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When Recovery Stalls

Identity Disruption as a Nervous System Process in ABI Rehabilitation

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What You Will Leave With

1. Identify identity disruption as a distinct clinical phenomenon in ABI — separate from mood, personality change, or adjustment disorder

2. Conceptualize the three interacting sources through which identity continuity is maintained and disrupted following brain injury

3. Articulate the Clinical Paradox of ABI identity reconstruction and its implications for treatment planning

4. Apply the four-step Reconstruction Pathway — a proposed integrative framework — in your clinical practice, case coordination, or file review

What Recovery Metrics Miss

What rehabilitation tracks

✓ Cognitive function (memory, attention, processing speed)

✓ Physical capacity and activities of daily living

✓ Emotional regulation and mood

✓ Return-to-work readiness

✓ Community integration scores

What the data cannot capture

"I no longer recognize myself in the mirror"

"My family treats me like a stranger in my own body"

"I know the rules but I don't feel like a person"

"I've been told I'm better, but something essential is gone"

Identity Is More Than a Story

It is embodied, relational, and socially situated.

Identity is the lived experience of continuity across time — produced through interoceptive signals, relational cues, and cultural patterning. ABI can disrupt the conditions through which that continuity is maintained.

B

Biological / Embodied

Interoceptive signals and autonomic regulation support the felt sense of embodied presence — the background experience of "I am here"

R

Relational

Co-regulatory interactions with others provide ongoing confirmation of the self and locate the person within familiar relationships and roles

C

Cultural / Social

Role-based belonging, shared meaning, and community participation situate the self within a social world that recognizes and confirms it

Thomas, Levack & Taylor (2014). Self-reported changes in identity following TBI. Neuropsychol Rehabil, 24(3–4), 595–621.

The Valentin Three-Level Identity System

An integrative clinical model

1 **INDIVIDUAL / EMBODIED**

Interoception · Autonomic Regulation · Cognitive and Neural Integration

2 **RELATIONAL**

Social Signalling · Interpersonal Feedback · Co-Regulation

3 **COLLECTIVE / SOCIAL**

Roles · Belonging · Cultural Meaning · Community Participation

Identity continuity emerges across interacting levels. ABI may disrupt more than one level simultaneously — and disruption at one level can alter the others.

What the ABI Literature Already Tells Us

SELF CAN CHANGE

1

Substantial self-concept change following TBI is well documented. Predominantly negative changes have been identified across diverse populations and injury severities.

"OLD ME / NEW ME" MATTERS

2

People consistently describe discrepancies between pre- and post-injury selves — loss of the person they were, uncertainty about who they are now, and ambiguity about who they may become.

OTHER PEOPLE MATTER

3

Recognition by significant others, changed relationships, and social responses — including stigma — are consistently identified as shaping identity experience after brain injury.

ROLES MATTER

4

Loss of valued roles, activities, and belonging are among the most prominent dimensions of post-injury self-concept change in both quantitative and qualitative research.

What remains less developed is an integrative clinical framework for recognizing and working with these processes across rehabilitation.

Beadle et al. (2016). Impact of TBI on self-identity: systematic review. J Head Trauma Rehabil, 31(2), E12–E25. · Villa, Causer & Riley (2021). Experiences challenging self-identity following TBI: meta-synthesis. Disabil Rehabil, 43(23), 3298–3314.

The Clinical Paradox

What recovery may require

Identity reconstruction — building a coherent sense of self that incorporates changed capacities and circumstances while preserving — or rebuilding — a meaningful sense of continuity with what came before.

but

What ABI may disrupt

Some of the very capacities reconstruction depends upon:

- Embodied regulation
- Autobiographical continuity
- Self-awareness and integration
- Relational attunement
- Social participation

Rehabilitation cannot bypass this paradox — it must work through it.

Exploring Identity Disruption: What to Ask

Six clinical prompts for exploring identity continuity after ABI

1. *"Do you still feel like yourself — or like someone new?"*
2. *"What do you miss most about who you were before?"*
3. *"Do the people closest to you see you the way you see yourself?"*
4. *"Are there things that used to be part of who you are that no longer feel like you?"*
5. *"When you imagine your future, does it feel like your future?"*
6. *"Is there anything that still makes you feel fully like yourself?"*

Exploratory clinical prompts — not a validated screening instrument or diagnostic tool.

Levack et al. (2025). BISOSS — Brain Injury Sense of Self Scale (egocentric, sociocentric, relational subscales).

The Valentin Four-Step Reconstruction Pathway

Proposed clinical framework for identity-focused rehabilitation after ABI

1

STABILIZE

Create sufficient regulation and predictability for identity work

2

RE-ANCHOR

Find what still carries continuity and recognizable self

3

INTEGRATE

Build continuity without requiring sameness

4

REINSTATE

Make reconstructed identity possible in everyday life

These are not four stages a patient graduates through. They are four problems rehabilitation has to solve.

For Your Practice

What changes when identity becomes an explicit rehabilitation target?

Clinicians & Rehab Teams

· Ask explicitly about changes in sense of self — it will not surface in standard cognitive batteries

· Look beyond cognitive scores to roles, relationships, belonging and future orientation

· Identify what still provides continuity and a recognizable sense of self

· Include identity-related goals in rehabilitation planning and documentation

Legal Professionals

· Do not assume functional improvement means the pre-injury sense of self has returned

· Ask whether changes in roles, relationships and self-continuity have been assessed

· Distinguish identity-related difficulties from cognitive impairment alone

· Consider whether rehabilitation has addressed participation and reconstruction of everyday life

Insurance & Case Managers

· Identity-related difficulties may remain clinically relevant after measurable functional improvement

· Look for observable outcomes in participation, relationships, role engagement and agency

· Rehabilitation goals can include meaningful participation as well as symptom reduction

· Identity-focused needs should be individually assessed — not inferred from cognitive status alone

Key Takeaways

1

Functional recovery and recovery of self are not the same thing.

A person may regain substantial cognitive and physical function while continuing to experience profound disruption in identity, roles, relationships, and belonging.

2

Identity after ABI is embodied, relational, and socially situated.

Neurological change occurs within a person who is also living in relationships, roles, communities, and a continuing life story. Identity disruption cannot be assessed through cognitive testing alone.

3

Identity can become an explicit target of rehabilitation.

Stabilize → Re-Anchor → Integrate → Reinstate offers a clinical framework for asking: What does this person need in order to recognize — and live as — themselves again?

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For clinical referrals and consultation:

Neuropsychological and psychological assessment and treatment incorporating identity-focused approaches to recovery.

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