

Counseling and Brain Injury: A Post Rehab Support View

Introduction

An important component of brain injury recovery is the screening and evaluation of patients for TBI when they present for psychotherapy as the injury may not be known to the therapist. Generally, counselors and therapists are not familiar with the special needs and issues of the head trauma patient (Butler & Satz, 1988). This presentation is aimed at closing the gap in understanding the specific issues related to brain injury. Furthermore, it will assist counselors and therapists to be better able to discern psychiatric issues as opposed to TBI issues, and how both relate to depression, anxiety, and behavioral issues. In addition, the information presented addresses various treatment modalities and interventions such as individual and group counseling to assist the patient and caregivers in returning to a reasonable quality of life.

Objectives

1. Learn how counseling is a support system post rehab.
2. Understand psychiatric symptoms related to brain injury.
3. Learn counseling interventions to assist the client with psychiatric issues.
4. Gain knowledge on family adjustment to brain injury and how counseling assists caregivers.

History of Psychotherapy with TBI

Nelson & Adams (1997) offer a brief history of the evolution of psychotherapy and individuals with brain injury. In the 1980's, neuro-psychologists developed neuropsychological rehabilitation (NPR) and were the practitioners of psychotherapy for persons with TBI. Initially, psychotherapies such as object relations did not prove useful for TBI. As psychotherapy evolved over time, it became widely held that there is a vital role for psychotherapeutic interventions in the affective component of TBI recovery. Therapists work in conjunction with traditional providers such as neurologists, occupational and speech/language therapist, and psychiatrists. A psychiatric evaluation is a first point of evaluation and provides psychotherapists with information in order to work with the affective components of recovery for individuals and their families. With the psychiatric evaluation as a guide, therapist can then use the clinical interview and other tools (e.g., OT and SL evaluations) to differentiate what symptoms constitute a psychiatric issue, a neurological issue, or both. Counselors and therapists work to restore the cognitive, behavioral, and social functions of the individual. Their work focuses on the mild to moderately impaired patient and looks to address moderator variables such as denial (lack of awareness of deficits), defense mechanisms, and affective reactions associated with recovery. One example is poor treatment compliance. The question for the therapist becomes, is a cognitive deficit present, or is it depression? In summary, the therapist provides cognitive remediation, individual and group psychotherapy, family support and milieu intervention (e.g., ensuring milieu remains with reasonable expectations).

Overview for the Practitioner (Butler & Satz, 1988)

Screening, evaluation, treatment planning and treatment are the cornerstones of psychotherapeutic endeavors. The process first involves a reliable and detailed history from all available sources. Evaluating current and premorbid history consists of clinical interviews with the patient, family members and others who can provide sufficient information to determine that

a head injury exists. Furthermore, it is important to obtain any available clinical records from doctors, psychiatrists, neurologists, neuropsychologists, occupational and speech/language therapists if available. If the patient has not had a neuropsychological evaluation, a referral for one may be indicated from the patient's history. These evaluations provide information on amnesias, intellectual ability deficits, dysphasia's, memory, attention and information processing problems. In addition, personality and behavioral issues are important components to evaluate. These may include information related to impulse control, initiation deficits, affective disorders, and poor social restraint.

Delineation of symptoms is important because the presentation of the patient with TBI is very similar to those presenting with depression. For example, apathy, lack of drive, and lack of emotional reactivity, at first glimpse may be explained with a diagnosis of depression. At the same time, these symptoms represent what is sometimes called pseudo depression in those with TBI. In addition, apathy toward treatment may not be resistance, depression, hostility or other issues, it may be neurologically based. Further, symptoms such as disinhibition, sexual or personal hedonism, and lack of concern for others could be considered some sort of pathology. However, these very symptoms are many times the result of a brain injury. Thus, the importance of a good premorbid history becomes evident as it assists in the differentiation of pathology vs. a TBI. If the history indicates a TBI, then the symptoms are related to the brain injury rather than acting out. In addition, if the premorbid history indicates issues such as these prior to an identified injury, then those behaviors are usually exacerbated by the injury. Lastly, denial is the hallmark of post acute head injury. As memory, planning, judgment, attention, concentration, speech and intellectual abilities are affected, the patient lacks sufficient intellectual abilities to immediately recognize deficits. Direct confrontation of denial is contraindicated as it may evoke anger and hostility. It is better to expose the patient to functional activities that provides a more natural confrontation of lost abilities. This opens the path to therapist support and management of affective reactions to realized issues.

In the psychotherapeutic process, behavior modification has been considered the treatment of choice and it remains an important aspect of recovery. At the same time, the individual is in need of supportive psychotherapy including individual and group modalities to address psychiatric symptoms, understanding, insight, affective responses, and coping skills. The trained therapist also recognizes that late or missed appointments and failure to complete homework is probably related to a memory disturbance rather than resistance. Awareness that patients are attempting to cope with a sense of loss of self is imperative. This loss of self is related to memory issues and evokes anger at the therapist and others. Furthermore, those with vocational disruption are a high risk to the loss of self and decreased self-esteem. In addition, those with a loss of self and significant depressive symptoms are a high risk for suicide. Finally, aphasia generates anger and anxiety as the speech process becomes circumstantial or tangential, and the patient is unable to access speech patterns once available to them.

Assessment of family and marital issues is important for those previously independent. As the patient becomes more dependent on the family, relationships are strained and the family may respond with frustration, resentment, and guilt. Family and patient denial arises from unrealistic expectations. There may be role reversal in the marital relationship where the normal give and take erodes into marital problems. The therapist is wise in evaluating the pre and post injury marital and sexual function. Problems such as the partner being uncomfortable because of thoughts that the spouse is "no longer the same" as there is lack of initiation, or disinhibition and sexual demands may exist. In summary, there are six general topics to discuss with the family:

- Feelings of anger, frustration and sorrow
- Caretakers taking care of self
- Caretakers relying on their own conscience and judgment in conflicts
- Role changes are likely and are distressing
- There is little the caretaker can do to change the patient and thereby avoid guilt
- With dependent children, explore divided loyalties & weigh responsibilities

The questions are: what approaches, under what conditions, and with what type of patient, are most effective? Thus, the role of the therapist is outlined and is explored throughout the following sections.

Individual Therapy

Psychotherapy with Mild TBI (Folzer, 2001)

The author of the following information has an adult child who suffers from mild brain injury. She speaks to the frustration, anger and guilt she has experienced in dealing with brain injury issues. In addition, she offers us insight into the role of the therapist and how they assist in realistic recovery.

The definitions of mild/moderate and severe are related to physical and psychological symptoms and are important to understand. Mild TBI is generally indicated by a loss of consciousness of up to thirty minutes, or a “dazed” consciousness consisting of transient confusion and disorientation. There is memory loss immediately before and after the event and a significant shift in mental state at the time of the trauma. Severe TBI is indicated on neuroimaging assessments (e.g., brain lesions) and generally refers to someone who is incapable of feeding or dressing themselves, and cannot carry on basic functions without assistance. In both cases, nerve cells are stretched or torn and may suffer secondary damage from edema, pressure, or hydrocephalus. The site of injury is important. 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 as indicated by an inability to plan, organize, problem solve with low initiative and motivation. To assist the therapist in understanding the impact of life changes, a patient states:

“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.”

In addition, these patients may present with PTSD symptoms such as intrusive memories, feelings of vulnerability, social withdrawal, anxiety, and emotional numbing.

Self-acceptance is another issue the mild TBI patient faces as their total sense of self is shaken. Many times after an event, the person is sent home without follow-up, and self-acceptance is more difficult because the problems are not apparent to others. An example of their thoughts and feelings is indicated from a doctor who suffers from mild TBI:

“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.”

Furthermore, mild TBI patients are unable to express themselves and appear uninterested in others. They feel overwhelmed with tasks resulting in anger, frustration, and depression which are displaced onto the family and co-workers. Interacting with others, they are unrealistic about their ability to handle arguments, adjust to change, knowing when they are upset, and ultimately, controlling their temper.

In individual therapy, the knowledgeable therapist is aware of the aforementioned aspects of recovery. It is important to address the patient's perceptions of the deficits and work toward better self-observation. In addition, it is necessary to understand the difference between the patient's assumptions and their ability to function. Using reality focused methods to address denial rather than direct confrontation is preferable. The therapist provides patience, sensitivity, and objectivity as the foundation. In addition, the therapist must know how grief and loss are affecting the patient and family. From the patient, anticipate feelings of frustration, being overwhelmed, family difficulty and withdrawal from interpersonal relationships. Engage the patient and family as active participants and encourage them to resume normal activities and assist in restoring the patient's diminished power. Help the patient deal with the loss of self, and develop a new acceptable identity. Be aware of emotional reactions such as depression, anxiety, flat affect, apathy, heightened emotions and even chemical dependency issues. Furthermore, be aware of and sensitive to counter transference issues from self. Therapist frustration is a major issue as our own expectations of recovery are not realized. Ultimately, provide the age old therapist assets of unconditional positive regard, genuineness, and empathy. Following are some specific methods to enhance individual counseling with TBI patients:

- 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
- 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
- Use reflection and re-statement of content extensively for clarification

A patient with mild TBI reflects on how individual psychotherapy helped them in the following statement:

"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."

Group work coupled with individual therapy is an efficacious approach. First, it reinforces the concepts addressed in individual therapy. Group therapy allows for psychosocial skills practice and motivates individuals as they recognize they have a cohort. Generally, patients accept input and suggestions from peers more readily. In the group process, the critical role of the therapist is to encourage and mediate emotional reactions to feedback. In addition, the therapist facilitates a simple process by defining desirable behavior and teaching verbal compensatory strategies.

Finally, the role of family with the mild TBI patient may not always be clear to them. The therapist assists the family by helping them find their role in the rehabilitation process, and

find support groups or respite as their efforts with the patient become more difficult. The family needs information, emotional support, a place to vent, and educated on ways to manage their own behavior with the patient. Of course, when the family is involved, the outcomes are more favorable.

More on MTBI Landau & Hissett (2008)

Dealing with long-term cognitive and physical problems accompanying mild traumatic brain injury (MTBI), the patient may develop a profound “loss of self.” This loss manifests itself as identity ambiguity. Self ambiguity correlates with perceptions of boundary ambiguity on the part of the patient and family resulting from the situation of ambiguous loss. “Loss of self” and boundary ambiguity with others is an important issue to screen for when evaluating brain injured patients presenting for therapy. What may first appear as a person presenting with neurosis, may take on a whole new look with careful evaluation for mild TBI. To illustrate, following is the story of Sarah who suffered a TBI in a car wreck.

Sarah was rear-ended one day at a stop light, taken to the emergency room and treated for whiplash. She was unaware of any long-term damage. About a week after the wreck, Sarah began to feel depressed, anxious, was unable to concentrate and not functioning at work. She would suffer from emotional outbursts at home, was experiencing back and shoulder pain, and found it impossible to communicate with her spouse. She was overcompensating by working more and sleeping less, and feelings of guilt, anger, and resentment began to permeate her relationships. Sarah presented at a clinic and was subsequently diagnosed with PTSD. This diagnosis did not take into account the wreck and possible mild TBI.

Ultimately, she began to fight with her parents, there was no communication in her marriage for fear of hurting or offending each other, and the marriage ended in divorce. Now, Sarah is setting more realistic goals and working with her family to resolve past issues.

This story illustrates how ambiguity or uncertainty about the self creates a loss of identity, and in turn, plays a role in the fading of boundaries with others. In other words, when Sarah felt depressed, anxious, unable to concentrate and not functioning at work, she began to lose sight of who she is. These same feelings began to cloud established boundaries in her relationships with spouse and family, and this created a sense of uncertainty about the relationships. Ambiguous loss has been described as “the most stressful kind of loss” because it defies closure. One reason is that with the death of a loved one, there is a general process that one goes through that, in most cases, ends with closure. With TBI, a stranger is left in place of the loved one. This loss of self, or an ambiguous loss such as the disappearance of a family member, 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. Early assessment is important to recognize the MTBI and understand it as a source of severe stress for all concerned. Self loss is described as a loss that creates a change in self-image, self-doubt and decreased confidence. There are three categories that depict this issue:

1. Loss of clear self-knowledge
2. Loss of self by comparison
3. Loss of self in the eyes of others

Assessing for and treating “loss of self” in psychotherapy is an important component of recovery.

Story of Tim

Another story of the loss of self and boundary ambiguity further illustrates issues to address in counseling.

Tim is a 45 year old professional who has been married fifteen years. He was hit from behind in an auto accident and after going to the ER, was sent home being told he was fine. Several weeks later he begins to experience audio and visual hallucinations, vision problems and trouble multi-tasking. Tim is diagnosed with a mild traumatic brain injury. As he attempts to work through the problems, over a short period of time, Tim begins to feel a sense of rejection from others, and as his recovery is slow in progressing, he is labeled as malingering. Taking a defensive position, Tim fights with others regarding this label. The not so obvious problem is that Tim cannot process incoming stimuli. This leads to more arguments with his wife who begins to believe he is malingering and she won't come to therapy. The family and wife do not understand why he asks questions over and over. No one can make any sense of the change and believe that he is deliberately avoiding issues and is lazy. Of course this creates tremendous stress for all and Tim's marriage ultimately ends in divorce.

Tim's story exhibits the importance of a therapeutic environment where individual and family, along with other support systems, is an important aspect of recovery. Early after an injury, the family assumes roles in the household ranging from the simple everyday errand to managing the family's financial matters. Boundary ambiguity with the family increases as the patient's identity ambiguity grows. When the patient is faced with physical and emotional pain, he/she begins to shut down and secrecy becomes a part of the dynamic that further clouds normal boundaries. First, proper screening and assessment leads to an MTBI diagnosis which in turn, allows for more focused intervention. Next, telling the family and patient that he/she "will recover soon", sets the expectations too high. In essence this is setting both up for failure. It is more efficacious to assist the patient and family in setting reasonable goals of who the patient wants to become instead of recapturing the past.

Cognitive Remediation, Gordon & Hibbard (1992)

This article speaks to the task of working with individuals who have suffered a brain injury secondary to a stroke. The authors note that working with those who have an acquired brain injury is analogous to peeling in onion. In other words, as the remediation continues, another problem may be revealed. Systematic remediation is the foundation for good treatment planning i.e., simple skills to the more complex. For example, focusing on sustained attention first before moving to more complicated tasks such as selective, alternating, and divided attention is desirable. The treatment of attention is the base from which the remedy of other cognitive deficits is built. Task complexity increases when the patient demonstrates attention competence.

Attention and self-talk are tools that the patient can use to work on other deficits. As the patient develops attention skills, it allows them to recognize other problem areas. Then, the patient can use self-talk to negotiate the problem areas identified to guide their own behavior. The ultimate goal is for the patient to be able to generalize to real life situations. Unfortunately, one of the pitfalls of this method is that when generalization is not successful, remediation attempts are often abandoned. Due to the lack of success in generalizing, the provider often becomes frustrated from preconceived notions of progress. (It is important to remember that for the individual with TBI, success is measured in inches, not feet.) As such, generalization becomes the standard from which the individual is measured rather than the goal and this exacerbates the patient's and provider's frustrations. Therefore, it is important to incorporate bridges between the skills being remedied and real life situations.

To make successful bridges, learning theory is a valuable tool to enhance generalization. Following are some basic ideas from learning theory to assist the therapist and patient.

1. Carefully plan and evaluate carryover strategies e.g., from the therapy session to the real life situation.
2. Alter methods and materials as needed to the appropriate life situation.
3. Teach mechanisms that underlie cognitive failures and improve cognitive performances (e.g., positive reinforcement) thereby assisting the individual to anticipate problems and plan solutions.
4. Ensure an adequate number of trials are used to learn the new skill with repeated demonstrations of competence. One success does not mean the skill is integrated (e.g., when memory issues are present).
5. Remember that abstraction skills are generally impaired thus hindering generalization to other situations; thus, repeated trials.

After an acquired brain injury, the person is faced with the task of integrating three separate perceptions of the self. The patient is attempting to integrate:

- Who they really are (current functioning)
- What they believe they are (premorbid cognitive and behavioral functioning)
- What they want to be (future assumptions about cognitive and behavioral functioning)

Optimal recovery occurs when the individual incorporates their altered self-image into their self-perceptions. The major goal of cognitive remediation is to minimize the discord among the three perceptions, and the extent of the disruption varies dependent on four factors.

- Severity of deficits
- Patient's awareness level of the deficits
- Impact of deficits on present and future functioning
- The value the patient places on premorbid thinking abilities

The key is to educate the patient and family about the cognitive losses, allow mourning of the loss of past abilities and the abilities they thought they would have in the future, and potential future cognitive loss.

With cognitive remediation, there are several factors to take into account among the practitioners. First, psychotherapists are not comfortable working with brain injured individuals as the thought processes are more concrete and not driven particularly by insight. At the same time, cognitive remediation is traditionally the realm of neuropsychologists, speech/language and occupational therapists. However, these providers are not trained in working with the affective components of recovery. Without treating the affective issues of the individual, the long-term efficacy of remediation is in question. Therefore, it is important to integrate cognitive remediation with psychotherapy to address the affective issues in order to maximize benefit. As such, psychotherapists play a key role in the affective components of recovery.

Lastly, the authors (Gordon & Hibbard) suggest the WAIS-R-NI as a method to evaluate the full range of the patient's skills and would serve well as pre/post measure of outcome. The WAIS assessment must be coupled with observational methods of cognitive functioning in daily life activities. Together, these methods provide a more realistic view of the efficacy of the interventions.

Basic Principles of Cognitive Remediation

1. Training must be based in theory.
2. Training must be multi-modal.
3. Intervention must integrate cognitive and skill training.
4. Training must generalize to be ecologically valid.

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 is an important component of cognitive remediation.
11. Remediation of memory deficits is a difficult task.
12. Computerized training must be used judiciously.

Group therapy and the self-concept, Vickery et. al. 2006

Vickery et. al. (2006) conducted a pilot study exploring the effectiveness of group therapy that focuses on the self-concept following an acquired brain injury (ABI). It is recognized that the physical, cognitive, and psychosocial limitations after an ABI impact the patient's self-concept and self-esteem. In short, the self-concept is the individual's belief system in given life dimensions (e.g., physical self-concept & social self-concept) that assists the person in regulating behavior. A negative view of self is associated with depression and life dissatisfaction. In addition, it is generally accepted that a patient's self-concept is lowered post-injury and is associated with emotional distress and perceived quality of life. However, the self-concept is amenable to change through therapeutic intervention such as individual and group counseling, social skills training, and physical conditioning. This study focused on group counseling with two general goals, those being to increase self-knowledge and to learn to appreciate positive self-aspects. More specific goals included (a) exploration of self-complexity and (b) exercise of important self-differentiation. Exploration of self-complexity assists the person in recognizing the many facets of self. Self-differentiation is a process whereby the individual recognizes some aspects of self are more important than others (e.g., physical functioning may not be as important as social functioning).

Results indicated a significant difference between pre and post intervention scores on the Head Injury Semantic Differential Scale (HISDS, Tyerman & Humphrey, 1984). In addition, there were significant differences on several sub-scales including perceived attractiveness, hopefulness, self-confidence, cooperation and perceived boredom. Following is an overview of the six week, one hour per week group therapy intervention provided by Vickery et. al., (2006).

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
4. Session 4
 - Discuss pre/post injury changes may affect 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 group members engaging in current behavior & activities that are 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
 - Final discussion focusing on highlights of group; 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

In summary, this pilot study indicates initial positive results for a group approach in those with TBI and self-concept issues. Furthermore, this group approach might well generalize over to other issues associated with TBI such as individuals dealing with physical losses.

Resilience

Resilience and Rehabilitation, White, Driver, & Warren (2008)

Resilience is a part of positive psychology that works to identify the strengths and positive qualities of the patient as opposed to the deficit model. Through these efforts, the patient and the family thrive. Although there is not a universal definition in the literature, in this context resilience refers to how an individual reacts and adapts to a traumatic event. It is considered multidimensional and includes the personal qualities of spirituality, personal competence, social competence, family cohesion, and social resources. The authors believe that resilience can be learned and is not necessarily a trait that one does or does not have. Initially, assessing the patient's level of resilience provides a method to measure efforts in the rehabilitation process. The general conception is that:

- Those with high Resilience (e.g., perceived competence and spirituality) are more likely to exhibit adaptive behaviors
- Those with low resilience (e.g., anger at others, chemical dependency, & isolation) likely will continue to operate in a state of disruption

Furthermore, it is important to recognize that resilience is malleable and learned through enhancing social skills, family support, spirituality, education, and self-competence. Figure 2 depicts Richardson's (2002) model of resilience.

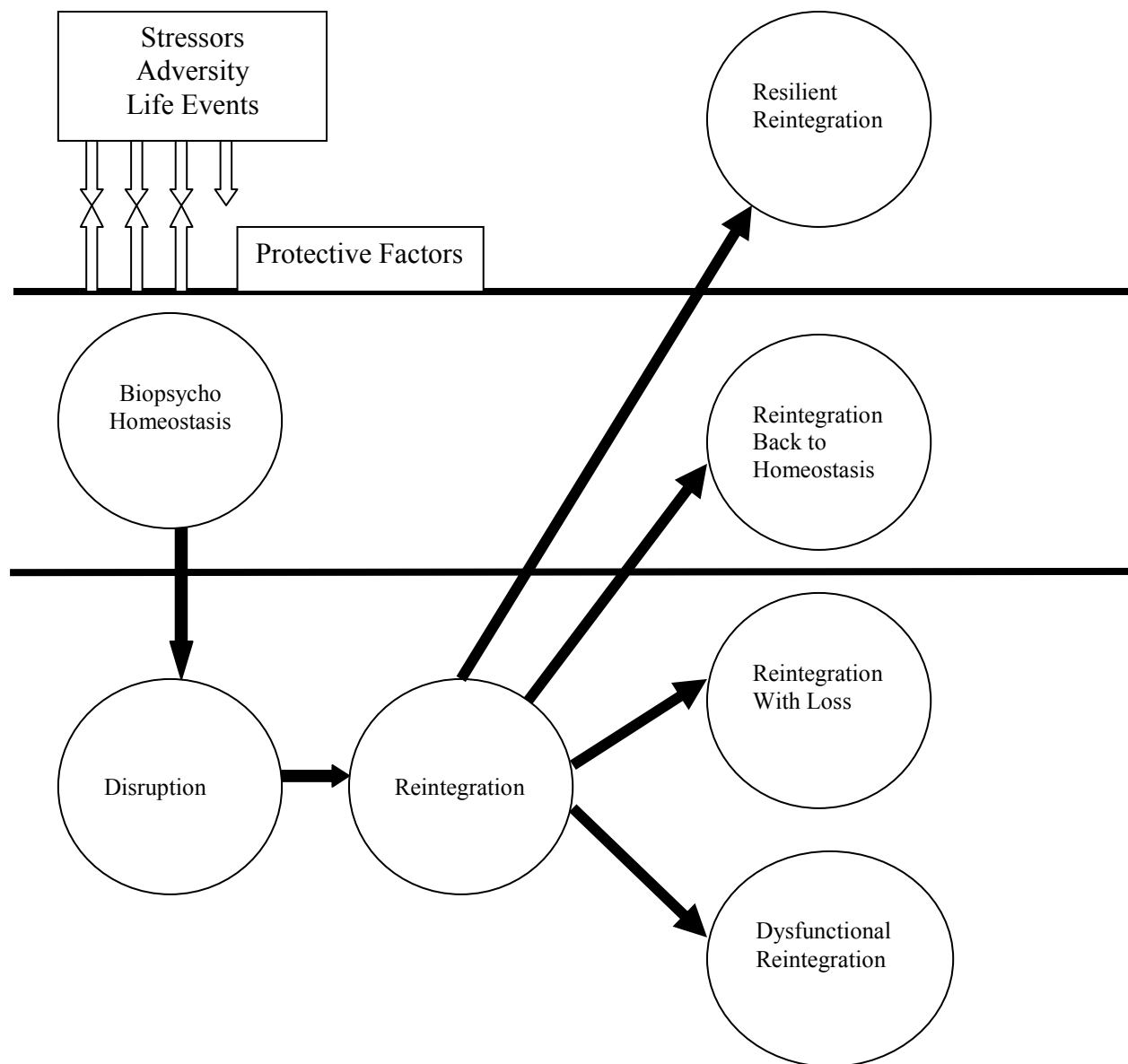


Figure 2. Richardson's (2002) model of resilience. Downward facing open arrows represent the stressors/adversity/life events an individual is faced with; upward facing open arrows represent the protective factors an individual possesses to be able to deal with those stressful events; closed arrows represent the direction that someone takes after experiencing a disruptive event.

The authors note that resilience in this context speaks to the emotional levels of functioning for the patient and family. For example, the loss of a spouse is a traumatic and emotional event yet it does not have the chronic physical loss of functioning. As such, there are two separate issues facing the individual with TBI a) the trauma that created the injury and b) the physical injury itself. A more definitive definition of resilience would include the following qualities:

1. Psychological and dispositional attributes including:

- a. Personal competence or the individual's belief in their ability, accomplishments, determination and realistic expectations
 - b. Personal structure or the individual's ability to plan and organize daily activities and
 - c. Social competence which is the individual's belief in their abilities in social situations and includes extraversion, social/communication skills, and social adaptability
2. Family support and cohesion e.g., how the families resolve conflict, cooperate for goal attainment and maintain stability
 3. External support systems e.g., the ability to give and receive support from family/friends and develop intimacy with those systems
 4. Spirituality, as another external support system, is the individual's belief in a universal power, perceived transcendence, or divine intervention

These attributes of resilience define our efforts as professionals in the rehabilitation process. Currently, there is little research on resiliency yet there is an obvious need to develop the research and be able to measure this important concept. A reliable measurement would facilitate identifying patients who would most benefit from resiliency interventions. In addition, it would identify the family's resilience and its relationship to the stress the TBI loved one experiences. And lastly, a reliable measure could help guide treatment planning and intervention. One such instrument is the Resilience Scale for Adults (Friborg et. al., 2003). The scale contains five factors a) Personal Competence, b) Social Competence, c) Family Coherence, d) Social Support, and e) Personal Structure, and is statistically reliable and valid. Although there is work being done to measure resilience, much work remains in the research arena. At the same time, that should not be a deterrent for those working with the TBI population. It is our responsibility to use new and innovative approaches as well as accepted practices to restore hope and return the patient to optimal functioning.

Survival and Resilience

The stories above provide a two layer model of recovery for the patient and the family. For the patient, identity reconstruction becomes the initial focus of recovery. For the family, collaboration with the patient and provider provides the integrated care that is necessary. If the approach is isolated to only work with the patient and identity reconstruction, patients begin to report a sense of helplessness. Therefore, it is important to have one provider to become the coordinator of care to restore the hope of the patient and family. Furthermore, thinking holistically and helping the patient and family heal mind, body, and soul begins to make meaning of the event. One method to accomplish the task is to do resiliency training. This approach includes the development of a new self, and resolving family issues to decrease psychological pain for all. For example, the appropriate use of humor, love, spirituality, nutrition, exercise and meditation facilitates psychological recovery for all. Ultimately, the therapist works toward reducing ambiguity, fear, and secrecy, and regenerates confidence by reconstructing the patient's identity and building tolerance for ambiguity in the family system. The therapist assists in fostering support and acceptance among all concerned.

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