Lost in Psychiatry: Addressing Brain Injury in a Psychiatric Hospital Population

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Objectives

1. Learn methods used to screen for TBI
2. Recognize that TBI may underlie psychiatric symptoms
3. Know how grief and loss affect the patient's identify
4. Learn therapeutic interventions to assist the patient's functioning and quality of life
5. Evaluate and address issues related to the caregiver

History of Psychotherapy with TBI

1. 1980"s Neuropsychologists develop neuropsychological rehabilitation (NPR)
2. Early efforts such as object relations not useful
3. Psychotherapy evolves and affective component recognized
4. Therapists work in conjunction w/ neurologists, psychiatrists, OT and SL
5. Therapists work to restore the cognitive, behavioral, and social functions of the individual
6. Focus on the mild to moderately impaired patient
7. Address moderator variables such as denial (lack of awareness of deficits), defense mechanisms, and affective reactions

Overview for the Practitioner

1. Assessment, evaluation, and treatment planning are cornerstones
2. Assessments include doctors, psychiatrists, neurologists, neuropsychologists, occupational and speech/language therapists
3. Information on amnesias, intellectual ability deficits, dysphasia's, memory, attention and information processing problems
4. Impulse control, initiation deficits, affective disorders, and poor social restraint

Delineation of Symptoms

1. Presentation similar to psychiatric issues
2. Apathy, lack of drive, and lack of emotional reactivity similar to depression
3. Apathy toward treatment may not be resistance, depression, hostility or other issues, it may be TBI
4. Disinhibition, sexual or personal hedonism, and lack of concern considered pathology
5. Symptoms are many times the result of a brain injury
6. Denial is the hallmark of post acute head injury
7. Patient lacks sufficient intellectual abilities to immediately recognize deficits

Mild to Moderate and Severe TBI

Mild to Moderate

- Loss of consciousness of up to thirty minutes or
- "Dazed" consciousness consisting of transient confusion and disorientation
- Memory loss immediately before and after the event
- Significant shift in mental state at the time of the trauma

Severe

- Indicated on neuroimaging assessments
- Brain lesion usually indicated
- Incapable of feeding or dressing themselves
- Cannot carry on basic functions without assistance

Site of Injury and Effects

- Frontal lobe damage is characterized by disinhibition and inappropriate behavior
- Temporal lobe damage can cause irritability and aggression
- Right frontal lobe injuries affect memory and executive control
- Inability to plan, organize, and problem solve with low initiative and motivation

Two Patient's Viewpoints

"Imagine waking up each day with a pounding headache, always feeling like you have a hangover plus a bad flu after being up three nights in a row; having trouble concentrating, remembering, and getting your thoughts together; losing your temper and snapping at people for no reason. On top of that, nobody believes you or thinks your crazy."

"How could I continue to live with a deficient brain? My head injury had been bearable only because it was temporary. Permanent injury meant I had already lost. My job, my identity, my life, the real me."

Individual Therapy & Mild to Moderate TBI

- Provide patience, sensitivity, and objectivity as the foundation
- Patient's perceptions of the deficits
- Work toward better self-observation
- Use reality focused methods to address denial rather than direct confrontation
- Anticipate feelings of frustration, being overwhelmed, family difficulty and withdrawal from interpersonal relationships
- Help patient deal with the loss of self, and develop a new acceptable identity
- Engage the patient and family as an active participants
- Encourage to resume normal activities and assist in restoring the patient's diminished power
- Emotional reactions such as depression, anxiety, flat affect, apathy, heightened emotions and even chemical dependency issues
- Frustration is issue as our own expectations of recovery are not realized
- Awareness of and sensitive to counter transference issues from self

Specific Methods for Individual Therapy

- Write out homework assignments
- Pair new learning tasks with old ones
- Write as much as possible
- Use over learning such as rehearsing in sessions
- Use other sensory modalities
- Make interpretations explicit to avoid misunderstanding
- Traditional open-ended statements may create confusion
- Model calm and controlled behavior
- Use reflection and re-statement of content extensively for clarification
- Redirect patient's attention when agitated rather than confronting the topic
- Do not over stimulate the patient
- Conscious self-monitoring by the therapist
- Use relaxation techniques
- Patient may be more attentive at certain times of the day
- Keep distractions to a minimum
- Start with easy tasks, use verbal praise, reinforce task completion
- Give the patient extra time to respond

Patient's Reflection on Individual Therapy

"It made me feel normal. I was not crazy, I was brain injured. My therapist helped me understand that everyone's healing process is different. She helped me understand the importance of not over extending myself. She made me feel safe."

MTBI, Loss of Self & Ambiguity

- Long-term cognitive and physical problems accompany mild traumatic brain injury
- Patient may develop a profound "loss of self"
- Manifests as identity ambiguity
- Ambiguous loss is most stressful & defies closure
- Self ambiguity correlates with perceptions of boundary ambiguity with others
- Important to screen for MTBI
- Three categories that depict this issue:
  - Loss of clear self-knowledge
  - Loss of self by comparison
  - Loss of self in the eyes of others

The Story of Sarah

- Car wreck & treated for whiplash
- Begins to feel depressed, anxious & unable to concentrate
- Unable to communicate w/ spouse
- Not functioning @ work
- Overcompensates by working more, sleeping less
- Diagnosed w/ PTSD
- Divorce
- Now recovering with more realistic outlook

Implications

- Ambiguity about self & others
- Boundaries blurred
- Loses sight of who she is
- Stranger left in place of loved one
- Recognize the MTBI as a source of severe stress for all
- Loss of self creates a debilitating illness that throws the individual and relationships into uncertainty
- Family members or others may "walk on egg shells" and discuss the loss with each other, but not the injured person

The Story of Tim

- Car wreck & released from ER—"your fine"
- Weeks later AVH's, vision problems & trouble concentrating
- Is diagnosed w/ MTBI

Implications

- Feels sense of rejection
- Slow progress
- Labeled as malingering
- Becomes defensive
- Cannot progress incoming stimuli
- Wife refuses therapy and believes malingering
- Divorce

Cognitive Remediation

Overview

1. Systematic remediation is the foundation for good treatment planning
2. Simple skills to the more complex
3. Treatment of attention base from which the remedy of other cognitive deficits is built
4. Task complexity increases when the patient demonstrates attention competence
5. Ultimate goal is to generalize to real life situations

Cognitive Remediation & Learning Theory

1. Plan and evaluate carryover strategies
2. Alter methods and materials to the life situation.
3. Teach mechanisms that underlie cognitive failures
4. Adequate number of trails to learn the new skill with repeated demonstrations of competence.
5. Abstraction skills are generally impaired thus hindering generalization to other situations

Basic Principles of Cognitive Remediation

1. Training must be based in theory
2. Training must be multi-modal
3. Integrate cognitive and skill training
4. Training must generalize
5. Intervention requires sufficient time to effect behavioral change
6. Time since injury does not preclude effective intervention
7. Intervention approaches may vary in locus.
8. Individual's awareness of cognitive deficits is crucial to successful intervention.
9. Verbal self-regulation is an effective intervention tool.
10. Psychotherapy important component
11. Remediation of memory deficits is a difficult task.
12. Computerized training must be used judiciously.

Group Therapy and Self-concept

1. Session 1
   - Complete HISDS
   - Discuss meaning of self-concept; poor vs. good
   - Discuss adjectives that people might use to describe themselves
   - Discuss how people's self-concept can affect their lives, behavior, and mood
2. Session 2
   - Have members provide adjectives they would use to describe themselves pre-injury
   - Discuss adjective members believe are most important pre-injury
   - Encourage more expanded self views
   - Discuss what happens when people experience sudden life change that challenges how they see themselves
3. Session 3
   - Have members provide adjectives used to describe themselves post-injury
   - Encourage more expanded view of self
   - Discuss how post-injury adjectives are different from pre-injury e.g., more negative, more positive, have not changed

Group Therapy and Self-concept (continued)

4. Session 4
   - Discuss pre/post injury changes, emotional functioning and view of self
   - Discuss how self-views may not have changed and how unchanged areas are important in describing self
   - Describe examples of engaging in current behavior & activities consistent with pre-injury self-concept
5. Session 5
   - Discuss effects of poor self-concept (e.g., lowered self-confidence, poor mood)
   - Discuss how the effects can impact recovery (e.g., avoiding challenges, feelings of failure and further self-concept reduction)
   - Discuss how failure in one view of self is not reflective of general failure; encourage development of expanded view of self by discussing areas where successful
6. Session 6
   - Fill out HISDS
   - Exercise to encourage integration: Group describes a negative change in self-view followed by a positive aspect of self
   - Encouragement to be mindful of other aspects of self that have not changed; encouragement to consider how important changed areas of self-concept are to overall happiness

Family & Relationship Assessment

Issues of Relationships

1. Assessment of family and marital issues
2. Relationships are strained
3. Family may respond with frustration, resentment, and guilt
4. Family and patient denial arises from unrealistic expectations
5. Thoughts that the spouse is "no longer the same"
6. Evaluate pre/post injury marital and sexual function

Topics of Discussion w/ Family

1. Feelings of anger, frustration and sorrow
2. Caretakers taking care of self
3. Caretakers relying on their own conscience and judgment in conflicts
4. Role changes are likely and are distressing
5. Caretaker avoid guilt
6. With dependent children, explore divided loyalties & weigh responsibilities

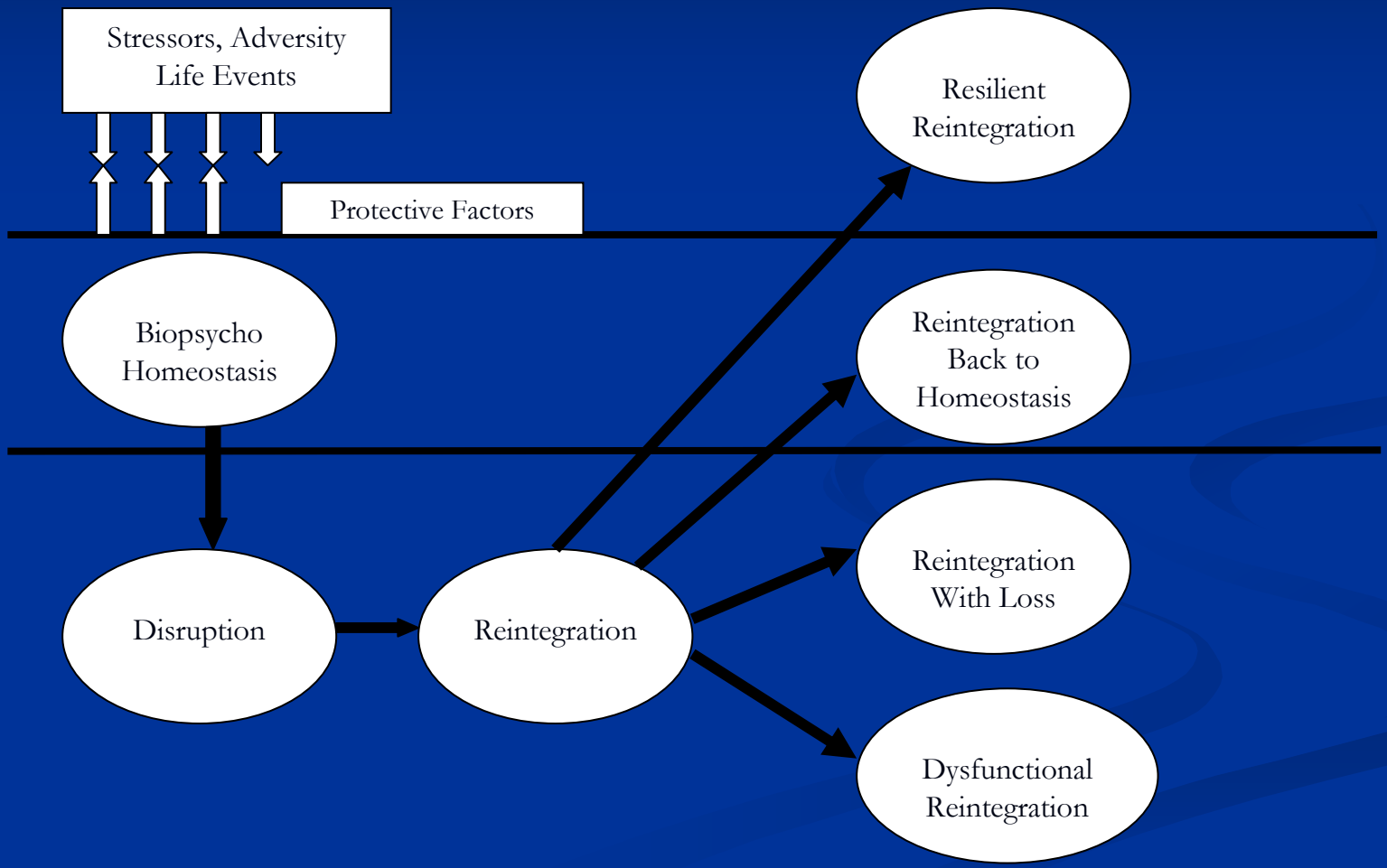
The Family and TBI

- Role of family may not always be clear to them
- Assist family helping find their role in the process
- Find support groups or respite
- Need information, emotional support, a place to vent
- When the family is involved, the outcomes are more favorable

Researcher States

"Psychotherapy with brain injured patients would be ineffective if there is not an ongoing relationship with family members."

Richardson's (2002) Model of Resilience



Conclusion

1. Talked importance of assessments
2. Distinguished mild to moderate and severe
3. Reviewed factors & interventions for individual therapy
4. Focused on cognitive remediation
5. Group therapy and self-concept
6. Caregiver issues
7. Importance of Resilience

Questions & Comments

- Reference list available
- Contact Ron Broughton via email at rbclark@brookhavenhospital.com
- Slide show and full manuscript available at www.brookhavenhospital.com