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Quality of Life Changes in Middle-Aged Men After an Acute Stroke or Traumatic Brain Injury

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Walden University

College of Psychology and Community Services

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Angela Jean Garner

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Walden University

2024

Abstract

Quality of Life Changes in Middle-Aged Men After an Acute Stroke or Traumatic Brain

Injury

by

Angela Jean Garner

MA, University of Findlay, 2006

Proposal Submitted in Partial Fulfillment

of the Requirements for the Degree of

Doctor of Philosophy

Health Psychology

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Abstract

Surviving a stroke or traumatic brain injury (TBI) can bring about life changes and negatively impact future quality of life. Studies that focus specifically on men who suffer these injuries is limited. The purpose of this qualitative study was to explore quality of life of middle-aged men who suffered an acute stroke or TBI. The transactional model of stress and coping and the social identity theory were theoretical frameworks. Common themes were established during data analysis. Three research questions explored the narratives of masculine identity and quality of life in middle-aged men who experience a stroke or TBI. How having a stroke or TBI negatively and/or positively changed life, and how use of rehabilitation including options and progress after stroke or TBI. Using a narrative inquiry approach, semi-structured interviews were conducted with six participants. Data analysis was completed using six steps with related actions. Nine themes emerged during the data analysis process. These themes suggested quality of life could be impacted after an acute stroke or head injury and having at least adequate support is necessary to decrease negative impacts. Healthcare providers could use these insights to design and implement effective treatment plans that support specific needs of men and provide insights for families, caregivers, and communities to help recognize and adapt to deficits and changes for increased function and improved quality of life. Because stroke and TBI are a global economic burden, improvement in these areas can result in decreased psychosocial and financial burdens, thus contributing to positive social change.

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Chapter 1: Introduction to the Study

Quality of life can be negatively affected in men who suffer a debilitating event (Hansson et al., 2012), especially those who strongly connect their personal identity to perceived masculine roles such as provider and protector (Moeller & Carpenter, 2013). Along with managing stressors directly related to the actual event, men who lack the ability to function may also feel guilty that they are a burden to others due to needed care or the inability to fulfill prior roles. The ability to perform prior roles can contribute to being bored and dissatisfied (Wood et al., 2010). This chapter includes an overview of the background of this study, problem statement, research questions, purpose of the study, conceptual framework, definitions of terms, assumptions, scope and delimitations, limitations, significance of the study, and a summary.

Background

Neurological injuries are a worldwide problem that can result in acute and chronic disability. Stroke and traumatic brain injury (TBI) are two examples of neurological injuries. Approximately 101 million people living have experienced a stroke, with 44% of those being men (Feigin et al., 2022). In the United States alone, an estimated 795,000 individuals suffered a first stroke that resulted in deficits completing basic activities of daily living and decreased mobility (Katan & Luft, 2018) and approximately 69 million individuals sustained a TBI (Dewan et al., 2018). In the long term, injuries such as TBI have consequences for the individual, their family, and society in general, including substantial economic burdens (Wilson et al., 2017).

Individuals who suffer TBI are at an increased risk for major depression, mood disorder, social isolation, anxiety, and substance abuse (Lavoie et al., 2017). According to Freeman et al.

(2015), loss of skills and abilities, changes in sense of self to their social world and intimate relationships were common themes reported by men who have suffered a TBI. Financial burden, feelings of worthlessness and hopelessness for a man who cannot return to prior employment can be devastating and worse if unable to return to some level of function that would allow for a sense of purpose and accomplishment. For individuals who have suffered a stroke, returning to work can be an important goal in their recovery process. Unfortunately, most rehabilitation interventions tend to be mostly in the first six months after the event (Kuluski et al., 2014). Leech et al. (2011) found that only 25% of participants who had suffered a stroke were able to return to work one-year status post. The chances of returning to employment after a stroke can be improved if rehabilitation interventions include return to work focus (Pearce et al., 2023)

Problem Statement

With men being two times more like to suffer a TBI (MacQueen et al., 2020) and 52% of stroke survivors being men (Lindsay et al., 2019) better understanding how their life may be affected can be beneficial for multiple reasons. Surviving a stroke or TBI can bring about life changes. Quality of life can be impacted negatively in men who suffer a debilitating event (Hansson et al., 2012), especially those who had strongly connected their personal identity to perceived masculine roles such as provider and protector (Moeller & Carpenter, 2013). Men's perceptions of masculinity can play a role in health behaviors which can contribute to morbidity and mortality (Salgado et al., 2019). Freeman et al. (2015) found loss of skills and abilities, changes involving sense of self, social world and intimate relationships were common themes reported by men who have suffered a TBI. Even in male stroke survivors who received three or

more levels of rehabilitation, there were reports of being less satisfied than the female subjects in the same study (Hansson et al., 2012).

Although there is a plethora of research on post stroke and TBI, research that focused, specifically on men. Having insight into the male survivor could be beneficial to healthcare providers for designing and determining interventions. It could also lessen negative economic impacts on families and individuals who have suffered these acute events if there was a better understanding of how to help men navigate their world after an acute event. This better understanding can improve quality of life, increase ability to complete functional tasks including working to make an income, being more self-sufficient in self-care and home management tasks, decreasing the number of medical interventions needed, and improving family and community relationships. Because stroke and TBI are global economic burdens, improvements in these areas could result in decreased psychosocial and financial burdens, thus contributing to positive social change.

Research Questions

Because the nature of this study was to explore the narratives of the subjects, I developed a primary research question with two secondary questions. The research questions were useful in the design of the semi structured interview questions and helped me guide the interviews while letting the interviewees tell their individual stories.

Primary Research Questions

Primary research question: What are the narratives of masculine identity and quality of life in middle-aged men who experience a stroke or TBI?

This question involves understanding the narratives of masculine identity and quality of life in middle-aged men who experience a stroke or TBI.

Secondary Research Questions

Secondary research question 1: How has having a stroke or TBI negatively and/or positively changed your life?

Secondary research question 2: How would you describe your rehabilitation including options and progress after you TBI or stroke?

The first involves understanding how having a stroke or TBI negatively and/or positively changed the participant's life, and the second encompasses the rehabilitation period including options and progress after TBI or stroke.

Purpose

The purpose of this study was to provide insight into the perspectives of men who have suffered a stroke or TBI including narratives of masculine identity and quality of life. Research that focuses on a male perspective after suffering a stroke or TBI is minimal. Along with providing insight, I explored satisfaction with current abilities and satisfaction with quality of life.

Theoretical Frameworks

The transactional model of stress and coping and the social identity theory (SIT) were the theoretical frameworks for this qualitative narrative study.

Transactional Model of Stress and Coping

According to the transactional model of stress and coping, primary and secondary appraisal occurs when attempting to cope with a stressor (Lazarus & Folkman, 1987). During

primary appraisal, an individual examines possible risks and benefits, and during secondary appraisal, the possible options for coping with a stressor (Lazarus & Folkman, 1987). Coping with not only the neurological injury, but also life changes that occur after an acute event contributes to increased stress. This theory aligned with the purpose of this study as quality of life is part of the experience of how one copes with and adapts to stress. I used this model to guide the development of the interview questions and analysis plan.

SIT

According to Henri Tajfel (1978), one author of SIT, social identity is the part of an individual's self-concept that is formed out of the emotional attachment that they connect to their membership of their social groups. Individual self-identity can be strengthened as result of feelings of inclusion in social groups (Islam, 2014). Trepte and Loy (2017) suggested that an individual's perception of self-image, whether negative or positive, can be determined by the social category in which they place themselves in. This theory supported the objective of this study as it explored the narrative specifically of men social group of focus.

Nature of the Study

The narrative analysis approach was useful as it allowed the participants to tell their story in their own words. The thematic approach in narrative analysis provides an opportunity to compare the stories from participants and establish themes (Riessman, 2005). Providing an opportunity to share personal insight into masculine identity and quality of life after a neurological injury can shed light onto what some men referred to as a "hidden injury" (Freeman et al., 2015, p. 200).

Phenomenological research is used to obtain subjective interpretations of events (Creswell & Creswell, 2018). Exploring quality of life from the perspective of the individual is supported by this method of research. To address this empirical gap, I used qualitative methods including interviewing to gain the perspectives of the participants. Using interviews that are then analyzed for consistencies and differences within the pool of subjects allowed for the recognition of themes that emerged.

Definitions

I used the following terms throughout this study:

Masculinity: For this study masculinity incorporates “gender norms include toughness dominance, self-reliance, heterosexual behaviors, restriction of emotional empowerment, and in voiding traditionally feminine attitudes and behaviors” (Weir, 2017, p. 34).

Quality of Life: According to the WHO (2012), quality of life is individual perceptions of positions in life in the context of culture and value systems in which people live in relation to their goals, expectations, standards, and concerns. It is a broad ranging concept that is affected in a complex way by the person's physical health, psychological state, personal beliefs, social relationships and their relationship to salient features of their environment (WHO, 2012).

Stroke: Neurological disease caused by obstruction of normal blood flow due to vessel rupture blockage which causes damage to brain tissue (Pérez-de la Cruz, 2020).

Traumatic Brain Injury (TBI): Injury that occurs as result of a trauma to the head that interrupts normal function of the brain (Traumatic, n.d.). These injuries can range from mild to severe and cause long-term issues.

Assumptions

Multiple assumptions were made in this study. The first was that the answers provided by participants were honest. Another assumption was that when subjects agreed to participate in the study, they understood the process and expectations including time commitment to complete interviews. A third assumption was that all participants had adequate cognitive and verbal abilities to participate in the interview and answer any questions asked.

Scope and Delimitations

The scope and delimitation of this study included the narrative experiences of men aged 30 to 75 who have suffered a stroke or TBI. Participants had to be able to complete all self-care (bathing, dressing, toileting, grooming) and home management tasks without assistance at baseline and must have suffered the event at least one year prior to the study. Although this study focused on narratives, I incorporated the use of semi structured interviews. These interviews, which included open-ended questions, ensured research questions were addressed and decreased the risk of missing pertinent information to support the study purpose.

Limitations, Challenges, and/or Barriers

Recruitment of individuals who fit the inclusion criteria of the study a barrier. Locating willing participants who fit the specific age span defined for this study while also having had a neurologic injury was difficult. To overcome this challenge, I used multiple sources such as Facebook and health care provider contacts. Also, ensuring the subjective responses were not skewed by cognitive deficits was also challenging in this population. To address this, the recruitment letter included specific inclusion criteria for current verbal/memory/cognitive abilities that provided guidelines for providers, participants, and families. Diligence in

acknowledging and addressing any limitations, challenges and /or barriers that may have risen at any time during this study was a priority.

Significance

As medical treatments advance, the odds of surviving a stroke or TBI improve. According to research findings, men suffer these neurological injuries at younger ages than women, therefore, having a better understanding of the male perspective after these events is necessary. The research has shown that men are disadvantaged in recovery and report less satisfaction with services (Hansson et al., 2012). Underutilization of medical services is connected to men and their internal perception of masculine norms (Salgado et al., 2019). This insight can be used by caregivers, healthcare professionals, and even employers to provide supportive care that encourages rehabilitation and long-term quality of life.

Exploring quality of life in men could also contribute to improved rehabilitation programs, education for healthcare providers and families and increasing the individual ability function in all daily activities. Better understanding will improve rehabilitation outcomes, personal relationships community reintegration, and health prevention and maintenance effects over-all quality of life.

Summary

Suffering a stroke or TBI can be life changing for anyone and as medical interventions advance, an increased number of survivors must figure out a way to navigate life after a neurological event. Although this can be difficult for anyone, recovery can present unique challenges for men. Although a large amount of literature has been done focusing on the after

effect of these neurological events, focus on men and how masculinity and masculine norms affect the outcomes of rehabilitation and recovery is limited.

In this chapter, I introduced this qualitative study, the problem statement, purpose of the study, and research questions. An explanation of stroke and TBI including causes, prevalence, treatments, and outcomes, the theoretical foundation for this study along with definitions of middle age, stroke, TBI, quality of life, and masculinity and were provided. Other information included was the nature of the study, assumptions, limitations challenges and or barriers, scope, and delimitations along with the significance of the study and a summary. The next chapter includes an introduction to chapter two, explanation of the search strategies used for the review of literature and exploration of pertinent literature related to this research study topic as well as a summary.

Chapter 2: Literature Review

The prevalence of stroke and TBI is a global issue, and with advances in medical treatment, individuals are surviving at an increasing rate. Wong et al. (2017) reported 6.5 million adults with stroke and 2.8 million adults with TBIs live in the United States alone. Unfortunately, surviving an acute event and recovering to a satisfactory level of function are not the same.

The purpose of this study was to explore the narratives of middle-aged men who suffer an acute stroke or TBI with the intention of providing insight into their post event quality of life. With a better understanding of how men cope with the after effects of an acute stroke or TBI, not only could medical professionals use this information to establish rehabilitation and health programs that lead to improved quality of life, but this information could be useful to families and loved ones to help with rebuilding relationships, to members of the community to improve the opportunity for community reintegration and to employers who can assist with adapting and accommodating for post stroke/TBI deficits for increased opportunities to achieve financial stability.

Literature Search Strategies

Current and historical peer-reviewed literature and books dated no earlier than 2010, unless pertinent to support areas such as theory and definitions were explored. Selected articles relating to quality-of-life changes in men after acute onset of stroke or TBI and definitions of terms used are described here. Academic Search Complete, Education Full Text, Education Source, Educational Administration Abstracts, ERIC, EBSCO Information Services, Google Scholar, ProQuest Central, and PsycArticles. An initial key word strategy and combination of the

following search terms were used to identify relevant materials: *quality of life, stroke/ traumatic brain injury, masculinity* and *stress/coping* in the Thoreau multi-database search and Psychology Databases Combined Search through the Walden University Library and Google Scholar. Materials reviewed and summarized resulted from relevant journal articles, books read and/or summarized, and articles, data, research studies and other pertinent information such as definitions and statistics found on websites. Literature more than 12 years old was reviewed when necessary to make connections or better understand concepts.

Theoretical Foundation

The theoretical frameworks for this qualitative study were the transactional model of stress and coping and SIT. These theories were used to address how people adapt to stress on an individual and societal/group level. After an acute neurological event internal and external factors can play a role in how the person adapts to changes and attempts to have a good quality of life.

Transactional Model of Stress and Coping

The transactional theory of stress and coping, developed by Lazarus and Folkman (1987), has been used over the past five decades to help shape stress and coping research (Cooper & Quick, 2017) . This theory suggests that stress and coping is affected by an individual's appraisal process of stimuli within their environment and that the individual appraises the stimuli in their specific situation, emotions are generated and used to establish one's perception of a specific event including the level of stressfulness to them. Cooper and Quick (2017) also proposed that cognition contributes to the primary appraisal process as meaning is ascribed to

events and stimuli, and this meaning helps establish significance to an individual's wellbeing. They suggested that appraisal of stimuli in one's own environment is constant (Cooper & Quick, 2017).

According to the transactional model of stress and coping, primary and secondary appraisal occur when attempting to cope with a stressor (Lazarus & Folkman, 1987). The authors suggest that in primary appraisal, an individual examines possible risks and benefits, and during secondary appraisal, the possible options for coping with a stressor. Coping with not only the neurological injury, but also life changes that occur after an acute event contributes to increased stress. This theory aligned with the purpose of this study as quality of life is part of the experience of how one copes with and adapts to stress. I used this model to guide the development of the interviews and analysis plan.

SIT

According to Henri Tajfel (1974), one author of the Social Identity Theory (SIT), social identity is the part of an individual's self-concept that is formed out of the emotional attachment that they connect to their membership of their social groups. SIT, as described by Islam (2014), contends that an individual's self-identity can be strengthened as result of feelings of inclusion into social groups. According to Trepte and Loy (2017), an individual's perceptions of self-image, whether negative or positive, can be determined by the social category they place themselves in. For the purposes of this study, male gender was the social group of focus. I used the SIT to explore masculine identity and the effects it has on quality of life. The SIT could be considered a classical social psychological theory that is used to help explain intergroup conflict.

One premise of this theory is that individuals use their perceived self-identities as a member of the social group to guard and improve their perceptions of themselves (Islam, 2014). This theory supports the idea that a person can define him or herself through group-based interactions and outcomes of inner group conflicts contribute to this formation of self (Islam, 2014).

They suggest seven underlying principles that are influenced by an individual's subjective belief structure. These principles are categorization, salience, social comparison, positive distinctiveness, social identity, self-esteem, and at the end of this process consequences on individual mobility/ social creativity/ social competition /stereotyping (Trepte & Loy, 2017). A negative social identity tends to contribute to low self-esteem but a positive social identity results in positive self-esteem (Trepte & Loy, 2017).

When an individual has defined themselves as a member of a social group, moving out of that social group may be difficult. An example of this was noted by Dirth and Branscombe (2019) in a study that explored how an individual with disability identified themselves with social groups of individuals with like disabilities. They also contend that it can be difficult to move from a social group that categorizes an individual by a level of disability, especially if it is observable. The SIT provides some understanding as to how beliefs and status play a role into identification with social groups (Dirth & Branscombe, 2018). This understanding may also provide guidance for managing stigmas in groups categorized as disabled. Studies have attributed stigmatized disability social identity to being a “psychological resource for well-being” (Dirth & Branscombe, 2018, p. 1315) .

Conceptual Framework

Masculinity

Weir (2017) proposed that masculinity incorporates “gender norms include toughness dominance, self-reliance, heterosexual behaviors, restriction of emotional empowerment, and in voiding traditionally feminine attitudes and behaviors” (p. 34). Because of this, Weir (2017) claimed that men are less likely to seek help when they need it if they value self-reliance. Per Kaya et al., (2019), masculinity includes social standards that provide an indication as to what it means to be a man. Masterfulness and strength are expectations that men tend to have, and their manhood must be constantly affirmed in public (King et al., 2020). For some men, this need may even drive them to participate in risky behavior or avoid activities that may negate their manhood. For men with disabilities this less than normal performance can contribute to increased anxiety. Establishing their own self-identity outside of stereotypical masculine norms affect rule changes such as going from breadwinner to not being able to work (King et al., 2020).

Some of these social standards portray masculinity as an indirect and stress provoking state, can be restrictive in behavior including repression of emotion, aggression, and risk taking (Kaya et al., 2019). In regards to mental health in men, some negative masculine norms can contribute to poor mental health (Kaya et al., 2019). Y. J Wong et al. (2020) suggested that masculine norms describe what men do and what men should or should not do as implied by society. Physicality, providing for family, avoidance of home making, work, and emotional toughness are included in these social norms.(Wong et al., 2020). Salgado et al. (2019) pointed out that masculine norms can play an important role in men's health including health prevention,

promotion, and intervention programs. Because of this, establishing gender specific programming that takes masculine norms into consideration can improve these areas. Research that looks specifically at the connection between masculine norms and men's health would be beneficial to support this (Salgado et al., 2019).

Traditional masculine norms including self-stigma and negative beliefs surrounding reaching out for help can be a barrier to receiving care. Because of this, traditional gender roles should be taken into consideration when designing and providing mental health care to men (Seidler et al., 2018). Talking openly about mental health can present obstacles for men and can elicit feelings of guilt and shame if they do discuss it (Talk, 2020). As Ragonese and Barker (2019) explained, in many countries statistics show that men underutilized primary care services and that men ask fewer questions and have shorter consultations. Herron et al. (2020) indicated that some men defined a healthy man as someone who is physically strong, financially successful, confident and for men living in rural areas rigid and traditional forms of masculinity may be expected.

Literature Review Related to Key Concepts

Acute Neurological Event

Although advances in medicine and medical care can increase the chance of surviving a traumatic brain injury or stroke, many survivors still have to live with some sort of disability or dependency that can negatively affect their quality of life after the trauma (Verdugo et al., 2019). In many cases, brain injury survivors have struggles that happen from the time of onset to years status post onset. These struggles affect not only the survivor but also their families, and both can

have new unmet needs. These needs can be result of changes of duty, ability to be employed, and changes in relationships such as spouse separation and roles / relationship (Proctor, 2019). As reported by Materne (2018), functional mobility after brain injuries is an important aspect for quality of life and reintegration back into the community. The ability to return to work and have a driver's license or be re-issued a driver's license after the injury can contribute to feeling less disabled (Matérne et al., 2018).

Coping with unexpected changes can be difficult but important in the recovery process. Executive functions in the brain can be affected after a brain injury thus influencing the ability to cope and psychosocial functioning. Because of this individuals are more inclined to use maladaptive passive coping styles including passive emotions instead of problem focus coping styles (Wolters Gregório et al., 2015). As well as learning to cope, having some feeling of control can support the recovery process. Freeman et al (2015) maintained that even when men make progress, others making decisions for them can lower their level of self-awareness thus inhibiting their abilities to take credit for their successes. Two factors that increase an individual with an acquired brain injury's ability to manage their own health are cognition that remained relatively intact and the ability to complete activities of daily living/ instrumental activities of daily living (Parker et al., 2018). Effective coping with life changes and adapting is important to progress towards some level of normalcy after an acute event.

Stroke

Perez-delacruz, (2020) and Feigin et al. (2022) emphasized that stroke is a worldwide problem that that is the second leading cause of death and the third leading cause of disability.

There are over 12 million new strokes a year with 47% occurring in men (Feigin et al., 2022). Men account for 51% of deaths from stroke (Feigin et al., 2022). One type of stroke is an ischemic stroke in which 50% of survivors have a permanent disability (Pérez-de la Cruz, 2020). Stroke is a global health problem that is the second most common cause of disability, some of which is long term (Palstam et al., 2019). It can impact physical and cognitive function. Stroke related disability accounts for 34% of healthy life lost (Feigin et al., 2022). Men and women differ in the prevalence of stroke. According to Willers et al. (2018), males less than 70 years old almost doubled to females who had a stroke meaning women were frequently older than men at stroke onset. Men account for 51% of deaths from stroke (Feigin et al., 2022).

Medical advances have contributed to decreasing death and disability in individuals who have suffered a stroke. Although this is the case, quality of life can still be negatively affected by functional dependence and depression (Ahmed et al., 2020). In the United States alone 610,000 individuals suffer a new stroke every year and 115,000 have recurrent strokes. Some type of disability is noted in 86% of the people including 86% mobility deficits, 39% communication deficits and 34% learning problems (Unibaso-Markaida et al., 2019).

The estimated annual cost of stroke in the United States alone is \$33 billion (Pappadis et al., 2019). Almost one third of post stroke survivors report cognitive and mood impairments which include anxiety and depression that tend to go unnoticed or untreated. Physical deficits tend to be at the forefront of post stroke deficits, and the amount of research reported that explores the lived experiences of individuals with chronic cognitive and mood symptoms is

limited. Communication difficulties and memory deficits have been reported to negatively affect quality of life (Pappadis et al., 2019).

Stroke is a neurological disease caused by obstruction of normal blood flow due to vessel rupture blockage which causes damage to brain tissue (Pérez-de la Cruz,2020). There are 3 different types of strokes including ischemic which affects 80% of people, hemorrhagic 3%, and 10% make up other strokes and of the 3 types, hemorrhagic strokes result in the greatest mortality (Unibaso-Markaida et al., 2019)

Ischemic stroke (IS) accounts for 87% of all strokes in the United States and is characterized by interrupted blood flow to the brain and can result in disability or even death (Roy-O'Reilly & McCullough, 2018). The number of United States stroke survivors is suggested to be 10 million by 2030 (Roy-O'Reilly & McCullough, 2018). Ischemic stroke epidemiology, treatment effectiveness and pathophysiology, age and sex are considerations with sex being “critically under assessed” (Roy-O'Reilly & McCullough, 2018). Ischemic stroke is a devastating brain injury resulting in high mortality and substantial loss of function. Understanding the pathophysiology of ischemic stroke risk, mortality, and functional loss is critical to the development of new therapies. Age and sex have a complex and interactive effect on ischemic stroke risk and pathophysiology. Aging is the strongest nonmodifiable risk factor for ischemic stroke, and aged stroke patients have higher mortality and morbidity and poorer functional recovery than their young counterparts. Importantly, patient age modifies the influence of patient sex in ischemic stroke. Early in life, the burden of ischemic stroke is higher in men, but stroke becomes more common and debilitating for women in elderly populations.

The profound effects of sex and age on clinical ischemic stroke are mirrored in the results of experimental in vivo and in vitro studies. Here, we review current knowledge on the influence of age and sex in the incidence, mortality, and functional outcome of ischemic stroke in clinical populations. We also discuss the experimental evidence for sex and age differences in stroke pathophysiology and how a better understanding of these biological variables can improve clinical care and enhance development of novel therapies (Roy-O'Reilly & McCullough, 2018) (Wilson et al, 2017).

Turner et al. (2019), reports TIA and minor stroke can result in psychological and physical impairments including anxiety and fatigue. Unfortunately, some residual problems go unnoticed and untreated as they are not physical but "hidden" per patient reports. Health care providers tend to overlook deficits such as mood, emotional problems including emotionalism, anger and mood swings, frustration, irritation, lack of empathy and lack of confidence that are not observable due to lack of physical manifestation (Turner et al., 2019).

Post Stroke Effects

For individuals who have suffered a stroke and develop depression, quality of life can be affected even after five years. An individual's autonomy and their ability to participate in life tasks is also known to influence quality of life in stroke survivors.(Palstam et al., 2019). Bullier et al. (2020) described aphasia as a deficit in language production and/or comprehension that has been suggested as a predicting factor along with functional limitations on quality of life in post stroke individuals.

In ischemic stroke sexual life, sexual frequency, erectile dysfunction (ED) and sexual desire can be directly affected in the male population. ED for men who have suffered an ischemic stroke is 77.8% higher than men who have not suffered an ischemic stroke (Dai et al., 2020). This type of issue not only affects the life of the person who suffered the stroke, but it can also have an impact on their partner and quality of their relationship. In the case of ischemic stroke survivors' anxiety depression and erectile dysfunction can have a reciprocating relationship in that depression can contribute to ED, and ED can contribute to depression. According to Dai et al. (2020), almost all men with depression also have ED. In treatment planning, it is necessary to broach erectile dysfunction if present to help increase quality of life and decrease the risk of developing anxiety and or depression (Dai et al, 2020). The stress put on a relationship after a stroke can be compounded by changes in sexuality. The ability to participate in sexual relations can be altered by physical and cognitive changes and is not always openly discussed amongst partners or health care providers (McGrath et al., 2019) .

Spasticity, a physical dysfunction which can be the result of a stroke can have an impact on ADL and health related quality of life. The presence of poststroke spasticity can be a cause of disability and weakness at varying levels. Research studies have supported the connection between the presence of spasticity and worse functional outcomes after 6 to 12 months post stroke(Schinwelski et al., 2019).

Executive functioning problems can also be the result of even a minor stroke or TIA . These problems can include the inability to process information, planning meals, returning to work, in education, relationships with family and friends, social lives, daily activities all more

difficult. Accepting a diagnosis can be difficult and contribute to a loss of identity for the person who has suffered the event (Turner et al., 2019).

Goverover et al. reported 1/3 to 1/2 of post-stroke individuals report concern with anxiety and depression as early as three months and as late as five years (2017). Although this appears to be a consistent concern with their diagnosis, it continues to be underdiagnosed and undertreated frequently (Goverover et al., 2017). Post stroke depression can have a significant effect on recovery and quality of life (Pérez-de la Cruz, 2020). For individuals who have suffered a stroke, finding effective ways to cope can be instrumental in their ability to rebuild their lives. In instances where emotion based coping skills are used, managing guilt, anger and sadness can be more difficult and result in feelings of helplessness and inability to accept the aftermath of the stroke (Reverté-Villarroya et al., 2020). Post stroke depression, even one year after a stroke, can negatively impact a stroke survivor's quality of life. In earlier phases, this may be a predictor of some aspects of quality of life. There is a connection between quality of life and post stroke depression and acute and chronic stages of stroke (E. S. Kim et al., 2018). Post stroke depression is a frequent psychiatric condition that is prevalent in approximately 33% of stroke survivors and contributes to worse functional recovery outcome on lower quality of life and higher mortality rates.(Volz et al., 2021). The results of a study by Forslund et al. (2021) indicated that 1/3 to 1/2 of individuals reported concern with anxiety and depression as early as three months and as late as five years. For a large number of stroke patients depression is present and this contributes to reduced life satisfaction (Oosterveer et al., 2017). Along with others, Perez de la Cruz (2020) also cited one common disability that can be the result of stroke, post

stroke depression. About one out of three patients who have suffered a stroke will develop post stroke depression, but it has been reported to go underdiagnosed and undertreated (Perez de la Cruz,2020). Post stroke depression, although acknowledged, is undertreated and can contribute to less levels of recovery and decrease quality of life than stroke survivors without post stroke depression (Volz et al., 2021). Although this appears to be a consistent concern with their diagnosis, it continues to be underdiagnosed and undertreated frequently (Forsslund et al., 2021).

Participation in rehabilitation after a stroke is important and can include intensive participation in practice and motor tasks, but for individuals who are suffering from disordered sleep recovery can be adversely affected (Fulk et al., 2020) . Unfortunately, sleep disturbances are not always recognized and addressed. Sleep disturbances not only affect physical function but mood dash related issues can also be a product of sleep deprivation (Fulk et al., 2020).

Quality of Life

Along with stroke, post stroke symptoms including aches/pain, limited mobility, fatigue and 1/3 of stroke survivors reported depressive symptoms over time (Shifren & Anzaldi, 2018). Improved treatment of depression can improve overall quality of life for stroke survivors so an improved knowledge of depression is useful (Shifren & Anzaldi, 2018). In a study by Schifrin and Anzaldi, (2018), the relationship between optimism, positive and negative aspects of mental health, and physical health in stroke survivors resulted in suggesting that optimism plays a “partial mediator role” (p 54) between mental and physical health perception. Karube et al. (2016) implies that there is a connection between psychological health and quality of life after a stroke if there was a hobby or work prior to a stroke. This is important because better

psychological health has been correlated to better quality of physical health (Karube et al., 2016). Stroke survivors not only have their own quality of life to worry about but also their family's quality of life as families of stroke survivors have poor psychological health care outcomes including depressive mood and higher levels of stress. In many cases not only do the survivors feel abandoned but the families also feel abandoned after the acute hospital stay (M. Kim & Lee, 2021).

Larsen et al. (2020) contends that health status in individuals who have suffered a stroke was affected by several variables and that increased self-rated mental health reports were reported when there were comorbidities, older, male, and mild stroke severity. Increased self-rated physical health was reported in individuals who had no comorbidity, mild stroke severity, higher education level, and younger age (Larsen et al., 2020). Mutai et al. (2016) pointed out that there is no one factor that is responsible for determining higher or lower QOL, but suggests that age, sex, ADL/IADL function, depression, marital status history, and quality of social supports may have some influence on an individual stroke survivors reports of quality of life. There is some research that does show a connection between ADL function and social participation which can contribute to a higher quality of life (Mutai et al., 2016).

Surviving a stroke can result in an increased risk of sedentary lifestyle. Poststroke anxiety, depression and fatigue can contribute to worse quality of life but higher independence levels with all daily activities and mobility, better socioeconomic level, social support and having a higher level of education can contribute to a higher quality of life (Ramos-Lima et al., 2018).

Rehabilitation

Although an increasing number of stroke survivors are reintegrating back into their community, there is not an adequate understanding of how to adapt to their new self and return to their society. In some cases stroke survivors returned back into their communities without sufficiently having their needs met rehabilitative wise so there may be participation limitations and decrease life satisfaction (Törnbom et al., 2019). Physical activity poststroke is important not only for working towards pre stroke function but also to maintain general health (Hamre et al., 2021). Positive effects of working including providing for self\ family economically, meaningful tasks and programs such as vocational rehab to assist individuals match their skills\ ability to work were suggested (Phillips et al., 2019).

For stroke recovery, it is important that appropriate care is available. Providing adequate post-acute stroke care is necessary to ensure that the individual is provided with adequate support and guidance to decrease risk of further decline and quality of life deficits after a stroke (Peng et al., 2019). Not only should care be adequate but timely. It is necessary to provide timely and effective intervention /treatment to individuals who have suffered a stroke as it can contribute to self-perceptions of good health. According to Mavaddat (2018), perceptions of timely treatment/ cares and supportive care professionals contribute to perceptions of good health. Self-rated health is multi factorial including looking at physical, psychological, and social components. Severity of physical limitations does not influence views on future recovery (Parker et al., 2018)(Mavaddat et al., 2018).

TBI

A TBI is an injury that occurs as result of a trauma to the head that interrupts normal function of the brain (Traumatic, n.d.). These injuries can range from mild to severe and cause long-term issues. Health and wellbeing can be affected consequently for a lifetime. Individuals who have suffered a TBI and research gaps in this area have been suggested (Roy-O'Reilly & McCullough, 2018). The long-term effect of TBI can affect the individual, their family and society in general. Roy-O'Reilly & McCullough (2018) speculated that chronic aftereffects of a TBI may go unrecognized and undertreated which can contribute to poorer outcomes. Some long term effects of TBI include post-concussion symptoms, emotional difficulty, cognitive impairments and functional limitations and can alter recovery outcomes even years after the initial event (Pappadis et al., 2019). Pappadis et al. (2019) contended that risk factors for impaired recovery or ongoing disability and even death after a TBI can include being older age at injury, being a man, and preinjury drug or alcohol abuse. They suggested a link between TBI and increased risk of stroke in the first 5 years after the initial acute injury. Exploring and understanding how a man identifies himself may be an important piece of knowledge that contribute to the effectiveness rehabilitation after a TBI. According to Macqueen et al. (2020), men are two times more likely to suffer a TBI and when a man's identity is affected by deficits from a TBI, his "ideals about independence, agency and roles within relationships was difficult to maintain" (p. 311) so when establishing rehabilitation and health programs incorporating the idea of the individual's male identity to develop activities improve effectiveness. The authors also suggest that adapting to the aftereffects of TBI is unique for men and their ideals and values

need understood. Combining new ways of adapting and old ones to meet their new needs will increase the likelihood that acceptance will occur. Exploring and understanding how a man identifies himself may be an important piece of knowledge that can contribute to the effectiveness of rehabilitation after a TBI (MacQueen et al., 2020).

Post TBI Effects

As reported by Khan et al. (2016), increased understanding of the long term effects of TBI is needed as survival rates improve to address long term quality of life and improving community participation will improve rehabilitation planning and program. Depression chronic and acute, other psychiatric disorders including PTSD, anxiety, suicidal thoughts, and behaviors are psychological issues that can develop because of a TBI (Khan et al., 2016). Behavior of concerns including aggression, lack of initiation, and inappropriate social behavior can be a concerning and common consequence of a moderate to severe TBI (Gould et al., 2019).

Jourdan et al. (2016) contended that somatic and cognitive problems after a traumatic brain injury can include fatigue, headache, other pain, memory deficits, irritability, and slowness. According to the results of their study, only seven percent of the sample returned to “quasi normal life “(p. 104) and spent limited time participating in productive activity including tasks such as studying, looking after children and volunteer work (Jourdan et al., 2016).

Lavoie (2017) indicated that some studies suggest that men with TBI are at an increased risk of depression and unfortunately the depression may go untreated. Feelings of sadness, hopelessness and worthlessness can all be characteristics of depression along with decreased ability to concentrate, sleep, initiate and/or participate in prior activities that were meaningful to

the individual. The prevalence of depression in survivors of TBI is notably higher than the average population and in the first year after suffering a TBI 25% to 50% will display major depression and 60% of individuals after seven years will show these signs.(Lavoie et al., 2017). Poritz et al. (2019) suggested that traditional male activities and occupations put them at increased risk for suffering a TBI and may be less able to return to work post injury if their job requires physical ability but beyond their level of function. Murphy et al. (2019) proposed that depression, a common issue after a brain injury can contribute to cognitive deficits. For individuals with depression treatments including cognitive behavioral therapy may be beneficial to improving mental health difficulties thus improving rehab outcomes and overall quality of life. (Murphy et al., 2019).

Quality of Life

Andelic et al. (2018) argued that health quality life for individuals who have suffered a severe TBI can be influenced by decreased employment rates, depression, decreased ability to function including physical, cognitive, and emotional impairments and to reintegrate back into society. Fernández et al. (2019) noted that in instances of acquired brain injury, dependency and disability often remain leaving lasting effects. Survivors frequently reported a decrease in quality of life after acquired brain injury with varying impairments including functional, cognitive, emotional and social deficits(Fernández et al., 2019).

Rehabilitation

Binder et al. (2019) proposed that integrating back into social settings including at home, occupational and social environment can improve rehabilitation success for individuals who

have suffered a traumatic brain injury as social isolation has been suggested contribute less than optimal rehabilitation success. In a study that explored men who suffered a TBI, the strong motivation to return to work was present with the negative feelings for those who are unable to return to work (D'Souza et al., et al., 2020). This is thought to be influenced by masculine norms. The drive to return to work for men can have negative consequences including forgoing health care treatment to go to work or pushing to return to work before being physically and/or cognitively ready (D'Souza et al., 2020).

Pettmeidou (2020) suggested how an individual performs in executive functioning and their self-awareness can contribute to changes in quality of life after a TBI. Executive functioning which includes the ability to formulate goals, initiate behavior, anticipate behavior/plan/ organize/adapt/ monitor behavior so that it is appropriate in different situations can be altered after a TBI. Self-awareness includes beliefs about oneself that have formed from past experiences, cultures, and values (Pettmeidou, 2020).

The ability to participate in activities such as employment, leisure activity, relationships with friends and family after a traumatic brain injury can be a contributing factor to the successful recovery of an individual (Goverover et al., 2017). They also suggest that individuals who report a more sedentary lifestyle report dissatisfaction with the lack of ability to participate. Both Goverover et al. (2017) and Karube et al. (2016) cited that participation and leisure activities, or work have a positive link to quality of life in both stroke and TBI survivors. Goverover et al. (2017) suggested that there are a limited number of studies that explain the

relationship between activity participation, functional outcome, and quality of life in individuals with neurological impairment.

Aftereffects of a traumatic brain injury can be long term and include psychiatric disorders such as anxiety, PTSD, and or sleep disturbances along with ongoing physical and cognitive deficits (Rauen et al., 2020).

Quality of Life

According to the World Health Organization, quality of life is an individual's perception of their position in life in the context of the culture and value systems in which they live and in relation to their goals, expectations, standards, and concerns. It is a broad ranging concept affected in a complex way by the person's physical health, psychological state, personal beliefs, social relationships and their relationship to salient features of their environment (WHO, 2012).

Kruithof et al. (2018) postulated that the quality of life for individuals who have suffered a traumatic event is not sufficiently understood. Because an individual's perception of quality of life is subjective, understanding their satisfaction with level of function in areas such as physical health, psychological state, independence level, relationships and personal beliefs is necessary. Patient concerns include difficulty with returning to work and financial burden, return to work, including financial burden from adaptive equipment. Along with providing some level of financial stability, returning to work can also improve inclusion in society, relationships with family and friends is important to the recovery process including increasing independence with basic ADLS (Kruithof et al., 2018).

Health Quality of Life

HQOL differs from quality of life in that HQOL refers to the direct effect that a medical condition has on an individual's perception of physical, emotional or social well-being (Forslund et al., 2021). According to the CDC, health quality of life (HQOL) includes physical and mental health perception such as energy levels and mood as they relate to health risks and conditions, level of functional ability, social support and socioeconomic status. (National, 2018). Health quality of life is an important assessment and explaining the impact of disease and disability on and is defined by an individual's life, includes emotional physical social and subjective perceptions of well-being (Donkor, 2018). Areas such as health, jobs, neighborhoods, culture/values/spirituality are encompassed in in the concept of HQOL (NATIONAL, 2018). For individuals who suffer a moderate to severe TBI, rehab and recovery is complex and continually changing and can take years to accept and adjust to (Forslund et al., 2021). Decreased health quality of life can result after chronic conditions such a stroke and mental disease (Arrospide et al., 2019).

Health quality of life after a traumatic injury can be negatively affected by cognitive dysfunction (Gorgoraptis et al., 2019). Depression , sleep disturbance and daytime sleepiness may also be observed as a result of the injury (Gorgoraptis et al., 2019). Donkor (2018) proposed that little is known about the HQOL of stroke survivors globally and a better understanding is “essential” (p. 7) to promote improved health quality of life.

In medicine and health research, the biomedical aspect has been the focus with quality of life outcomes being less of the focus (Haraldstad et al., 2019). Haraldstad et al. (2019)

explained HQOL as the health aspects of quality of life, including how disease and the treatment of a disability impact the completion of daily activities along with an individual's perception of personal health on the ability to live a fulfilling life. Understanding quality of life is important as the consequences of illness and subsequent treatments can impact medical decision making (Haraldstad et al., 2019). For men, admitting the need for treatment and seeking it out can be problematic. According to D'Souza et al., et al. (2020) a common understanding of masculinity is the resistance to admit any form of "weakness" and avoidance of help seeking for health prevention and treatment. This can be consequential as it can lead to a lack of diagnosis and treatment services (D'Souza et al., et al. , 2020).

Wong et al. (2017) proposed that participating in life situations for individuals with brain injuries can have a positive effect on health quality of life and wellbeing although demands of and environment are not always compatible with the abilities of an individual who has functional deficits, and this can be a deterrent.

Summary

This chapter explored the effects of acute stroke and TBI on quality of life. I explained important concepts and the theoretical framework. The literature consistently showed that stroke and TBI are worldwide problems that can result in varying levels of disability. Although medical advances are contributing to decreased rates of mortality, survivors still must navigate a world that has been altered in many cases. Not all deficits are physical, in fact in many cases the deficits may be cognitive or psychological which is supported by the consistent theme of depression in my literature review. Depression after a stroke or TBI contributes to a host of

deficits alone, but it also increases the odds that an individual will have other physical and cognitive issues. An example of this in men is the correlation between depression and erectile dysfunction after an ischemic stroke.

Chapter 3 includes a discussion of the research design and rationale for this study. I explore the sampling strategy and population. Methods for data collection are defined along with a brief description of the qualitative approach to research and rationale for the processes to answer the research questions. I also explained trustworthiness and ethical considerations in Chapter 3 along with evidence of ethical integrity of the study.

Chapter 3: Research Method

The purpose of this study was to provide insight into the perspectives of men who have suffered a TBI or stroke including narratives of masculine identity and quality of life. As stated earlier, research that focuses on a male perspective of TBI or stroke is minimal. Along with providing insights, I explored satisfaction with current physical and cognitive functional abilities and perceived quality of life. Quality of life may be negatively affected in men who suffer a debilitating event (Hansson et al., 2012), especially those who had strongly connected their personal identity to perceived masculine roles such as provider and protector (Moeller & Carpenter, 2013). Along with managing stressors that are directly related to the actual event, men who lack the ability to function may also feel guilty that they are a burden to others whether due to care needed or inability to fulfill prior roles. Lack of ability to perform prior roles can contribute to being bored and dissatisfied (Wood et al., 2010).

In this chapter, I explained the research design and rationale, role of the researcher, methodology, issues of trustworthiness, and summary.

Research Design and Rationale

Primary research question: What are the narratives of masculine identity and quality of life in middle-aged men who experience a stroke or TBI?

Secondary research question 1: How has having a stroke or TBI negatively and/or positively changed your life?

Secondary research question 2: How would you describe your rehabilitation including options and progress after you TBI or stroke?

Quality of life changes that occur due to physical and/or cognitive deficits after an acute neurological event can have a direct effect on how an individual adapts to the changes and continues living their life. Every individual reacts and adapts differently to their personal situation, and how the process evolves and changes as they move forward in life. Factors that can affect recovery include age group, level of functioning and prior perceptions of quality of life. Because of the subjective nature of exploring an individual's perception of quality of life, use of narrative inquiring supports the objective of this study. Although there may be other approaches that could have been used, this approach was more than appropriate.

The research tradition used in this qualitative study was narrative inquiry. Although there are other qualitative research traditions such as phenomenological, grounded theory, ethnographic, historical and case study (Renjith et al., 2021) would not support the objective of this study. In phenomenological research, the focus is on interpretation and exploration of a specific phenomenon, which was not the case for this study. The purpose of grounded theory research is to generate a theory and does not support the objective of this study. Ethnographic research looks at a specific group of people who share commonalities and is completed over an extended period of time, which was not appropriate for this study. Historical research involves using the past to gain insights about the present, and data are typically gathered from primary and secondary sources, which did not fit this study. Case study research involves using in-depth analysis of one or more cases in order to write a detailed case study report (Renjith et al., 2021). The narrative inquiry fits the aim of this study while the others would not. Exploring the perspective of the individual as seen through his eyes provided insight into how he perceived his

quality of life after the traumatic event. The use of the narrative also allows for some level of autonomy for the participant.

I used the thematic model of narrative analysis to find common themes as they occur in the narrative of multiple individuals. Narrative analysis is an approach that uses varying types of text to gather information in a storied form. Typically, in psychology and sociology personal narratives, extended accounts of an individual's experience that could be received through either a single interview or multiple interviews are used. This type of analysis is useful in cases where a researcher uses narrative reports from multiple individuals to establish themes that are consistent among the participants of the study (Riessman, 2005).

Interviews are useful to provide an opportunity for the participant to subjectively present their experiences, opinions, and motivations (Busetto et al., 2020). In this study, I used semi structured interviews. Semi structured interviews include open ended questions, interview, and several sub questions (Busetto et al., 2020). These are included as appendix A.

Role of the Researcher

My role in this study was interview guide. As interview guide my responsibility was to guide the interviews including asking and answering questions. As a researcher in qualitative study, one of my responsibilities was to be the mediator between the experience of the participant and the population reviewing the information (Sanjari et al., 2014). I provided support to the participant including moral support if the participant needed it. The participants did not know me personally prior to completing the research study.

As an occupational therapist for over 22 years, recognizing and managing any bias I may have regarding this topic was necessary. Healthcare workers as researchers should display a level of caution when completing research that is in their field as biased from prior experiences may influence study results (FitzPatrick, 2019). To do this, I completed a personal inventory of any beliefs I had prior to the interviews and made a diligent effort to not allow this to influence my questions or how I presented them.

As the researcher, it was my responsibility to ensure that informed consent was thoroughly understood and agreed to (Sanjari et al., 2014). This was achieved by clarifying procedures and providing a thorough explanation of informed consent. Informed consent may evolve and change as the study progresses, so continuously addressing this throughout the study, known as the “consent process” is necessary (Cypress, 2019). Informed consent is an integral part of ethics in research and includes the nature of the study, participants’ potential roles, my identity as the researcher and financing body, objectives of research, and how results will be published and used (Sanjari et al., 2014) .

I also address ethical procedures in terms of relationships that may form between the researcher and participant during the study, respect for privacy, open and honest communication, confidentiality, and autonomy.

Methodology

Participation Selection Criteria

The participant inclusion criteria for the study were men aged 30 to 75 who had suffered a stroke or TBI and had to have been independent with all daily tasks including bathing,

dressing, toileting, and household management at baseline and must have suffered the event at least 1 year prior to the study. Along with this, participants had to demonstrate an adequate level of cognition and verbal skills to be able to understand interview questions and report their answers. The initial recruitment letter included inclusion criteria, questions I would ask during the initial contact, and an explanation of requirements. This provided the physician/ healthcare practitioner guidance in terms of determining if an individual was a fit for this study. I further verified this when I made my first contact by asking potential participants several questions. These questions included demographics and history of their injury. I also asked about age, prior occupation, level of independence with daily tasks, including bathing, dressing, toileting, and household tasks, and type, cause, and time since injury. If they were able to understand and sufficiently answer these questions, their cognition and verbal skills were at an adequate level to participate in the interview. All six participants met criteria, so no one was excused.

Purposeful Sampling

Purposeful sampling increases the opportunity to obtain in-depth information that supports the objective of this study from a small sample size that fit set categories such as age, gender and experiences (Shaheen et al., 2019). The participant pool includes six men who had suffered acute stroke or TBI. Although, the use of purposeful sampling in qualitative research increases the likelihood that saturation would be reached even with a small participant pool (Busetto et al., 2020), this study recruited six participants.

Instrumentation Logic

Semi-Structured Interviews

The semi structured interview is a common method in qualitative research to explore the human experience (Bearman, 2019). Qualitative interviews provide richer data than short cognitive or mood test (Pappadis et al., 2019). Establishing an interview schedule that incorporates a list of talk topics and associated questions will help provide guidance for the interview and ensure that rich data associated to the research questions will be received (Bearman, 2019). This study used a list of open-ended questions that have been included as appendix A. The questions provided guidance to help ensure that the information gathered will support the objective of the study and the research questions while allowing the participants to tell their story subjectively.

Sample Size and Data Saturation

Because this was a qualitative study that used a narrative approach, the number of participants was limited to six. When using a narrative approach, a small participant pool that meets the inclusion criteria is sufficient. I chose to limit the number of participants to six. Using a small sample size for this study allowed for a more in-depth exploration of the personal narrative of each participant. According to Sim et al. (2018), although a sample size can be from 3 to 60, the quantity of the sample is not as important as the quality of the results and how they are used. In qualitative research studies data saturation, the point at which little useful or new information appears during data analysis, has been reported after the first five or six interviews, little new information is found in sample sizes beyond this (Guest et al., 2020). Sample size

effectiveness can vary depending on the study purpose. Some research findings support rich qualitative findings in studies that used a small sample size resulting in adequate themes and codes (Young & Casey, 2019).

Procedures for Recruitment, Participation, and Data Collection

Recruitment Procedures

I wrote a recruitment letter that included an explanation of the purpose of the study, criteria for subject inclusion, brief explanation of the process including the approximate time that was required to complete the interview and means for completing the interview including in person or via electronic video communication.

I selected the participants for this study using several procedures including Facebook, word of mouth and physician/ physical or occupational therapist referral. My private Facebook page was used by posting an explanation of my study and the inclusion criteria and a request for private communication if anyone was interested in participating. This private communication consisted of an email detailing the purpose of the study and inclusion criteria for participants along with my cell phone number. To reach out to physicians and therapy providers, I sent explanatory letters to 24 physicians/therapy providers within a 50-mile radius of my location explaining my study and my request for participants. The physicians included primary care practitioners or neurologists. The therapy providers included therapy departments that offer physical and/or occupational therapy. For this study, word of mouth meant that I could receive a referral from an individual who had knowledge of my study and the participant criteria. For example, an acquaintance inquired about the topic of my study and after I provided an

explanation, they voiced that they knew someone who may fit my inclusion criteria. I offered them my contact information to forward to the possible participant.

The participants were selected as they agreed to participate. I was the only person to interact with the participants or individuals who had questions during the process. During the initial contact, I asked the potential participants some broad questions to ensure that cognition and speech were at an adequate functional level to allow for participation in the interviews.

Data Collection

For this qualitative study, the data was collected from the participants through narrative interviews. I, the researcher, collected the data. One face to face or technology-based interview process using an option such as zoom, or video calling was used to gather the data. The interviews lasted less than one hour. The data was completed in one interview unless unforeseen circumstances such as time constraint or equipment malfunction require another session. Data collection should be done openly as possible and all findings recorded as it occurs to ensure accuracy (Sanjari et al., 2014). The interviews were recorded via an audio recording system and then dictated into the computer by me. Although I had planned to utilize up to eight participants, there was no need as data saturation was achieved with six.

There was a three-step process to exiting the study. The first step was debriefing, including any questions or concerns the participant may have which was via telephone call or video conferencing as needed. The second step was for me to provide the results of the study to the participants and allow time for them to read. The last step was for me to reach out to them

and answer any questions or concerns including corrections that they feel needs to be made. I will provide them with a copy to keep when the study is complete.

Data Analysis Plan

The semi structured interview questions, included as appendix A, were written to allow for the participant to provide their response in a narrative form while providing guidance so that the answers received support the research questions. Some specific topics will include their individual perception of what masculinity is, how their acute stroke or TBI has changed their life/ affected their quality of life and their description of the rehabilitation they participated in. The goal was to provide them with the opportunity to tell their story while ensuring that the data received contributed to answering the research questions and supported the purpose. Emerging themes were recognized during data analysis.

Reflexive thematic analysis involves development of themes after data is coded which will show established patterns and includes six themes (Braun & Clarke, 2021). The themes are familiarization; coding; generating initial theme; reviewing and developing themes; refining, defining and naming themes; and writing up (Braun & Clarke, 2021). This six-step process will be the guiding structure for coding the data analysis step for this study. The steps in the table below were designed using guidance from Maguire and Delahunt (2017).

Table 1

Data Analysis and Reporting

Data Analysis Steps	Researcher Actions
Familiarization	Read and Re-read the data 3 times to gain an understanding
Coding	Organized the data/ assigned codes for the pertinent ideas that emerged (NVivo used)

Data Analysis Steps	Researcher Actions
Generating initial themes	Sought out any themes, which were present and supported the research questions
Reviewing and developing themes	Pulled all information from the data that was related to the themes
Refining/defining/naming themes	Reviewed the themes to determine what each theme entailed and determined if it was a support of the research goals
Writing up	Wrote up the findings

Issues of Trustworthiness

It is necessary to be aware of issues of trustworthiness during research. These issues can include credibility, transferability, dependability, and confirmability. Validation in qualitative research can be supported by utilizing checks including using appropriate sampling, collecting rich data, engaging in long term involvement, providing thick descriptions, using at least one form of triangulation, search for/ report discrepant evidence, seek respondent validation, and having debriefing sessions with researcher and participants (FitzPatrick, 2019).

Decreasing bias when reporting results is necessary for qualitative strategies as the data is extracted from narratives of the participants and is interpreted and reported by the researcher (Shaw & Satalkar, 2018). Objectivity and honesty from the researcher must be considered important to keep from researcher bias and assumption influencing the study results including common themes (Shaw & Satalkar, 2018). This is important to support validity.

Credibility

Credibility includes the confidence that the research results are interpreted and presented correctly and presented in the way that the participant intended (Korstjens & Moser, 2018). To help ensure that the results of this study were credible, a copy of the data interpretation was

given to the individual and a follow-up conversation took place to determine if any discrepancies were reported and appropriate changes made.

Transferability

To improve transferability of the study results, purposeful sampling was used to determine the criteria for participants. Purposeful sampling increases the opportunity to obtain in depth information that supports the objective of this study from a small sample size that fit set categories such as age, gender and experiences (Shaheen et al., 2019).

Dependability

To improve the dependability of my study the steps of recruitment, data analysis and reporting were the same for each participant and reported in a manner that would make it possible for replication of the study. Several pieces of information were included in the reporting to support the study's dependability. These items were a detailed explanation of the recruitment process, interview steps including the semi-structured interview questions (Appendix A), the data prep and coding checklist and the six-step process was used as the guiding structure for coding the data analysis.

Confirmability

Confirmability ensures that the data gathered is truly derived from the participants reports and not fabricated by the researcher (Korstjens & Moser,2018). One way to decrease this risk is to use quotes or similar data from the participants (Stenfors et al., 2020). Member checking by providing a copy of the transcribed data to the participants gives them an opportunity to verify

accuracy of interpretation of the interviews and will contribute to supporting confirmability of the study results.

Reflexibility

Reflexibility by the researcher is achieved by ongoing self-reflection as the researcher continuously monitors their relationship to the respondent and how this relationship may influence responses by the participant (Korstjens & Moser, 2018); (Stenfors et al., 2020). As the researcher, I continuously self-reflected on my thoughts and biases as they evolved during the study and adjusted my responses as needed to decrease my influence on the participant answers.

Ethical Procedures

The use of narratives can open up opportunities for sensitive topics in depth which may result in emotional risk to not only the participant but the researcher (Sanjari et al., 2014). To minimize the potential risk for causing emotional distress during participation in this research study, resources including state and national phone hotlines/websites along with the recommendation to reach out to the individual's physician were included in the consent letter. Ethical dilemmas can be decreased by having a clear understanding of what the purpose of the study is (Cypress, 2019). During the initial contact with the potential participants, I explained the purpose and process of the study and asked if they had any further questions. A letter of informed consent was introduced prior to starting the interview and an opportunity for further explanation as needed and then signed by the participant. These steps reduced the risk of ethical issues.

Confidentiality

Anonymity can be more difficult in qualitative studies, so it will be imperative that extra precautions be taken. One measure to help ensure that confidentiality was maintained was by only using personal information that was absolutely necessary to support the purpose of study (Cypress, 2019). Some strategies to maintain anonymity are securing storage of data, removing identifiers such as biographical information, along with debriefing after the study to address any questions or complaints (Cypress, 2019). To maintain confidentiality, the data is stored on my personal password protected computer and saved on a flash drive that is locked in my personal lock box in which I only have the key. Also, the results of the final study use only the first name of the participant to decrease the risk of identification.

Summary

In this chapter, I outlined the qualitative study design which was used to explore the narratives of masculine identity and quality of life in middle-aged men who experience a stroke or TBI. I conducted this study as a basis for understanding how these events affect quality of life and provide some insight which can be useful for designing rehabilitation interventions along with assisting healthcare providers and others affected by acute neurological events. The rationale for choosing the phenomenological method of inquiry was discussed and my role as the researcher was also addressed. Recruitment and sampling strategies were discussed along with an explanation of inclusion criteria necessary to participate in the study. Additionally, the components of the data collection process were addressed including semi-structured interviews and standardized tests. To ensure trustworthiness of results, credibility, transferability,

dependability, confirmability, and reflexivity in qualitative research were addressed. Common themes among participants were identified and coded. Finally, ethical procedures for this study were addressed, including elements of informed consent, confidentiality, and dissemination of the research results. The study results are presented in Chapter 4.

Chapter 4: Results

The purpose of this study was to provide insight into the perspectives of men who had suffered an acute stroke or TBI including narratives of masculine identity and quality of life. Research that focuses on the male perspective after suffering a stroke or TBI is minimal. Along with providing insights, I explored satisfaction with current abilities and quality of life.

Research Questions

Primary research question: What are the narratives of masculine identity and quality of life in middle-aged men who experience a stroke or TBI?

Secondary research question 1: How has having a stroke or TBI negatively and/or positively changed your life?

Secondary research question 2: How would you describe your rehabilitation including options and progress after you TBI or stroke?

This chapter includes an explanation of the purpose of the study, settings, demographics, data collection and analysis, evidence of trustworthiness, results, and summarize the answers to the research questions supported by the data.

Setting

Interviews for this study were conducted in multiple settings. They took place in person or via video chat platforms. Two interviews were completed in participants' private homes, one interview was completed via Facebook video chat with me in my home and they in theirs, one interview was completed in a nursing home which was the participant's home, one was completed while walking outside, and one was completed in a hospital cafeteria that was mostly

empty. Participants were provided opportunities to choose which setting was most comfortable and accessible for them. They also were given opportunities to choose how interviews would be completed, face to face or video chat. P2 and P3 requested to have their wives present to help provide details as needed.

Prior to interviews, contact was made with each participant/contacts in which sample questions were presented. I explained the informed consent form and voluntary nature of the interviews, the fact that they would be kept anonymous, the decision as to when/where /and how the interviews would take place, and the need for a consent form. All agreed to complete the consent form at the interview except for P1 who consented via email. We also discussed the approximate length of the interview and that it would be recorded. Participants/contacts did not have questions.

Demographics

To achieve the goal of this study, men ages 30 to 75 were the target participant population. The six participants studied were of varying ages that ranged from 55 to 72 years of age. There were no criteria for demographics such as economic status, work status or prior career experience, or location of living (rural/urban). The inclusion criteria required was being a man, having suffered a stroke or TBI no more than 3 years prior, having been independent or mostly independent in daily tasks prior to the event and being able to participate in the interview.

Initial recruitment procedures included reaching out to medical providers and social media as well as word of mouth. Most participants were recruited through social media and word of mouth. The table below depicts the participant demographics.

Table 2*Demographics*

Participant	Age	Diagnosis	Time Since Diagnosis
P1	69	TBI	1 year
P2	54	TBI	3 years
P3	72	Stroke	5 Months
P4	65	Stroke	2 years
P5	72	TBI	2 Years
P6	54	Stroke	1 Year

Data Collection

Upon approval of my proposal from Walden University Institutional Review Board, I began the recruitment process. The application was approved on July 14, 2023, and assigned the approval number 07-14-23-0725320. There were no partners to assist with finding participants, and that responsibility was solely mine. Six men participated in the study. I used interviews to gather data. A list of questions (see Appendix A) designed by me was used to help determine whether potential participants met criteria for participation. I used open-ended questions that would allow the participants to present their experiences using a narrative format. I presented intermittent questions to help guide the interviews and ensure that the areas being studied were addressed. For a number of participants, this was necessary to accommodate some cognitive/speech deficits. P6 required more detailed supplemental questions due to some underlying word finding and speech deficits.

Prior to beginning the interviews, participants were reminded that the interviews would be recorded. I recorded the six interviews using a handheld voice recorder as primary source and

my cellphone as a backup. Interviews took place in a variety of settings including P2 and P3's personal homes, P1 in his home via Facebook video chat, P4 in a public dining area (participant had chosen setting, table was somewhat secluded), P5 while walking outdoors (his request) and P6 in the nursing home where he resides. Each participant participated in one interview, except P6 who agreed to a second interview to expand on the first interview, as some of his answers were vague.

Data Analysis

There was a total of six interviews. Each interview was downloaded and saved onto my password-protected computer. The saved file was uploaded into Turboscribe (a transcription service that I subscribed to). Turboscribe is a computer-generated speech transcription program that turns audio into text. Files were then downloaded and renamed to correspond with participants in sequential order. The first interview, for example, was saved as "firstinterview." Next, I relistened to the interview audio recording and compared them with the transcribed text for accuracy. Changes were made as indicated to the written text to match the audio file. During the second listen/read, some notes were also made separately for notable changes in voice tone, difficulty with finding words, and other variables that stood out to me. After this step of verifying the transcript accuracy, I read over the printed transcriptions again making note of what I thought was noteworthy.

Coding Procedure

Next, I began coding. A mixed coding method, inductive and deductive, was used in the coding process. Initially, broader deductive codes were formed using the research questions and

my initial exposure to the data during the interview process. These deductive codes included quality of life, post-event medical care, masculinity, and depression. Using these deductive codes as a starting point, inductive codes were produced. As discussed in chapter 3, NVivo software was the tool of choice that was used in the coding process for this study. I downloaded the transcriptions into NVivo and began my coding process. For this step, I chose to use inductive coding to allow the codes to emerge from the interview data. The more specific inductive codes were cognitive deficits, physical deficits, negative effect, positive effects, pre-event career, current career, relationship changes and physical strength for masculinity and head of the family for masculinity. The transcripts were read three times prior to coding and three times to complete the coding until I reached saturation and could no longer find new codes that I thought were pertinent to my study. Next, these codes were used to develop themes.

This six-step process was used as the guiding structure for coding, establishing themes and data analysis step for this study. The steps in the table below were established using guidance from Maguire and Delahunt (2017).

Table 3

Data Analysis and Reporting

Data Analysis Steps	Researcher Actions
Familiarization	Read and Re-read the data 3 times to gain an understanding
Coding	Organize the data and assign codes for the pertinent ideas that emerge
Generating initial themes	Seek out any themes, which are present and support the research questions
Reviewing and developing themes	Pull all information from the data that is related to the themes

Refining/defining/ naming themes	Review the themes to determine what each theme entails and determine if it is a support of the research goals
Writing up	Write up the findings

To help ensure that my process for preparing, coding, and analyzing the data was consistent for each participant, I designed and followed a data prep/coding checklist that I have included below as table 4. Having the checklist decreased the risk of missing a step when coding and establishing the themes. Following this checklist contributed to the dependability of the results of this research study.

Table 4

Data Prep/Coding Checklist

DATA PREP CHECKLIST	P1	P2	P3	P4	P5	P6
AUDIO TRANSCRIPTION	X	X	X	X	X	X
1ST TRANSCRIPTION CHECK	X	X	X	X	X	X
2ND TRANSCRIPTION CHECK	X	X	X	X	X	X
READ OVER WITH NOTES	X	X	X	X	X	X
FIRST CODE	X	X	X	X	X	X
SECOND CODE	X	X	X	X	X	X
THIRD CODE	X	X	X	X	X	X

Theme Development

During the coding process similarities became apparent and those similarities were used to develop themes. Reflexive thematic analysis involves development of themes after data is

coded. These steps are familiarization; coding; generating initial theme; reviewing and developing themes; refining, defining and naming themes; and writing up (Braun & Clarke, 2021). These steps were used to provide guidance during the data analysis process of this study. Several themes emerged during the coding process including their personal definition of masculinity being focused on physical strength/ muscles, the definition of masculinity that focused on the man being head of the household/protector of the family, lack of post event medical care beyond immediate stroke/TBI, positive after effect – taking better care of health/safety, negative after effect- physical deficits, and career changes after the acute event. The themes including a summary along with supporting quotes from the participants are included in the results section of this chapter.

Evidence of Trustworthiness

Credibility

Credibility includes the confidence that the research results are interpreted and presented correctly and presented in the way that the participant intended (Korstjens & Moser, 2018). To help ensure that the results of this study were credible, a copy of the data interpretation was given to the individual and a follow-up conversation took place to determine if any discrepancies were present and appropriate changes needed to be made. The changes were then made.

Transferability

To improve transferability of the study results, purposeful sampling was used to determine the criteria for participants. Purposeful sampling increases the opportunity to obtain in

depth information that supports the objective of this study from a small sample size that fit set categories such as age, gender and experiences (Shaheen et al., 2019).

Dependability

To improve the dependability of my study the steps of recruitment, data analysis and reporting were the same for each participant and reported in a manner that would make it possible for the study to be replicated. Several pieces of information were included in the reporting to support the study's dependability. These items were a detailed explanation of the recruitment process, interview steps including the semi-structured interview questions (Appendix A), the data prep and coding checklist and the six-step process was used as the guiding structure for coding the data analysis.

Confirmability

As stated in chapter 3, confirmability ensures that the data gathered is truly derived from the participants reports and not fabricated by the researcher (Korstjens & Moser,2018). One way to decrease this risk is to use quotes or similar data from the participants (Stenfors et al., 2020). In the data report and analysis, two to three quotes from different participants for each theme was included to support confirmability. Also, each participant was offered a copy of the transcripts to give them an opportunity to verify accuracy of interpretation of the interviews to support confirmability of the study results.

The following results section includes a restatement of the research questions, the recognized themes that correspond with the questions along with the supporting findings along

with a summary of findings that although may not be considered a theme are important to the study findings none the less.

Results

The purpose of this study was to explore the quality-of-life narratives of men who had suffered an acute stroke or TBI. The use of semi- structured interviews supported the chosen methodology, narrative inquiry as stated earlier in the previous chapters.

For this results section, I have included the research questions with each correlating themes/theme and a general summary at the end of the chapter. Each theme has been supported with a summary and a quote from at least two participants.

Primary Research Question

What are the narratives of masculine identity and quality of life in middle-aged men who experience a stroke or TBI?

When each participant was presented with the question of how they define masculinity, all six (100%) struggled, requiring extra time to find words. P3, P5, P6 mostly correlated their definition of masculinity with muscles and physical strength. P1, P2, P3, P4 connected their definition of masculinity with being the head of the household, protecting their family and being self-sufficient. P3 was the only participant who defined masculinity providing a combination of both- describing physical strength and being the head of the household/family. The majority of participants could not say specifically that being a man-made recovery more or less difficult. Two themes in regard to masculinity emerged and are stated below with supporting quotes from the participants.

Table 5

Themes	Example Quotes
Theme 1: Definition of masculinity focused on physical strength, muscles	“Strength. If your muscles are strong, that would go along with that...”(P4) “Very big ... how much their muscles show”(P6)
Theme 2: Definition of masculinity focused on being head of the household, protector of the family.	“Head of household basically... I feel like a sis man...My masculinity is gone. Yeah, now I'm crying.”(P2) “Masculinity is nothing to do with muscle...masculinity is self-sufficient... masculinity was being able to work”(P4)

When asked about the prevalence of depression post stroke or TBI, the participants had some difficulty providing an answer until I gave more specific symptoms as listed in this paragraph. Depressive symptoms were a common report with the participants. Five of the six participants (83%), P1,P2,P3,P4 and P6 reported some symptoms associated with depression including lability, increased sadness, decreased interest in prior activity, and decreased interaction with others acutely after their stroke or TBI. P5 was the only participant who reported experiencing none of the symptoms even acutely post TBI.

Table 6

Themes	Example Quotes
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Theme 3: Experienced depressive symptoms post stroke or TBI.	<p>“I can answer that with absolute clarity. And the answer is absolutely yes... it was like depression, guilt and physical injury.” (P1)</p> <p>“After the accident...I am an emotional roller coaster from hell...I don’t like to cry. I will not cry, and I bawl now.”(P2)</p> <p>“You are a lot quieter P3 than he used to be...you have changed a little bit. He doesn’t communicate as much when there’s people together.”(P3 Spouse)</p> <p>“In the first year, but not the last eight months or so...I guess I’m out of the depression side, I’m still upset about it.” (P4)</p>
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Secondary Research Question

How has having a stroke or TBI negatively and /or positively changed your life?

When the six participants were asked if their quality-of-life changed after their acute event, there were mixed reports. Four of the six participants (66%) were able to voice at least one positive that came out of their event. All three men who suffered a stroke (P3,P4,P6) stated that they were managing their medical health better including medication for blood pressure and AFib. P3 and P4 were also thankful to still be alive. Only one of the TBI survivors (P5) provided a positive change and that was better safety including wearing safety gear. One theme regarding positive after effect emerged and is stated below with supporting quotes.

Table 7

Themes	Example Quotes
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Theme 1: Positive aftereffect – “I’m glad to know that we know about the A-ferb”. Maybe it’ll be taking better care of something maybe will enable my life a little longer because health/safety. of that... I know there’s lots of people that have strokes, and they’re lots worse.”(P3)

“I took my meds down to the T...Well, I’m thankful to be alive”(P4)

“I wear a helmet all the time now”(P5)

When the participants contemplated the question of negative effects to their life as a result of the stroke or TBI, physical and cognitive deficits were revealed. All six participants (100%) reported some physical deficit as a result of their event with varying severity. P1, P3, and P5 cited less debilitating deficits including shoulder/hand strength deficits, fatigue while P2, P4, and P6 voiced higher level, debilitating deficits including migraines, balance issues, strength/sensation/ROM deficits. The cognitive deficits identified during the interviews included memory, word finding/speech, and executive functioning. Four of the six participants (67%) reported/demonstrated some type of cognitive deficit during the interview. P2, P3, P4, P6 had some level of memory loss although mostly short term and/or directly after the stroke or TBI. Along with memory deficits, word finding, attention span deficits and emotion management were noted.

Employment seemed to be an important topic for all participants. Although P1 and P5 reported no deficits that affected their ability to return to their prior level of function at work,

both mentioned deficits that could have been a concern but resolved. Four of six participants (67%) had their ability to be gainfully employed interrupted or completely halted by their diagnosis. The inability to return to work an area of contention for P4 and P6, and having to adapt due to post event deficits was talked about for P2 and P3.

When discussing the area of post event deficits including the impact on their ability to function within their families, at work and within their other relationships, all six participants (100%) demonstrated a change in their tone of voice and observable body language. Their affect became flatter, voice tone softer/ monotone/gloomy and their posture changed. Three themes regarding negative after effect emerged and included below with supporting quotes from the participants.

Table 8

Theme	Example Quotes
Theme 1: Negative after effect- physical deficits	<p>“I’ve always had migraines since the accident... my balance is completely shot...I’ve got a problem with my right leg now...the lightning bolts that come into your eyesight.” (P2)</p> <hr/> <p>“my wrist still hurts from the two broken bones there....shoulder bothers me a lot and the shoulder show arthritis now that wasn’t there before... some ringing in the ears.” (P5)</p> <p>“right side affected ... my right leg, my right um” (did not finish but I asked if it was also his right arm, and he said “yea”).(P4)</p>
Theme 2: Negative after effect- Cognitive	<p>“I’m terrified of heights now...I got stuttering out of this...like short-term memory now... I used to have a thing they called</p>

sensory shutdown... I don't care where I'm at anymore. I don't. I have no filter." (P2)

"My speech problems I have...it aggravates me sometimes. My speech isn't' near like it was at one time. Peripheral vision" (P3)"Sometimes I lose my train of thought...my speech was affected too...short term's a little more, you know" (P4)

Theme 3: Negative – inability to return to work/hobbies at all or without some adaptations or accommodations.

"my work lets me; he knows about it. If it gets bad enough...so I can get driving truck again... I didn't get to drive a truck for three years."(P2) "...never been bashful about talking to customer, but I have stumbled around a few times, so I watch who I'm talking to...email to get around that curve."(P3)

"I was a painter for 30 years."(P4)

Secondary Research Question

How would you describe your rehabilitation including options and progress after you TBI or stroke?

When asked about their medical care after their stroke or TBI, differing reports were provided. P1 and P5, who said they completely recovered with little to no residual deficits on commented on the acute medical needs. P2, P3, P4 and P6 voiced some frustrations with their aftercare, mostly subacute care including inability to find specialist near them, issues with insurance, and being left with chronic issues post injury that could not be fixed. P2 and P4 reported that they were left to figure out how to navigate their ongoing deficits and issues on

their own. P4 did report that he felt like he had adequate rehab and resources after his stroke as he had to go to inpatient rehab/skilled nursing facility due to his level of deficits. P1, P2, and P3 demonstrated having strong family support including input/presence of their spouse during the interviews as P4, P5 and P6 had no one with them during their interview.

Table 9

Theme	Example Quotes
Theme 1: Lack of post event medical care beyond actual acute stroke/TBI care	<p>“more focused on the medical. They didn’t give a rat’s butt.” (P2)</p> <p>“we’ve only been there one time...just to tell us you know what she observed by looking at him”(P3 spouse report when asked about neurologist)</p> <p>“because I thought that after five, six months, close to a year that I would be okay... I never had anybody really tell me what to expect with my stroke.”(P4)</p>

Summary

In Chapter 4, I explained the purpose of this study and restated the research questions. Along with this, I provided details regarding interview settings, demographics, data collections process, touched on evidence of trustworthiness, explained the coding process, and described the themes that emerged during data analysis. A summary paragraph correlating with each research question was included along with the supporting quotes from the participants. The reported data from this chapter is interpreted in chapter 5. Chapter 5 includes an introduction, interpretation of findings, limitations of the study, recommendations, implications for social change, and a conclusion.

Chapter 5: Discussion, Conclusions, and Recommendations

Quality of life can be affected negatively in men who suffer a debilitating event (Hansson et al., 2012) and especially those who had strongly connected their personal identity to perceived masculine roles such as provider and protector (Moeller & Carpenter, 2013). With men being two times more like to suffer a TBI (MacQueen et al., 2020) and 52% of stroke

survivors being men (Lindsay et al., 2019) having insight into the recovery process for men and the toll it can take on their quality of life and function. Although the prevalence of stroke and TBI in men is high, research that focuses specifically on men and the male perspective after suffering one of these events is minimal.

I employed the research tradition of narrative inquiring to explore the quality of life of men who have suffered an acute stroke or TBI. Semi-structured interview provided an opportunity for each participant to offer their experience of recovery while maintaining some level of autonomy allowing the researcher to view this through the participants' eyes.

The thematic model of narrative analysis aligned with the purpose of this research study as it provided a way for me to explore the individual's interview and establish consistencies that conformed to the participants.

In this qualitative study, I provided insight into the perspective of men who have suffered an acute TBI or stroke including narratives of masculine identity and quality of life. Along with providing insight, I explored satisfaction with current abilities and quality of life.

Three research questions were crafted to explore the quality-of-life narratives of participants and provide a foundation for semi-structured interview questions and completing subsequent interviews.

Primary research question: What are the narratives of masculine identity and quality of life in middle-aged men who experience a stroke or TBI?

Secondary research question 1: How has having a stroke or TBI negatively and/or positively changed your life?

Secondary research question 2: How would you describe your rehabilitation including options and progress after you TBI or stroke?

This chapter includes an introduction, key findings, interpretations of findings, limitations of the study, recommendations, implications for social change, and a conclusion.

Key Findings

I used narrative analysis and thematic analysis to provide insight into life after suffering an acute stroke or TBI for men ages 30 to 75 years of age. Data analysis revealed nine themes: that included definition of masculinity focused on physical strength, muscles, definition of masculinity focused on being head of the household, protector of the family, experienced depressive symptoms post stroke or TBI, positive after effect – taking better care of health and safety, negative after effect- physical deficits, negative after effect- cognitive, negative – inability to return to work/hobbies at all or without some adaptations or accommodations, relationship changes and struggles, and lack of post event medical care beyond actual acute stroke/TBI care. These findings support potential benefits of having a strong family support system after acute stages of the event, the importance of being able to return to employment, hobbies, and activities with as minimal changes as possible, and the effect physical deficits can have on overall quality of life. There are several key takeaways. There was a high percentage of participants who had experienced or are still experiencing depressive symptoms even after a year or more has passed. Even minor residual deficits can influence quality of life after a stroke or TBI. There was a notable difference between stroke and TBI survivors regarding being able to identify positive aftereffects. All stroke survivors described taking better care of themselves

(taking meds/monitoring BP) after the stroke whereas the TBI survivor struggled and could describe only one positive aftereffect. All participants struggled with forming and expressing their definitions of masculinity, and five of the six participants described masculinity focusing on physical strength.

Interpretation of the Findings

Quality of life can be affected negatively among men who suffer a debilitating event (Hansson et al., 2012), especially those who had strongly connected their personal identity to perceived masculine roles such as provider and protector (Moeller & Carpenter, 2013). Along with managing stressors directly related to the actual event, men who lack the ability to function may also feel guilty they are a burden to others whether in care needed or the inability to fulfill prior roles. Lack of ability to perform prior roles can contribute to being bored and dissatisfied (Wood et al., 2010).

There is a lack of research that focuses on men who have suffered a stroke or TBI, including their quality of life after. There were some notable details and observations that occurred during the interviews. Participants who reported higher levels of deficits post-acute event, also cited less hobbies and were unable to return to work. Individuals who had strong family or other relationship support seemed to have better quality of life afterwards and were able to participate more fully in life. Those who did not have that support tended to be less involved in any activity after their recovery from their incident.

Emergent Themes

Definitions of Masculinity

Two themes emerged during the data analysis process pertaining to definitions of masculinity. The first was masculinity focusing on physical strength and muscles and the second was being head of the household/ protector of the family. When exploring how masculinity was defined in the review of the literature for this study, several consistencies were noted, including physical strength and toughness, self-reliance, and reduced emotional expression. For men with disabilities this less than normal performance can contribute to increased anxiety. Establishing their own self-identity outside of stereotypical masculine norms affect role changes such as going from breadwinner to not being able to work (King et al., 2020). Masterfulness and strength are expectations that men tend to have, and their manhood must be constantly affirmed in public(King et al., 2020). For masculinity, “gender norms include toughness, dominance, self-reliance, heterosexual behaviors, restriction of emotional empowerment, and in voiding traditionally feminine attitudes and behaviors” (Weir, 2017, p. 34). and claimed that men are less likely to seek help when they need it if they value self-reliance.

When exploring how masculinity is defined in my literature review for this study several consistencies were revealed including physical strength\toughness, self-reliance, and reduced emotional expression. The results of this study supported prior literature and revealed several commonalities including narrative definitions of masculinity that concentrated on physical/muscular strength, self-reliance, and restricting emotions. For the majority of participants at least part of how they described masculinity was being the head of the household or being self-sufficient. While all participants struggled to some level to define masculinity in

their own words their perception of masculinity mostly fit with the literature review. During my observation of the participants during the interviews, several details were noteworthy. When discussing changes in their status as the head of the household family or being the provider for the household due to their stroke or TBI, all the participants demonstrated changes in tone of voice and/or body language. The changes included increased word finding deficits, less confident posture, and facial expression changes (sullen/frustrated).

Depression

The presence of depressive symptoms after their acute stroke or TBI was a theme that emerged from the data analysis in this study. Prior research studies reports that 1/3 to 1/2 of post-stroke individuals report concern with anxiety and depression as early as three months and as late as five years (Goverover et al.2017) and depression chronic and acute can develop because of a TBI (Khan et al., 2016). Although this appears to be a consistent concern with their diagnosis, Post stroke depression can have a significant effect on recovery and quality of life (Pérez-de la Cruz, 2020) and it continues to be underdiagnosed and undertreated frequently (Goverover et al., 2017).

The results of this research study supported the prior literature in regard to the frequency of depression post-acute stroke or TBI. Five of the six participants reported some symptoms of depression at least six months after their event, and two of the six had ongoing symptoms more than one year after. One participant had not reached the one-year mark yet but had ongoing depression depressive symptoms. Only one of the six denied having any depressive symptoms. Of the three stroke survivors all of them had experienced varying levels of depressive symptoms.

Two of the three TBI survivors reported experiencing depression symptoms after the event. 83% of this study's participants had encountered depression as a result of their stroke\ TBI. The additional stress of dealing depressive symptoms when trying to navigate recovery can complicate an already difficult situation. The implications of this study regarding the prevalence of depression for men is raising awareness for healthcare providers and family.

Positive Aftereffects

Improved Self- Health/Safety

It can be difficult to find a positive in a negative situation. As suggested by Shifrin and Anzaldi (2018), there can be a relationship between optimism and mental and physical health perception. Discovering an underlying health issue and being able to initiate treatment can decrease the risk of further complications. Timely treatment by health professionals can contribute to perceptions of good health (Mavaddat, 2018). Health management is important for stroke survivors. For men who have suffered a TBI, implementing safety measures for preventions is important. According to prior research, it was suggested that traditional male activities and occupations put them at increased risk for suffering a TBI (Poritz et al., 2019).

When asked if there were any positives that came out of their stroke or head injury, surprisingly four of the six were able to provide one positive after effect. For all three stroke survivors (P3, P4, P6), finding out that they had underlying medical issues (AFib and abnormal blood pressure) that needed ongoing management was a good thing that was discovered post stroke. The only TBI survivor who was able to offer a positive after effect was P5 as he had begun wearing a bike helmet/reflective jacket and added lights to his bicycle as safety

precautions. Although they were able to produce an answer to this question, it did take extra time and thought in comparison to the other questions.

Negative Aftereffects

Physical Deficits

Physical deficits can occur in stroke and TBI. Physical deficits tend to be at the forefront of post stroke deficits (Pappadis et al., 2019) and even minor strokes can result in physical impairments including fatigue (Turner et al., 2019). Other physical post stroke symptoms can include aches/pains and limited mobility (Shifren & Anzaldi, 2018). Poststroke fatigue can contribute to worse quality of life and increased risk of sedentary lifestyle (Ramos-Lima et al., 2018). Individuals who suffer a TBI are also at risk for decreased activity. According to Goverover et al.(2017), individuals who report a more sedentary lifestyle report dissatisfaction with the lack of ability to participate. Examples of physical issues that can be the result of a TBI include fatigue, headache, and other pain (Jourdan et al.,2016). Aftereffects of a traumatic brain injury can be long term with ongoing physical deficits (Rauen et al., 2020).

For all six of the men in this study some type of physical deficits was present at varying level status post their stroke or TBI. The deficits included headaches, fatigue, shoulder/ hand pain and stiffness, balance deficits, and leg pain. These ongoing physical impairments whether minor or not contributed to changes in their prior level of function including the ability to get dressed (P5), the ability to maintain balance during activities including home/work tasks (P2, P6), demonstrate adequate level of endurance to participate in functional daily activities including home\ work task (P3), or use their arm functionally with any task (P1, P4). The

frustration voiced and shown with body language when discussing the ongoing physical deficits was apparent. Even in the instances where the deficits were not observable to the eye the effect that it had on their autonomy was present. These physical deficits are an ongoing reminder of the function they once had and what they have lost since their acute event.

Cognitive Deficits

According to research, post-acute cognitive deficits after a stroke or TBI can occur. Health quality of life after a traumatic injury can be negatively affected by cognitive dysfunction (Gorgoraptis et al., 2019). Nearly one third of post stroke survivors report cognitive and mood impairments which include anxiety and depression that tend to go unnoticed or untreated. Communication difficulties and memory deficits have been reported to negatively affect quality of life (Pappadis et al., 2019). Cognitive abilities including thought processes, speech, memory, and emotional management are at risk for interruption as a result of a stroke or TBI. Executive functioning, including the inability to process information, can also be the result of even a minor stroke or TIA. Deficits after TBI, including emotional difficulty and cognitive impairments can alter recovery outcomes even years after the initial event (Pappadis et al., 2019) and contribute to reports of decreased quality of life (Fernández et al., 2019). Language production and/or comprehension was suggested by Bullier et al. to play a role in determining post stroke quality of lift (2020).

For the participants of this study, cognitive deficits complicated their recovery process. Memory/ speech / attention span deficits and difficulty with emotional management were all areas of cognition changes that were described and/or observed during the interviews.

Frustrations were reported and intermittently observed through facial expression and body language during the interviews. All three stroke survivors had some deficits in these areas and one of the three TBI survivors reported frustration with residual deficits. For P2, P3, P4, and P6 memory deficits and speech deficits including word finding and stuttering were reported to interfere with their ability to work and participate in relationships as per prior level of function.

Inability to Return to Work and Hobbies

The inability to return to work /hobbies at all or at the prior level was another theme that emerged from the interview data. Previous research suggested connection between participation in work/ hobbies pre stroke /TBI and post stroke plays a role in recovery and subsequent life satisfaction. In men who suffered a TBI, the strong motivation to return to work was present with the negative feelings for those who are unable to return to work (D'Souza et al., 2020). While similarly, Palstam et al. argued that an individual's autonomy and their ability to participate in life tasks is also known to influence quality of life in stroke survivors.(2019). For men, the drive to return work can have a strong influence and can result in negative consequences including forgoing health care treatment to go to work or pushing to return to work before being physically and/or cognitively ready (D'Souza et al., 2020). The ability to participate in employment after a TBI can contribute to recovery success (Goverover et al., 2017). Positive effects of working including providing for self\ family economically, meaningful tasks and programs such as vocational rehab to assist individuals match their skills\ ability to work were suggested (Phillips et al., 2019).

Results of this study appeared to align with the prior literature as the participants who expressed the ability to return to work at their prior level of employment and/ or participate in previous hobbies appeared to have less negative quality of life changes. Two participants were able to completely return to work and hobbies with no adaptations or change (P1, P5) and voiced no concerns or change in quality of life. Two participants (P2, P3,) had residual deficits and were only able to return to work with accommodations/adaptations due to continuing deficits inhibiting their ability their work\ hobby performance different from their prior level of function. Although both were thankful that they could continue working, there were frustrations noted when talking about the changes during the interview. Two (P4, P6) of the participants have ongoing deficits that prevent them from having employment and participating in prior hobbies. During the interviews, the importance of being able to work and participate in hobbies was observed not only visually in body language but also verbally in tone of voice. P2 and P3 even commented on the positive effect that being able to work had on their coping and recovery thus far.

Relationship Changes and Struggles

The struggles after an acute stroke or TBI affect not only the survivor but also their families/friends, and both can have new unmet needs. These needs can be result of changes of duty, ability to be employed, and changes in relationships such as spouse separation and roles / relationship (Proctor & Best, 2019). Maintaining prior relationships at the same level can become complicated by new behaviors. Common changes in behavior after a moderate to severe TBI can include aggression, lack of initiation, and inappropriate social behavior (Gould et al.,

2019) and can make it difficult for individuals to maintain relationships. According to Macqueen et al. when a man's identity is affected by deficits from a TBI, his ability to maintain roles within relationships can be difficult to maintain (2020).

This study's results paralleled results of prior studies regarding the difficulties that can occur for men who have suffered a stroke or TBI. Only one participant (P5) in this study denied any relationship changes or struggles after his TBI. Five participants (P1, P2, P3, P4, P6) discussed changes in social/family relationships after having suffered their acute event. Two of the six (P1, P2) expressed struggles with their inability to be the head of household and how their behavior changes caused fallouts with their spouses that required work to repair. Changes in communication with family and friends were consistent for four of the six participants citing speech deficits and anxiety /anger management being a source of the problem. The participants that did report relationship changes also were able to report that as their recovery progressed, their relationships improved.

Lack of Post Event Medical Care Beyond Acute Stroke and TBI Care

Providing adequate post-acute stroke care is necessary to ensure that the individual is provided with adequate support and guidance to decrease risk of further decline and quality of life deficits after a stroke (Peng et al., 2019). Participation in rehabilitation after a stroke is important (Fulk et al., 2020) and in cases where needs were not met rehabilitative wise participation limitations and decrease life satisfaction have been suggested (Törnbohm et al., 2019). According to Roy-O'Reilly & McCullough unrecognized and undertreated deficits after a TBI can result in poorer outcomes (2018).

Exploring and understanding how a man identifies himself may be an important piece of knowledge that can contribute to the effectiveness of rehabilitation after a TBI (MacQueen et al., 2020). For a number of the participants in this study the support after their stroke or TBI was less than what they needed. They reported that there was not a good explanation of what to expect from the recovery process including the chance that they will have residual, even debilitating deficits. Also, several participants suggested that the healthcare providers that they encountered post-acute recovery were not concerned with their ongoing deficits including the impact on their ability to function and return to prior activities. For the participants such as P2 and P3 who have a strong family support in their spouses, their care seemed to be more satisfactory than P4 who was single and had less support. Also, the participants who had more observable deficits such as visual/speech deficits or more obvious physical deficits, reported increased deficit recognition and interventions.

Theoretical Analysis of Findings

The transactional theory of stress and coping and the social identity theory were utilized to guide the methods and data analysis of this study.

The transactional theory of stress suggests that stress and coping is affected by an individual's appraisal process of stimuli within their environment, emotions are generated and used to establish one's perception of a specific event including the level of stressfulness to them. Cooper and Quick (2017) also proposed that cognition contributes to the primary appraisal process as meaning is ascribed to events/stimuli and this meaning helps establish significance to an individual's wellbeing. For the majority of participants in this study, there was some level of

cognitive deficits at least in the acute stages of recovery. In this theory, primary and secondary appraisal occur when attempting to cope with a stressor (Lazarus & Folkman, 1987) so attempting to process and cope with new stressor could be complicated by cognitive deficits. For individuals who have suffered a stroke, finding effective ways to cope can be instrumental in their ability to rebuild their lives. In instances where emotion based coping skills are used, managing guilt, anger and sadness can be more difficult and result in feelings of helplessness and inability to accept the aftermath of the stroke (Reverté-Villarroya et al., 2020).

For all the participants dealing with the additional stress of recovery from their stroke or TBI in addition to their normal daily stress, the ability to progress and adapt presented challenges. Following the basic idea of this theory of assessing stressors and evaluating their level of importance in one's life as it is simply explained this theory could be used to describe how these participants handled their stress and were able to find ways to cope. Through the process of the interviews and data analysis come with the participants appeared to have progressed through all or most of these suggested steps. P1, P3, and P5 for example described how they were able to work through and beyond deficits that were not significantly debilitating or inhibiting for their daily activities. This theory aligned with the purpose of this study as quality of life is part of the experience of how one copes with and adapts to stress.

According to the Social Identity Theory (SIT), as described in chapter 2, self-concept is formed out of the emotional attachment that they connect to their membership of their social groups (Henri Tajfel, 1974) feelings of including into social groups can result in strengthened self-identity (Islam, 2014). For four out of six participants in this study their participation in prior

established social groups was disrupted or completely changed. For a number of the participants, concerns were voiced regarding others' perceptions of them after their injury and with ongoing deficits. Some of these reports were feelings of worthlessness, people being frustrated with them, concerns that verbal deficits at work would interfere with customer communication, and deficits with being able to hold a conversation due to train of thought deficits. According to Trepte and Loy (2017), an individual's perception of self-image, whether negative or positive, can be determined by the social category they place themselves in. When an individual has defined themselves as a member of a social group, moving out of that social group may be difficult. With that being said, the importance of maintaining good social connections for better quality of life is important for continued recovery and life satisfaction. An example of this was noted in a study by Dirth and Branscombe (2019) that explored how an individual with disability identified themselves with social groups of individuals with like disabilities (2019). According to Dirth & Branscombe (2018), it can be difficult to move from a social group that categorizes an individual by a level of disability, especially if it is observable.

Limitations of the Study

This study provided a look into the quality of life of a small number of men from a variety of ages and demographics. There was a broad demographic including age, location of residence (rural or urban) and not specified level of post event deficits beyond being able to participate in the interview.

Recruiting participants was an obstacle to completing this study. I modified the planned procedure for finding and securing participants to include sending recruitment information to an

increased number of health care providers. This unfortunately not more successful so I relied on my Facebook and word of mouth. Along with securing participants, being able to find participants and making sure that the participants were able to provide rich and thorough information also had its struggles. Overall, the participants were willing to talk to me, but word finding /memory deficits made it harder for some than others.

Recommendations

The finding of the study suggested nine themes. Recommendations can be made because of the emergent themes. One recommendation is for health care providers be more exploratory into quality of life and changes especially mental health concerns for men who have suffered an acute stroke or head injury. Another recommendation that could come from this study is better education for individuals/family members/caregivers including what to expect in their recovery process. Also, providing opportunities for programs such as vocational rehab to allow individuals who have suffered an acute return to some level of employment. Along with these, follow healthcare provider follow ups that occur beyond the sub-acute phase and that explore the narratives of the individuals more thoroughly than their outside appearance. Further research that focuses on men including beyond the three-year mark and with more specific deficits could be useful.

Implications for Social Change

Several implications for social change because of this study findings can be suggested. For health care providers working with this population, a better understanding of quality-of-life narratives can contribute to designing and implementing treatment plans that are more effective

for a better outcome and improved function and quality of life. Along with providing support for health care providers, this information can also be beneficial to families/caregivers/participant to offer insight into recognizing hidden deficits, adapting to deficits/change both physical and cognitive to increase crease function and improve quality of life. This better understanding can improve quality of life, increase ability to complete functional tasks including working to make an income, being more self-sufficient in self-care and home management tasks, decreasing the number of medical interventions needed, and improving family and community relationships. Improving rehabilitation outcomes can result in increased independence with all daily activity including self-care, home care, and employment which can help the stroke/TBI survivor be a more functional part of his family and society. Because stroke and TBI are a global economic burden improvement in these areas can result in decreased psychosocial and financial burdens thus contributing to positive social change.

Conclusion

Chapter 5 included an introduction which offered a summary of the analysis of the data presented in Chapter 4. Along with the introduction, chapter 5 consisted of limitations of the study, suggested recommendations, implications for social change and a conclusion to summarize the chapter.

As stated above, although the prevalence of stoke and TBI in men is high, research that focuses specifically on men and the male perspective after suffering one of these events is minimal. This study achieved the research aims of contributing to the body of knowledge in this area and lessening the gap in literature by exploring the lived experience quality-of-life

narratives of men ages 30 to 75 years old who have suffered and acute stroke or TBI. Having insight into the male survivor could be beneficial to health care providers for designing and determining interventions and lessening the negative economic impact on family and the individuals who have suffered these acute events if there was a better understanding of how to help men navigate their world after and an acute event. This better understanding can improve quality of life, increase ability to complete functional tasks including working to make an income, being more self-sufficient in self-care and home management tasks, decreasing the number of medical interventions needed, and improving family and community relationships.

This study reached its aim of exploring the quality-of-life narratives of men who have suffered an acute stroke or head injury TBI. Through the exploration of the narrative multiple interesting ideas surfaced. The first is that negative changes in quality-of-life were less notable for individuals who had less significant residual deficits whether physical or cognitive. The ability to participate in home management tasks, employment, or hobbies with lower levels of interruption contributed to better quality of life. There also appeared to be some connection between the presence of supportive relationships including family with better quality of life. The participants who had supportive relationships including family, friends, work, social groups appeared to have a more positive quality of life and outcomes.

This study added to the current body of literature and stroke and TBI quality of life and recovery by including insight into men who have suffered these in their own words and perceptions. The results of this study can improve the understanding and provide recognition of the unique needs of men who must navigate the post-acute recovery process after having a stroke

or TBI. This improved knowledge can contribute to better community return, financial stability, decreased health care costs, improved family reintegration and quality of life and better overall life satisfaction for all navigating this journey.

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Appendix A: Semi-Structured Interview Questions

Interview Questions for Angela Garner

Interview Script

Before starting the interview, I just want to verify that I received your signed informed consent form. I appreciate you returning it to me. During this interview, I will ask you some questions that are open-ended so that you can answer them in your own words. With these questions, there are no right or wrong answers so I hope you will feel comfortable being honest with me. The answers should be based on your own experience. Your contribution is extremely important and is needed to ensure that the study will help present and future outcomes. I will begin recording if you have no questions or concerns. Do you understand? Do you have questions? I will begin recording now.

[Document time, place, interviewer, and interviewee, then proceed to prior level of function and interview questions.]

Time of Interview:

Date:

Place:

Interviewer:

Interviewee:

Prior level of function Questions

Let's start with some questions about your life prior to having the stroke/TBI.

1. When did you have the stroke/TBI?
2. Were you independent with self-care/ household chore/employment
3. What did you do for a living?
4. Did you have any hobbies?

Interview Questions

How has your life changed since your stroke/TBI?

5. Have you changed physically? If so, how?
6. Have your cognitive abilities changed – for example memory deficits, personality changes ?
If so, how?
7. Have your relationships changed – family/friends? If so, how?

8. Has your health changed? If so, how?

During my research, I read that depression is not uncommon after a stroke /TBI and I would like to explore that with you.

9 . Did you have any symptoms of depression such as loss of interest in activities, loss of pleasure, crying, agitation, changes in sleep patterns prior to suffering your stroke/TBI? If so, what did you do to manage them?

10. Have you had any of these symptoms since? Have they gotten worse? If so, what do you do to manage them?

For my research study, I chose to only include men as my participants as I wanted to focus on the male perspective after having suffered an acute neurological event.

11. Can you briefly give me your definition of masculinity?

12. Do you think that having a stroke/TBI has changed how you view your own masculinity? If so, how?

13. Do you think it has been more difficult because you are a man to recover from the stroke/TBI? If so, could you tell me why?

Finally, let's explore how you view your quality of life- positive and negative aspects since this has happened.

14. Do you feel as though anything positive has come out of having a stroke/TBI? If so, could you explain this to me?

15. Do you feel as though anything negative has come out of having a stroke/TBI? If so, could you explain this to me?

16 . How would you describe your quality of life now? Is it different now than it was before? If so, how?

You have answered my final question and I truly appreciate your time. Is there anything you would like me to know after having completed this interview?

Ending

Thank you again for your participation in this study. Everything that you have told me will be kept completely private and confidential. To ensure that I have transcribed all the information you have given me, I will be sending you a verbatim transcription of the recorded interview in an email (or mail if they have no email) for you to review, verify accuracy, and provide feedback.

If you have any questions or concerns during this process, please call or email me at area code (419) 348-8074 or angela.garner@waldenu.edu.

Angela Garner

Appendix B: Exit Process Checklist

	P1	P2	P3	P4	P5	P6
DEBRIEFING	X	X	X	X	X	X
PROVIDE RESULTS	X	X	X	X	X	X
CONTACT FOR QUESTIONS	X	X	X	X	X	X