

TBI: Fundamentals of Support & Treatment

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**The Hidden Problem: Brain Injury & Addiction
NYS Office of Alcoholism and Substance Abuse Services
Committee on Traumatic Brain Injury
Conference for Northeast Providers**



Terminology

- ABI = Acquired Brain Injury—includes all causes—trauma, anoxia, toxi-metabolic, tumors, infections, electrocution, CVA
- TBI = Traumatic causes only—falls, car accidents, gun shot wounds, blasts

Traumatic effects on the brain

- Coup/Contre Coup (Blow/counter blow)
- Diffuse Axonal Injury (Stretch, strain, tear)
- Pressure (Swelling, Bleeding, CSF)
- Implication: *Lots* of damage

Severity of brain tissue damage

Classifications:

- **Mild**—LOC: None or <30 min.; GCS 13-15; PTA <24 hrs; Temp or perm altered mental or neurological state.
- **Moderate**—LOC: >20-30 min, <24 hrs; GCS 9-12; signs on imaging; some long term problems.
- **Severe**—LOC >24hrs; GCS 3-8

Source: The Essential Brain Injury Guide, 2007, American Academy for the Certification of Brain Injury Specialists, Brain Injury Association of America.

Severity of functional impairment

Common Scales:

Glascow Coma Scale

JFK Coma Recovery Scale

Disability Rating Scale

Functional Assessment Measure

Functional Independence Measure

Mayo Portland Adaptability Inventory

Neurobehavioral Functioning Inventory

Level of Cognitive Functioning Scale (Rancho)

For more information on measurement scales used with TBI go to:

<http://www.tbims.org/combi/>

Impairment categories

- Medical
- Physical
- Cognitive
- Behavioral
 - Social
- Emotional
- Spiritual

Daily obstacles

- Bathing, dressing, toileting, grooming
- Bed mobility, transfers, ambulation
 - Making a sandwich
 - Tying a shoe
 - Communicating
 - “Skill deficits” sometimes due to cognitive impairments

Loss of familiar routine(s)

Do you have a “get up” routine?

- A morning work routine?
- A drive to work routine?
- An after work routine?
 - A weekend routine?

Due to

- Replacement of old with *new* routines (e.g., needed for care giving/helping, institutionalization)
- Interference by physical problems—can't perform the actions
- Interference by cognitive problems—can't stay on track

How cool are you?

- Your shoelace breaks
- Your car won't start
- Your child is home sick
- There's an accident blocking the road

Routines are necessary because

- They **conserve** physical, mental, and emotional energy
- Create a **reserve** for when you really need it
- Cognitive reserve can be used to **monitor**, i.e., —attending to *how* your doing, *while* you're doing

Routines = efficiency + effectiveness

- How *tired* are you after a “bad day”--too many interruptions of your normal routines?
- How *effective* are you once you get tired?
- How emotional are you?

Reduced ability to re-group

- “Coping” involves being able to *process* what has happened
- Processing impaired after B.I.
- Further impaired by chronic emotional stress (“downshifting”)

Loss or impairment of socially valued roles

- Feeling needed, necessary
- Worker, father, mother, sister, brother, pal, neighbor, constituent, team mate, regular customer...
- Loss of purpose--the “armature” of identity
- Identity collapse/crisis

Reduced impulse control

- “Impulse control” = thinking
- Relates to control of all impulses including losing your temper, smoking, spending too much, *drinking...*
- Potential for further harm: physical re-injury, relationship/emotional crises, financial losses, legal problems

Failure, failure, failure

Month to month,
Week to week,
Hour to hour...

Lost or diminished support

- Early abandonment by family and friends
- Belief he/she's "just not trying"
- Loved ones who become coaches or adjunct therapists
- Frustration and anger
- Abandonment emotionally, physically

Alienation and isolation

- Loss of job, social connections
- “Social Capital”
 - People you love
 - People you do things with
 - People you know
- Key to opportunity, support, wellbeing
- Defiance, capitulation, or both

B.I.D.

Big Invisible Deficits

Reduced reflection

We are...

- Never where we appear to be
- Never doing what we appear to be
- Time travelers!

...Proof?

“Reflecting” =

- Perceiving the whole
- Task, conversation, situation, ...life!
- Thinking about doing while doing
- “Hovering awareness”
- “Metaconsciousness”
- “Virtual virtual reality”
- Construction of identity, “reality”

Basis of

- Integration--connecting the dots
- Thinking ahead
- Thinking back
- Follow through/remembering to remember
- Evaluation/Course correction
- Learning from experience
- Persistence in the face of difficulty

Helps us

- Make connections
- Keep things “in perspective”
- Create “our story”
- Formulate our identity

Reflection & Injury Severity

Past

Present

Future

|-----Normal-----|

|-----MTBI-----|

|-----ModTBI-----|

|-----STBI-----|

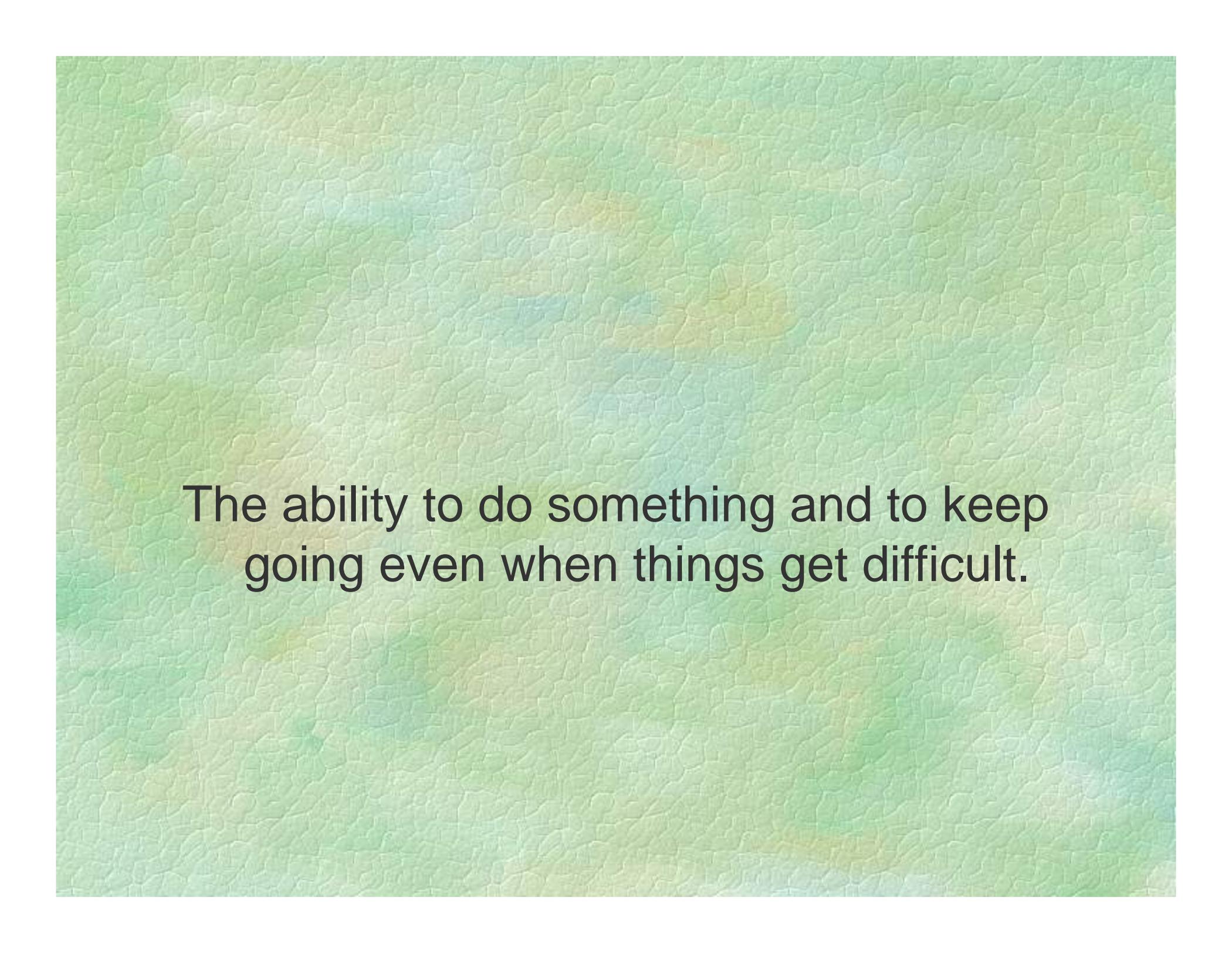
Calling Dr. Freud...

Write down the first 5 words
you associate with

“Motivation”

Some web definitions

The tendency of an *animal* to engage in a particular behavior, e.g., a feeding motivation or a sexual motivation.



The ability to do something and to keep going even when things get difficult.

Desire to accomplish a goal or participate
in an endeavor.

Feelings that drive someone toward a particular objective.

The positive or negative needs, goals, desires and forces that impel an individual toward or away from certain actions, activities, objects or conditions. The inner needs and wants of an individual what affects behavior.

The need or desire that determines an individual's effort, behaviors and actions.

What's the common thread...

...that runs through your word list and these definitions?

Fill in the Blank

Difficulty thinking, recalling, learning, doing +
Impairments of awareness/reflection +
Anger, futility, hopelessness +
Lack of supports and support +
Chronic stress

= _____ disability ?

Answer:

“Motivation Disability”

Desire and Motivation

- We may know we need to do something, and do it, without *desiring* it.
- We may desire something we do not pursue.

Associated Clinical Conditions

Some terms and clinical conditions
associated with Motivation Disability:

Abulia, adynamia, anosagnosia, apathy, aspontaneity,
confusion, deficient drive, depression, disinhibition,
disorientation, executive dyscontrol, flat affect, frontal
lobe syndrome, impulsiveness, passivity, post-
concussive syndrome

When we fail to recognize motivation disability...

- ...we fall victim to the “bad patient myth.”
- “He doesn’t *want* to get better”

Eventually:

- “He’s not appropriate for treatment.”

Support & Treatment

Awakeness

- 1st of 4 cognitive “pillars”
- Arousal system may be damaged
- Sleep disorders
- Teach sleep hygiene

discoveryhealth.queendom.com/sleep_hygiene_abridged_access.html

sleepfoundation.org/site/c.huIXKjM0IxF/b.2422637/k.5B7E/

[Ask_the_Sleep_Expert_Sleep_Hygiene.htm](#)

- Exercise and Diet

Attention

- 2nd of the 3 pillars
- Don't assume it
- Re-alerting
- “Chunk” information
- Requiring frequent active responses
- Improves with exercise of it

Mood Regulation

- The 3rd pillar
- The emotional “thermostat”
- Common in frontal injury
- Green, yellow, red
- Relaxation response (Herbert Benson, MD)
- Stress inoculation:
www.apa.org/divisions/div12/rev_est/sit_stress.html
- Social Scripts

Problem Solving

- SODAS method of problem solving
pki.nebraska.edu/studentinfo/simp/mentoring_guide/SODAS%20Text.pdf
- Teach S.O.'s, family, sponsors too
- Teach “Checking in” with a mentor (or sponsor)

Medication management

- The balancing act:

Avoid sedation

Enhance cognition

Stabilize behavior

Treat addiction

- Brain Injury Medicine, Zasler, Katz, Zafonte, 2007

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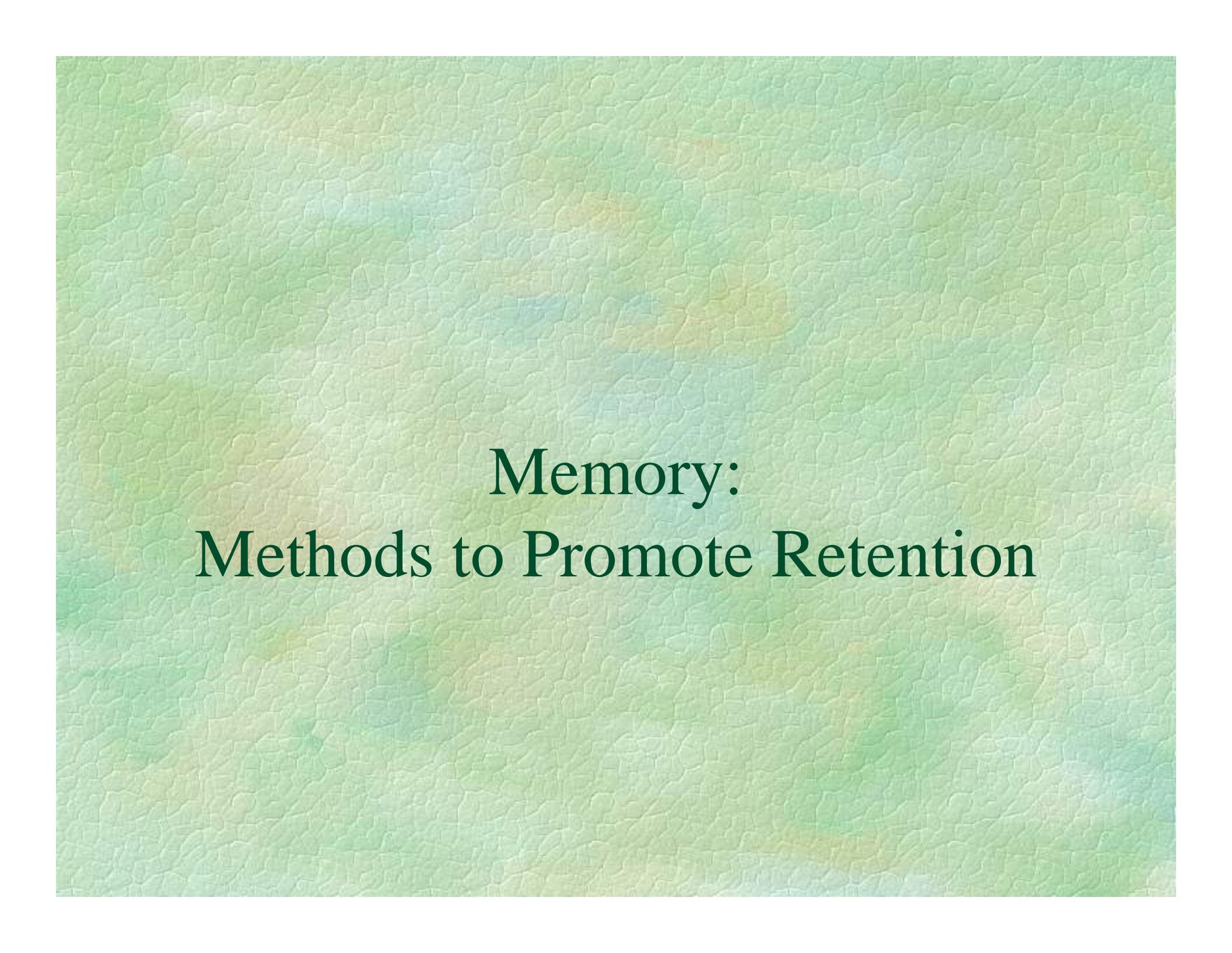
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Nonverbal communication as a method of mood stabilization

- Facial expression
- Tone of voice
- Body movements and position
- Sincerity and approval
- Positive milieu (families, treatment centers)

Orientation

- Registering what is going on, making basic sense of it (who, what, where, when, why)
- Who you are, Who we are, What we're doing, Where we are in space and time, and Why
- Don't assume it
- "Continuity cues" (a look back and at upon entrance; a look forward before you exit)
- Consistency/routine
- Positive sign: Person anticipates what's next



Memory: Methods to Promote Retention

Promoting Retention

Communication :

- Chunk
- Bullet—e.g., giving directions,
 - » “2nd floor
 - » Left
 - » Left”
- Teach “check the message out”
- Be *delighted* to repeat, encourage asking

Promoting Retention, Con't

Groups:

- Less content, more repetition
- Build carefully upon repeated basics
- Continual re-arousal during groups
- Preview-review the essentials
- Hand outs, bullets, sub/super/co-ordination
- Re-formulation exercises/formal presentations:
“Organization occurs at output”)

Promoting Retention, Con't

Other:

- Treatment Mottos/Mnemonics—brief, meaningful, and memorable:

“Stay on track, stay connected,”

“People, places, things”

Functional thinking

(“Executive Control”)

- Includes reflecting, analyzing, figuring out, keeping multiple things in mind (e.g., time, other tasks, other ideas, other people), keeping something in the “back of your mind”
- In order to: get organized, stay on track, come up with a better way, see the forest *and* the trees, gain insight, learn something new, carry on a conversation, participate in a group, remember to remember

Functional thinking, Con't

- Type 1: Problem is taking correct action--
disorganized thinker
- Type 2: Problem is taking *any* action--
adynamic thinker
- Type 1 needs to practice: sorting, selecting,
sequencing, developing inertia
- Type 2 needs to practice: sorting, selecting,
sequencing, developing momentum

Functional thinking, con't

- Type 1 needs “form”
Trusting relationship, feedback, awareness, acceptance, practice, tolerance, patience, time
- Type 2 needs “substance,”
Trusting relationship, input, awareness, acceptance, stimulation, suggestions, prompting, time

Functional thinking, con't

- Both will benefit from cognitive prosthesis
- Examples: Schedules, checklists, dayplanners
- Help *accepting need for these*
- **Question:** Do we give aides to support mastery of tasks or do we provide tasks to support mastery of aides?

Functional thinking, con't

- Checklists
- Dayplanners
- Calendar boards
- Picture totems
- BlackBerry
- Interval timers
- Timex data-link watches : <http://www.timex.com>
- PEAT: <http://www.brainaid.com>

Functional thinking, con't

- Organizational routines
- Before-during-after approach
- Morning preview
- Through-the-day tracking system
- Evening review
- Journaling (daily reflection)

Self-Awareness: Connecting the Dots

- Brain injury diminishes capacity
- Need to re-build it
- Use of therapeutic narratives
- Adjunct to any counseling process
- Consists of: Historical milestones,
Current situation, a Look ahead

Narrative Therapy Approach

- Write it
- Read it
- Fill in with word bank
- Fill in without word bank
- Re-tell from outline
- Re-tell from key words
- Repeated presentations (“OOAO”)
- Periodic updating (repeating above as needed)

Provide Disability Education

- About brains and brain injury
- Neurologic disability vs. “mental retardation” vs. psychiatric disorder
- Strategic re-education of most needed abilities—e.g., reading, calculation

Develop Natural Supports

- Work with families, friends
- Educate concerning brain injury
- Role recovery for family members—family role vs. therapist role
- Include them in treatment where possible

Avocational Rehabilitation

- Community cannot be “re-entered,”
- Each of us creates our own
- Doing things we love → relationships
- “Social capital”
- Identifying STRENGTHS, PASSIONS
- Willingness to explore new interests
- Read: Together is Better, Al Condelucci:
<http://www.lapublishing.com/condeluci-book-disability/>

“Ultimate” Recovery?

- Survivors vs. Victims
- Support without judgment or pity
- Aim for inter not independence
- Avoid inflated expectations, “Can you really do anything you put your mind to?”
- Don’t accept the unacceptable
- Happiness as a choice and a responsibility

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Information about brain injury:

<http://www.northeastcenter.com/>

The End

Thank you!