Progressive Treatment Team Approach for Clients with Mild Traumatic Brain Injury

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Counselors and SLPs share common therapeutic territory when dealing with mild TBI

Cognitive deficits from TBI can result in performance deficits in the following areas:
- Communication
- Emotional regulation
- Relationships
- Occupation

Mild traumatic brain injury and post concussion syndrome often go undiagnosed due to unsought medical care, inconclusive screening or scans, and poor societal education regarding causes and effects of mild TBI.
It is likely that a counselor could be the first professional sought by a client suffering from the effects of mild TBI, making recognition and referral invaluable.

What does an SLP do?
Assess and treat cognitive and communication deficits:
- Memory, attention, executive functioning (e.g. judgment, problem solving, higher level cognitive skills, decision making)
- Speech, language, social communication/skills
- Retrain and compensate for areas of deficit
- Education and informational counseling with client and family regarding diagnosis and areas of deficit, including motivational interviewing and identification of realistic functional goals
- Communication partner training

Mild TBI Defined
Constitutes 80-90% of TBI cases in U.S.
~2.3 million cases in the U.S.
Multiple terms, definitions, and diagnostic criteria
American Congress of Rehabilitation definition:
Traumatically induced physiological disruption of brain function with at least one of four manifestations:
- Any loss of consciousness (LOC)
- Any loss of memory for events immediately before or after injury
- Any alteration in mental status at time of accident
- Focal neurological deficits that may or may not be transient

Mild TBI Facts
Usually negative radiological findings (CT/MRI)
Patient may be unaware of LOC if brief or alone
Most have good recovery of symptoms in approximately 1-3 months
Some patients have persistent symptoms resulting in social and vocational difficulties that appear to be out of proportion with the severity of the neurologic insult – Post Concussion Syndrome
Typical Presenting Issues

- Headache (most common)
- Problems with hearing (e.g. tinnitus, hearing loss)
- Vision impairments (e.g. fatigue, blurred vision)
- Sensory impairments (e.g. numbness, pain, tingling, altered taste and smell)
- Fatigue
- Disturbed sleep/insomnia
- Difficulty processing large amounts of information at once
- Disorganized thinking
- Difficulty multitasking
- Task completion issues
- Difficulty retaining new information/learning
- Difficulty scanning when reading
- Fatigue
- Amplified prior issues
- Social problems
- Emotional lability
- Increased irritability “short fuse”
- Feelings of inadequacy
- Grief and loss
- Decreased motivation
- Personality change
- Impulsiveness
- Overstimulation (e.g. groups, concerts, kids)
- Anxiety and depression
- Occupational problems
- Attention/focus issues “zoning out”
- Memory problems (mild episodes of memory loss)
- Indecisiveness

Common Event History Examples

- “Bell rung”
- Falls
- Auto accidents (including motorcycle with helmet)
- Physical altercations
- Contact and high risk sports (e.g. downhill skiing)
- Concussive blast injury
- Dismissed cause (e.g. sports related), but may report “weird” incidents, e.g. new unusual behavior

Red Flags

- Sudden onset of symptoms
- Crossover of symptoms (e.g. with PTSD)
- Symptoms present in multiple environments and areas of functioning (e.g. memory/task completion problems and impulsiveness)
- General feelings of incompetence/inadequacy not present prior to onset of presenting issues

Example Assessment Questions to Determine Referral

- Around the time you noticed your difficulties, did anything happen to you? (Give examples to trigger memory – e.g. MVA, sports accident, etc. Look for minimization, such as “bell rung.”)
- Have you been to the ER or physician in the last (estimate period of time based upon report of onset of symptoms)?
- Do you have frequent headaches?
- Do you have trouble sleeping/sleep too much?
- Have you had any changes in vision or sensation?
- Have you had any changes in memory and/or concentration?
- Any changes in emotional regulation or mood?
- Has your performance at work/school changed (e.g. lower grades, decreased work productivity, etc.)?
- Do you have moments of feeling overwhelmed in places with lots of people and activity?
- Do you have more difficulty organizing your thoughts? Especially when emotionally overwhelmed or anxious?
- Any changes in long term relationships?
Ideal Referral Process
Insurance dependent – counselor advocacy important
Get ROI from client to consult with GP and communicate possible MTBI symptoms
GP will refer patient to Neurologist
Neurologist confirms diagnosis and refers patient to other services: SLP, neuropsychologist who may refer to OT or psychiatrist (if needed), or Outpatient Brain Injury Program

Continuity of Care and Treatment Team Participation
Counselor must be aware of treatment plan in order to facilitate maximal therapeutic outcomes in all settings – close contact with treatment team, especially SLP and adherence to therapy (e.g. motivational interviewing)
Inclusion of family in emotional process
Client acceptance (grief and loss)
Family acceptance/support
Vocational future can be unpredictable and based on myriad factors (e.g. age, gender, medical/mental health history, number of presenting issues)
Participate in return to work/school plan with Treatment Team
  Determination as to whether previous occupation or academic plan is appropriate
  Determination of accommodations/modifications (e.g. work/school schedule, duties, environment)
  Guidance for possible change of career or academic plan and accompanying emotional distress
  Counselor is emotional liaison for treatment team

Barriers to Rehabilitation/Counseling
Fatigue, Frustration, & Anxiety (FF&A)
Limited recall of info learned
Concrete thought
Difficulty with carryover from one area to another
Insight – difficulty connecting specific deficits with overall functioning
Attendance
Walking Wounded – perceived failure and no one understands

Interventions & Techniques
Normalize deficits
  Finding “new normal” for clients who may not recover completely
  Accepting temporary change and rehabilitation
Multiple modalities to facilitate processing
  Visuals – client or counselor produced
  Written examples and therapeutic instructions
  Present concepts in multiple ways with functional examples that specifically pertain to the client
Emphasize bodily felt sense of emotion, emotion naming, physical cues (e.g. tension) to increase emotional awareness – body responds to external/internal stress before mind
Facilitate family understanding of client’s external cues to emotion and communication for need for break
Managing FF&A
Brain Breaks – identify how, when, where
Anticipate and plan for difficult situations
Alternate high and low demand tasks
Encourage routine
Wellness Concerns
Sleep hygiene
Nutrition & activity
Relaxation/grounding techniques

Advantages of Interdisciplinary Collaboration
Reinforcement of therapeutic goals
Increased emotional support (from counselor and family)
Maximization of therapeutic interventions by clear assignment of goals
   SLP would focus more on cognitive rehabilitation and family training
   Counselor would focus more on emotional process and family support
This will ensure appropriate scope of practice for all therapists

Bibliography