comics.
- Lezak, Muriel D. and Kevin P. O'Brien. 1988. "Longitudinal Study of Emotional, Social, and Physical Changes after Traumatic Brain Injury." *Journal of Learning Disabilities* 21(8):456-463.
- Light, Donald W. 2000. "The Medical Profession and Organizational Change: From Professional Dominance to Countervailing Power." Pp. 201-216 in *Handbook of Medical Sociology*, 5<sup>th</sup> ed., edited by Chloe E. Bird, Peter Conrad, and Allen M. Fremont. Upper Saddle River, N.J.: Prentice Hall.
- Lin, Katherine and Michael Wroten. 2019. *Ranchos Los Amigos*. In: StatPearls [Internet]. Treasure Island, FL: StatPearls Publishing. Available from: <https://www.ncbi.nlm.nih.gov/books/NBK448151/>.

- Locke, J. 1689. *An Essay Concerning Human Understanding*. Retrieved March 14, 2015 (<http://www.earlymoderntexts.com/assets/pdfs/locke1690book2.pdf>).
- Lorig, Kate and Halsted Holman. 2003. "Self-Management Education: History, Definition, Outcomes, and Mechanisms." *Annals of Behavioral Medicine* 26(1):1-7.
- Lorenz, Laura S. 2010a. *Brain Injury Survivors: Narratives of Rehabilitation and Healing*. Boulder, CO: Lynne Rienner Publishers.
- . 2010b. "Discovering a New Identity after Brain Injury." *Sociology of Health and Illness* 32(6):862-879.
- Maines, Mary Jo, Jennifer L. Pierce, and Barbara Laslett. 2008. *Telling Stories: The Use of Personal Narratives in the Social Sciences and History*. Ithaca, NY and London: Cornell University Press.
- Malabou, Catherine. 2008. *What Should We Do with Our Brain?* New York: Fordham University Press.
- Mantlo, Bill (w), Mike Mignola (p), and Gerry Talaoc (i). 1985. "Monster." *The Incredible Hulk* Volume 1, No. 312, October 1985. New York: Marvel Comics Group. Retrieved July 30, 2017 <http://readcomiconline.to/Comic/The-Incredible-Hulk-1968/Issue-312?id=18707#1>.
- Marriott, McKim. 1989. "Constructing an Indian Ethnology." *Contributions to Indian Sociology* 23(1):1-39.
- Martin, Emily. 1994. *Flexible Bodies: Tracking Immunity in American Culture from the Days of Polio to the Age of AIDS*. Boston: Beacon Press.
- . 2000. "Mind-Body Problems: AES Presidential Address." *American Ethnologist* 27(3):569-590.
- Masschelein, Anneleen, Christophe Meureé, David Martens, Stéphanie Vanasten. 2014. "The Literary Interview: Toward a Poetics of a Hybrid Genre." *Poetics Today* 35(1-2):1-49.
- Mattingly, Cheryl. 2000. "Emergent Narratives." Pp. 181-211 in *Narrative and the Cultural Construction of Illness and Healing*, edited by Cheryl Mattingly and Linda C. Garro. Berkeley and Los Angeles: University of California Press.
- McCrum, Robert. 1999. *My Year Off: Recovering Life After a Stroke*. New York: Broadway Books.
- Mead, George Herbert. 1934. *Mind, Self, and Society from the Standpoint of a Social Behaviorist*. (Edited by Charles W. Morris). Chicago: University of Chicago Press.
- Medved, Maria I. and Jens Brockmeier. 2008. "Continuity Amid Chaos: Neurotrauma, Loss of Memory, and Sense of Self." *Qualitative Health Research* 18:469.
- Meili, Trisha. 2003. *I Am the Central Park Jogger: A Story of Hope and Possibility*. New York: Scribner.
- Miller, Laurence. 1990. "Major Syndromes of Aggressive Behavior Following Head Injury: An Introduction to Evaluation and Treatment." *Cognitive Rehabilitation* 8(6):14-19.
- Mills, C. Wright. 1940. "Situated Actions and Vocabularies of Motives." *American Sociological Review* 5:904-13.

- Mingus, Mia. 2011. "Access Intimacy: The Missing Link." *Leaving Evidence*. Retrieved February 15, 2020 (<https://leavingevidence.wordpress.com/2011/05/05/access-intimacy-the-missing-link/>).
- Mishler, Elliot G. 2009. "The Struggle between the Voice of Medicine and the Voice of the Lifeworld" In *Health & Illness: Critical Perspectives*, 8<sup>th</sup> ed., edited by Peter Conrad. New York: Worth Publishers.
- Mol, Annemarie. 2002. *The Body Multiple: Ontology in Medical Practice*. London: Duke University Press.
- MossRehab. 2014. "New Roads, New Directions: Finding Your Way After Brain Injury." Presented by MossRehab Traumatic Brain Injury Model System, Philadelphia, November 8, 2014.
- Nerone, John C. 1987. "The Mythology of the Penny Press." *Critical Studies in Mass Communication* 4:376-404.
- Nilsson, Nils Gunnar. 1971. "The Origin of the Interview." *Journalism Quarterly* 48:707-13.
- Nochi, Masahiro. 2000. "Reconstructing Self-Narratives in Coping with Traumatic Brain Injury." *Social Science & Medicine* 51:1795-1804.
- Nussbaum, Martha C. 1994. *The Therapy of Desire: Theory and Practice in Hellenistic Ethics*. Princeton, NJ: Princeton University Press.
- Orbuch, Terri L. 1997. "People's Accounts Count: The Sociology of Accounts." *Annual Review of Sociology* 23:455-78.
- Parfit, D. 1984. *Reasons and Persons*. Oxford: Clarendon Press.
- Pennebaker, James W. 2000. "Telling Stories: The Health Benefits of Narrative." *Literature and Medicine* 19:3-18.
- Pescosolido, Bernice and Beth Rubin. 2000. "The Web of Group Affiliations Revisited: Social Life, Postmodernism, and Sociology." *American Sociological Review* 65:52-66.
- Phillips, Craig J. 2015. *Living with a Brain Injury: What Helped Me To Stop Being My Enemy and Create a Life for Myself*. Retrieved December 28, 2015 (<https://secondchancetolive.wordpress.com/>).
- Pitts-Taylor, Victoria. 2010. "The Plastic Brain: Neoliberalism and the Neuronal Self." *Health* 14(6):635-52.
- Prigatano, George. 1991. "Disordered Mind, Wounded Soul: The Emerging Role of Psychotherapy in Rehabilitation after Brain Injury." *Journal of Head Trauma Rehabilitation* 6(4):1-10.
- Purcell, L. Sebastian. 2017. "Eudaimonia and Neltiliztli: Aristotle and the Aztecs on the Good Life." *APA Newsletter on Hispanic/Latino Issues in Philosophy* 16(2):10-21.
- Pykett, Jessica. 2015. *Brain Culture: Shaping Policy through Neuroscience*. Bristol, UK: Bristol University Press.
- , 2013. "Neurocapitalism and the New Neuro: Using Neuroeconomics, Behavioral Economics, and Picoeconomics for Public Policy." *Journal of Economic Geography* 13(5):845-869.
- Regalado, Aldo J. 2015. *Bending Steel: Modernity and the American Superhero*. Jackson, MS: University Press of Mississippi.

- Reeve, Joanne, Mari Lloyd-Williams, Sheila Payne and Christopher Dowrick. 2010. "Revisiting Biographical Disruption: Exploring Individual Embodied illness Experience in People with Terminal Cancer." *Health* 14:178-195.
- Riessman, Catherine Kohler. 2000. "'Even If We Don't Have Children [We] Can Live': Stigma and Infertility in South India." Pp. 128-152 in *Narrative and the Cultural Construction of Illness and Healing*, edited by Cheryl Mattingly and Linda C. Garro. Berkeley and Los Angeles: University of California Press.
- Riessman, Catherine Kohler. 2002. "Illness Narratives: Positioned Identities." Invited Annual Lecture, Health Communication Research Center, Cardiff University, Wales, U.K..
- Rizzo, John Kennedy. 2016. *Rising from Hell: It Is in the Darkest of Nights That We See the Stars*. Self-Published, Amazon Digital Services. Kindle edition.
- Roberts, Celia. 2006. "'What Can I Do to Help Myself?' Somatic Individuality and Contemporary Hormonal Bodies." *Science Studies* 19(2):54-76
- Rose, Nikolas. 2004. "Becoming Neurochemical Selves." Pp. 89-136 in *Biotechnology: Between Commerce and Civil Society*, 1<sup>st</sup> ed. edited by N. Stehr. New Brunswick, NJ: Transaction.
- Rose, Nikolas. 2001. "The Politics of Life Itself." *Theory, Culture & Society* 18(6):1-30.
- Rose, Nikolas and Joelle M. Abi-Rached. 2013. *Neuro: The New Brain Sciences and the Management of the Mind*. Princeton, NJ: Princeton University Press.
- Rose, Nikolas and Carlos Novas. 2005. "Biological Citizenship." Pp. 439-463 in *Global Assemblages: Technology, Politics and Ethics as Anthropological Problems*, edited by Aihwa Ong and Stephen Collier. Malden, MA: Blackwell.
- Rothblatt, Martine. 2015. "What Is a Mindclone?" *LifeNaut*. Retrieved February 15, 2020 (<http://lifonaut.com/mindclone>).
- Sandberg, Anders and Nick Bostrom. 2008. "Whole Brain Emulation: A Roadmap." Future of Humanity Institute. Retrieved February 15, 2020 (<https://www.fhi.ox.ac.uk/brain-emulation-roadmap-report.pdf>).
- Schechtman, Marya. 2014. *Staying Alive: Personal Identity, Practical Concerns, and the Unity of a Life*. Oxford: Oxford University Press.
- Shildrick, Margrit. 2005. "Unreformed Bodies: Normative Anxiety and the Denial of Pleasure." *Women's Studies* 34:327-344.
- Scott, Marvin B. and Stanford M. Lyman. 1968. "Accounts." *American Sociological Review* 33(1):46-62.
- Seneca, Lucius Annaeus. 1928 (translation). "On Anger." In *Moral Essays, Volume 1*, translated by John W. Basore. London: W. Heinemann. Retrieved July 30, 2017 ([http://www.sophia-project.org/uploads/1/3/9/5/13955288/seneca\\_anger.pdf](http://www.sophia-project.org/uploads/1/3/9/5/13955288/seneca_anger.pdf)).
- Seung, Sebastian. 2010. "I Am My Connectome." TEDGlobal 2010. Retrieved February 15, 2020 ([https://www.ted.com/talks/sebastian\\_seung\\_i\\_am\\_my\\_connectome?language=en](https://www.ted.com/talks/sebastian_seung_i_am_my_connectome?language=en)).
- Shopes, Linda. 2002. "What Is Oral History?" *History Matters*. Retrieved February 13, 2017 (<http://historymatters.gmu.edu/mse/oral/oral.pdf>).
- Skelton, John R., Andy M. Wear, and F.D. Richard Hobbs. 2002. "A Concordance-Based Study of Metaphoric Expressions Used by General Practitioners and Patients in Consultation." *British Journal of General Practice* 52(475):114-118.

- Small, Mario Luis. 2009. "How Many Cases Do I Need?: On Science and the Logic of Case Selection in Field Based Research." *Ethnography* 10:5-38.
- Snow, David, Calvin Morrill and Leon Anderson. 2003. "Elaborating Analytic Ethnography: Linking Fieldwork and Theory." *Ethnography* 4:181-200.
- Somers, Margaret R. 1994. "The Narrative Constitution of Identity: A Relational and Network Approach." *Theory and Society* 23:605-49.
- Sontag, Susan. 2001. *Illness as Metaphor and AIDS and Its Metaphors*. New York: Picador USA.
- Sotala, Kaj and Harri Valpola. 2012. "Coalescing Minds: Brain Uploading-Related Group Mind Scenarios." *International Journal of Machine Consciousness* 4(1):293-312. Retrieved March 29, 2020 (<https://intelligence.org/files/CoalescingMinds.pdf>), and repaginated.
- Stearns, Peter N. 1994. *American Cool: Constructing a Twentieth-Century Emotional Style*. New York: NYU Press.
- Stevenson, Robert Louis. 1886. *Strange Case of Dr Jekyll and Mr Hyde*. London: Longmans, Green, and Co. Retrieved July 9, 2017 (<https://babel.hathitrust.org/cgi/pt?id=hvd.hwp4xp;view=1up;seq=5>).
- Stiles, Anne. 2006. "Robert Louis Stevenson's *Jekyll and Hyde* and the Double Brain." *SEL Studies in English Literature 1500-1900* 46(4):879-900.
- Strawson, Galen. 2004. "Against Narrativity." *Ratio* 17(4):428-452.
- Strohming, Nina and Shaun Nichols. 2015. "Neurodegeneration and Identity." *Psychological Science* 26(9):1469-79.
- Taylor, Jill Bolte. 2008. *My Stroke of Insight: A Brain Scientist's Personal Journey*. New York: Viking.
- Thoits, Peggy. 1989. "The Sociology of Emotions." *Annual Review of Sociology* 15:317-42.
- Tilly, Charles. 2002. *Stories, Identities, and Political Change*. Lanham, MD: Rowman & Littlefield.
- Timmermans, Stefan and Tavory, Iddo. 2012. "Theory Construction in Qualitative Research: From Grounded Theory to Abductive Analysis." *Sociological Theory* 30:167-86.
- Tollefsen, Deborah. 1999. "Princess Elisabeth and the Problem of Mind-Body Interaction." *Hypatia* 14(3):59-77.
- Toombs, S. Kay. 1998. "Where Would SHE Like to Sit?" Women and Health Lecture, presented at the Center for Health Policy and Ethics, Creighton University, Omaha, Nebraska. Retrieved December 9, 2011 (<http://www.wmeades.com/id244.htm>).
- Turner, Jonathan H. and J. E. Stets. 2005. *The Sociology of Emotions*. New York: Cambridge University Press.
- van der Vaart, Gwenda, Bettina van Hoven, and Paulus P.P. Huigen. 2018. "Creative and Arts-Based Research Methods in Academic Research: Lessons from a Participatory Research Project in the Netherlands." *Forum Qualitative Sozialforschung / Forum: Qualitative Social Research* 19(2). Retrieved January 28, 2020 (<http://www.qualitative-research.net/index.php/fqs/article/view/2961/4227>).

- Vidal, Fernando and Francisco Ortega. 2017. *Being Brains: Making the Cerebral Subject*. New York: Fordham University Press. Kindle edition.
- Vidal, Fernando. 2009. "Brainhood, Anthropological Figure of Modernity." *History of the Human Sciences* 22:5-36.
- Virgin, J. J. 2017. *Miracle Mindset: A Mother, Her Son, and Life's Hardest Lessons*. New York: North Star Way. Kindle edition.
- Wajnryb, Ruth. 2001. *The Silence: How Tragedy Shapes Talk*. Australia: Allen & Unwin.
- Weiner, Talia. 2011. "The (Un)managed Self: Paradoxical Forms of Agency in Self-Management of Bipolar Disorder." *Culture, Medicine, and Psychiatry* 35:448-83.
- Weiss, Robert S. 1994. *Learning from Strangers: The Art and Method of Qualitative Interview Studies*. New York: Free Press.
- Wellington, Naomi. 2014. "Whole Brain Emulation: Invasive vs. Non-Invasive Methods." Pp. 178-192 in *Intelligence Unbound: The Future of Uploaded and Machine Minds*, edited by Russell Blackford and Damien Broderick. West Sussex, U.K.: John Wiley & Sons, Inc.
- Wertsch, James V. 2008. "Collective Memory and Narrative Templates." *Social Research* 75(1):133-156.
- Williams, Gareth. 1984. "The Genesis of Chronic Illness: Narrative Re-Construction." *Sociology of Health and Illness* 6(2):175-200.
- Williams, Simon. 2000. "Chronic Illness as Biographical Disruption or Biographical Disruption as Chronic Illness? Reflections on a Core Concept." *Sociology of Health and Illness* 22(1):40-67.
- Young, Iris Marion. 1984. "Pregnant Embodiment: Subjectivity and Alienation." *The Journal of Medicine & Philosophy* 9(1):45-62.
- Zerubavel, Eviatar. 2018. *Taken for Granted: The Remarkable Power of the Unremarkable*. Princeton, NJ: Princeton University Press.
- , 2015. *Hidden in Plain Sight: The Social Structure of Irrelevance*. New York: Oxford University Press.
- , 2006. *The Elephant in the Room: Silence and Denial in Everyday Life*. New York: Oxford University Press.
- , 2003. *Time Maps: Collective Memory and the Social Shape of the Past*. Chicago: University of Chicago Press.