Effective Strategies for Treating Individuals with Brain Injury in Group and Individual Therapy Settings

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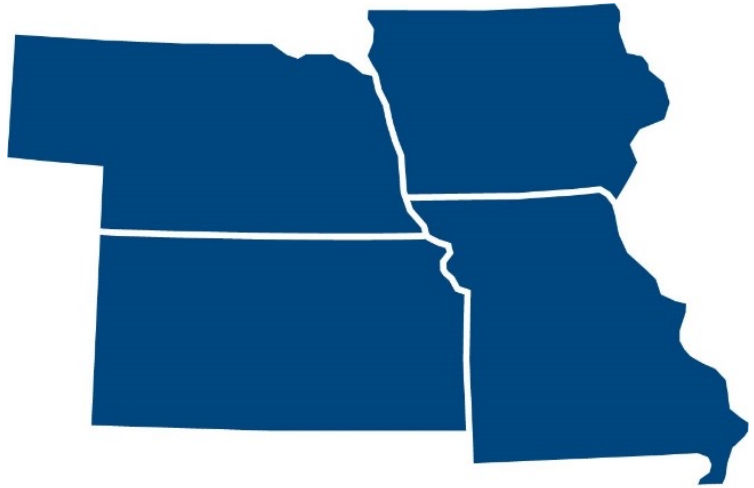
Mid-America ATTC & Mountain Plains ATTC



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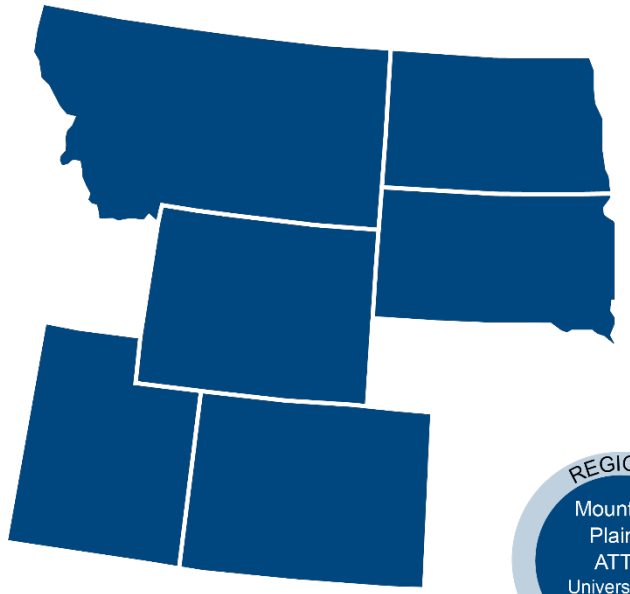

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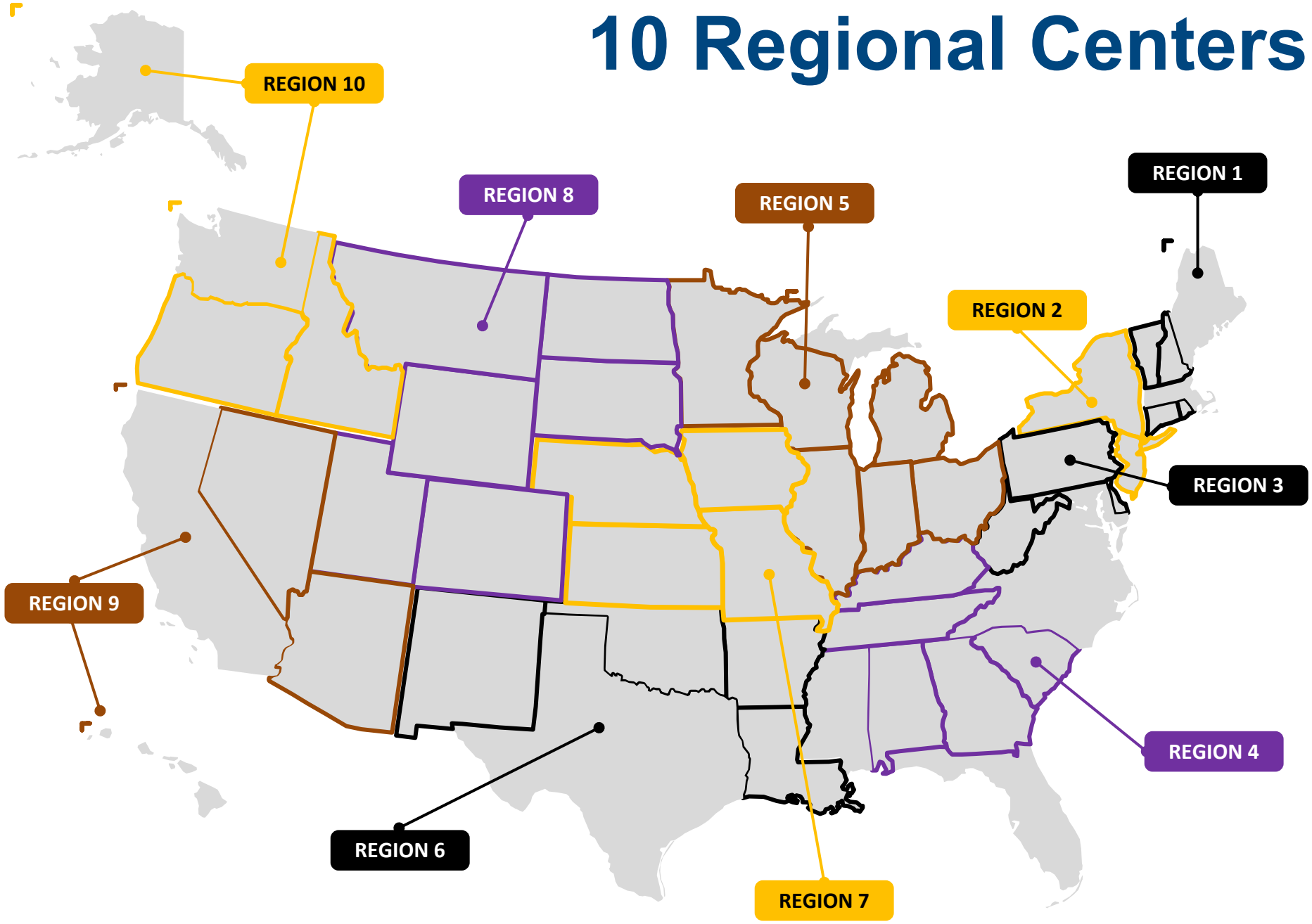
HHS Regions

10 Regional Centers



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Other CEs

- Iowa Board of Certification
- Missouri Credentialing Board
- Kansas Behavioral Sciences Regulatory Board
- Nebraska (deemed alcohol and drug specific – accepted for continuing education for licenses alcohol and drug counselors in NE)
- NASW
- CRC

Housekeeping Items

- All attendees are muted and attendees cannot share video during this session.
- Remember to ask questions using the Q&A feature
- How to access training materials

Objectives

At the end of this activity participants will be able to…

1. Conduct a brief cognitive mental status examination
2. Understand the implications of cognitive impairment for the implementation of treatment
3. Modify the treatment experience for the client maximizing the benefit of the treatment experience
4. Integrate formal treatment with Recovery Model
5. Understand the need for family involvement

Dr. Frank R. Sparadeo

- Practiced as a neuropsychologist for over 34 years
- Experience evaluating and treating people with people experiencing brain disorders or chronic pain, and/or addiction.
- Most recently involved in the formation of a special program in the combined problem of chronic pain and addiction
- Experience in switching patients from pain meds to suboxone
- Closely involved in the treatment of chronic pain utilizing a new theoretical approach that relies on information theory to reduce pain responses. The neuromatrix theory of pain is the basis of this treatment.

Neuropsychological Assessment

Neuropsychological assessments are used for identification of cognitive impairment and strengths as well as determining important clinical issues such as:

- prognostication
- development of treatment plans
- and rehabilitation of individuals with neurologic conditions,
- health problems
- neurodevelopmental disorders
- cognitive problems
- learning disorders
- and psychiatric conditions

Conducting a Cognitive Mental Status Exam

The cognitive MSE does not have to be difficult or complicated, but you have to be sure you address key areas of cognitive functioning:

- Attention/Concentration
- Learning/Memory
- Language
- Visuospatial
- Reasoning

Techniques: Attention and Memory

- Attention/concentration
- Give the patient 20 single digit numbers randomly placed on a card with 10 odd numbers and 10 even numbers. ”Tap the table every time I say and Odd number
- Learning/memory (read the sentences out loud to the patient)
- A hunter/killed/a wolf/at the edge/of the Forrest
- In an Orchid/behind/a tall/fence/there were trees/with many/ripe/apples

Techniques: Language

- Confrontation naming
- Responsive naming
- Repetition: “The lawyer’s closing argument convinced him.”
- Dictation: “The weather of Providence is unpredictable showing frequent temperature fluctuations”
- Comprehension: “With your right hand, take this piece of paper, fold it in half and give it back to me”
- Fluency: “Tell me every 4-legged animal you can think of” (60 secs)

Techniques: Visual perceptual

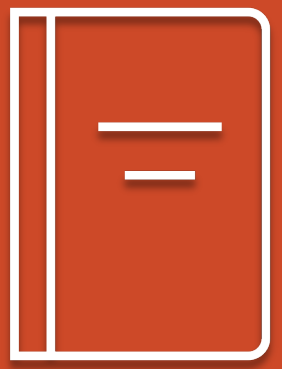
- Draw a cube
- Draw a Greek Cross
- Use a visual organization task
- Draw a clock and set it for “ten after eleven.”
- Symmetry
- Planning (number placement)
- Setting: symbolic synthesis

Techniques: Reasoning

- Similarities
- Knee and elbow
- Laughing and crying
- Praise and punishment

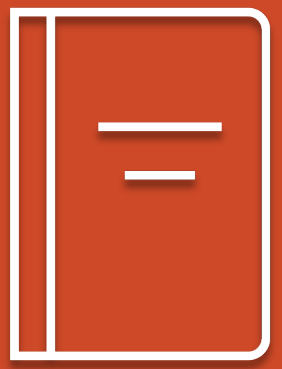
Executive Function

Importance of Executive Function



- Executive functions are important for successful adaptation and performance in real-life situations.
- They allow people to initiate and complete tasks and to persevere in the face of challenges.
- Because the environment can be unpredictable, executive functions are vital to human ability to recognize the significance of unexpected situations and to make alternative plans quickly when unusual events arise and interfere with normal routines.
- In this way, executive function contributes to success in work and school and allows people to manage the stresses of daily life.

Executive Function: Impulse Control



- Executive functions enable people to inhibit inappropriate behaviors.
- People with poor executive functions often have problems interacting with other people since they may say or do things that are bizarre or offensive to others.
- Most people experience impulses to do or say things that could get them in trouble, such as making a sexually explicit comment to a stranger, commenting negatively on someone's appearance, or insulting an authority figure like a boss or police officer; but most people have no trouble suppressing these urges.
- When executive functions are impaired, however, these urges may not be suppressed. Executive functions are thus an important component of the ability to fit in socially.

Executive Function: Training

Response Inhibition: The capacity to think before acting

Working Memory: The ability to hold information in memory while performing complex tasks

Self-regulation of Affect: The ability to manage emotions in order to achieve goals, complete tasks or control or direct behavior

Sustained Attention: The capacity to maintain attention to a situation or task in spite of distractibility, fatigue or boredom

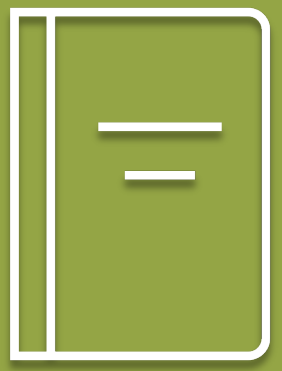
Task Initiation: The ability to begin projects without undue procrastination, in an efficient or timely fashion

Planning/Prioritizing: The ability to create a roadmap to reach a goal or to complete a task

Organization: The ability to arrange or place things according to a system

Impact of Cognitive Impairment

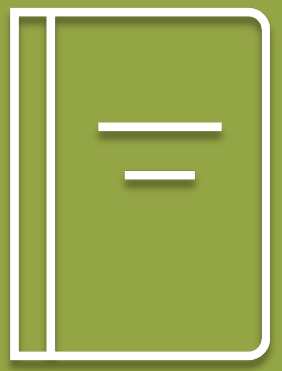
Impact of Cognitive Impairment #1



- Neuropsychological deficits contribute to the inattention, distractibility and apparent lack of motivation early in treatment

- Understanding the cognitive weaknesses and strengths is useful for clinical decision making and in providing clinicians with realistic expectations about treatment goals

Impact of Cognitive Impairment #2



- For individuals in recovery, a number of “executive” functions are important to the process
- Self-monitoring/self-guidance
- Use of knowledge to guide behavior
- Impulse Control
- Learning from negative feedback
- Reflection/Empathy

Mechanisms of Behavior Change: Key Question

Do the direct effects of alcohol/drugs on the brain, or neurocognitive problems due to co-occurring TBI, and metabolic and nutritional disturbances have down-stream effects on addiction treatment processes and thereby alter substance-use-related treatment outcomes, and/or psychosocial adaptation more generally?

Mechanisms of Behavior Change: Tx Compliance

- Clinically, neuropsychological impairments have been associated with reduced treatment retention and compliance, self-efficacy to resist urges to use alcohol/drugs, coping-skill development and other prognostic indicators of addiction treatment outcomes
- In a large study of clients with alcohol use disorders, impairment led to less treatment compliance and lower self-efficacy to resist urges to use alcohol, which in turn predicted less successful outcomes following treatment

Mechanism of Behavior Change: Self-Efficacy

- In addition, in both clients with alcohol and other substance use disorders, neuropsychological impairment interacted with self-efficacy to resist urges to use, such that a relatively higher level of self-efficacy was a less robust indicator of successful substance use outcomes in impaired clients compared to those without neuropsychological impairment

- This finding suggests that mechanisms of behavior change, such as perceptions of self-efficacy to resist urges to use alcohol and drugs, operate differently, or are perceived or reported less accurately in impaired clients

Mechanisms of Behavior Change:

Social Support

- Greater involvement in A.A. has been observed in impaired compared to unimpaired clients, suggesting that social support for recovery might be particularly useful to bolster treatment effectiveness in cognitively impaired clients

- More severe executive and verbal impairment at treatment entry predicted better substance-use outcomes in outpatients who had frequent contact with a social network that supported recovery, while impairment predicted poorer substance-use outcomes in clients with more severe alcohol-use histories who had frequent contact with a social network that encourage drinking

Making Modifications

Making Modifications to Treatment

Formal Treatment approaches must be understood well enough that modifications can be made.

Even Self-Help approaches may need modifications

Initiating Treatment

- The first step is to identify the sensory-perceptual, attentional, linguistic, memory and reasoning or planning deficits that could prevent the delivery of effective psychological treatment
- These deficits represent the most basic level of potential obstacles for the therapist
- The integration of cognitive rehabilitation may be critical

Modifications: Strategies for Attention

- For successful psychological intervention, a patient must be able to attend to and understand verbal material or therapeutic dialogue as it unfolds within a session
- Strategies to assist a patient in staying focused may be needed

Modifications: Rules for Refocusing

- Early in treatment, the therapist should establish a contract or predefined set of rules for refocusing the discussion if a session becomes derailed due to the patient's inattention or decreased self-monitoring

- The therapist and the patient should agree on a prompt or cue phrase, such as "Let's get back on track," to regain focus

Modifications: Limit the Topics of Discussion

- At the outset of each session, the therapist should present a limited number of topics or themes to be covered in the session; providing a patient with a written list of these topics strengthens this strategy

- The patient will find it easier to retain the topical thread of a discussion if the therapist avoids long, complex sentences and dialogue

Modifications: Pausing

The patient's risk of becoming lost also can be reduced if the therapist pauses frequently while presenting therapeutic material or during dialogue to allow the patient to mentally review the previous 5 min of the session

Modifications: Consider Memory Difficulty

It is difficult to achieve a cumulative effect if memory deficits prohibit a patient from retaining the conclusions, insights or context of even a single session

Three aspects of memory dysfunction are germane to the success of psychotherapeutic intervention: working memory, long-term memory and meta-memory

Modifications: Working Memory and LTM

Working memory: Limited, temporary store where new information is held while it is manipulated in a meaningful way to solve a current problem

Long-term memory: Formed over a longer period of time from minutes to days or longer

Modifications: Meta Memory

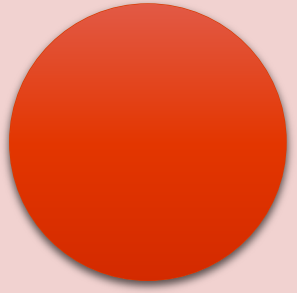
Self-monitoring of one's own memory

(Example: remembering to remember)

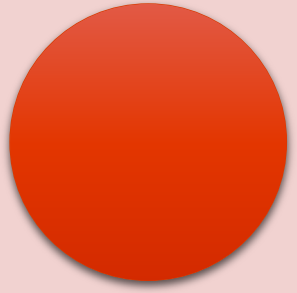
Modifications: Working Memory Adjustments

- Frequently rehearsing verbal information
- Grouping similar psychotherapeutic topics or goals
- Regulate the rate at which verbal information is presented

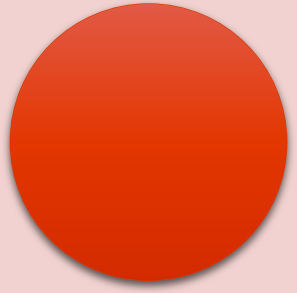
Modifications: Long-Term Memory Compensation



Instruct the patient in ways to use symbolism



Teach the client ways to generate visual images



Use of mnemonic strategies

Modifications: Meta-Memory Compensation

- Help the patient to recognize and monitor his/her own limitations. Such an awareness motivates the patient to learn and use compensatory strategies and devices, the most critical of which is the ***memory notebook***.

- The memory notebook fosters organization and provides a method for rehearsal of treatment information. Can be coupled with an alarm device found on a digital wristwatch.

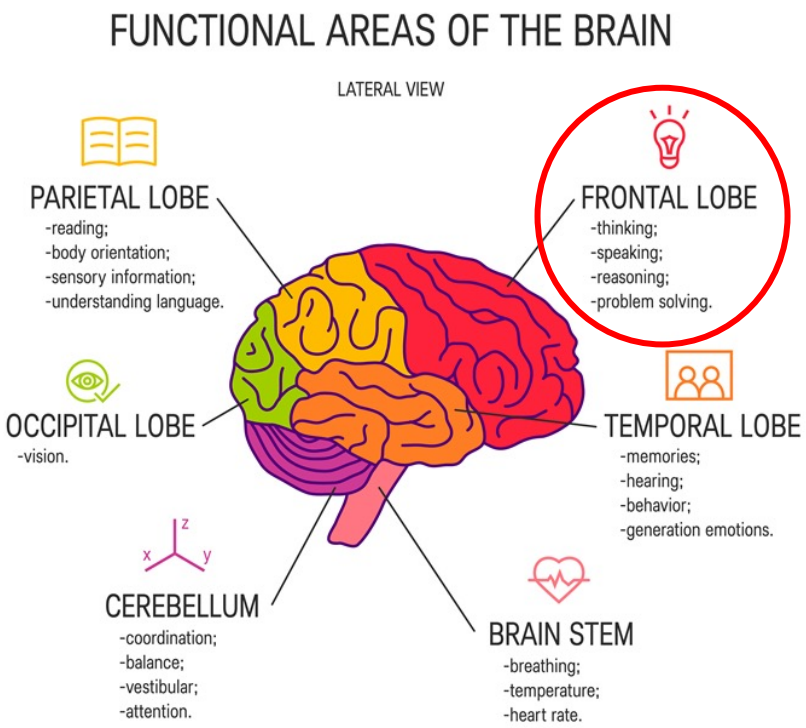
Modifications: Language Compensation

- In view of the highly verbal nature of psychotherapy for substance abuse language deficits can seriously diminish its effectiveness.
- Direct consultation with a speech/language specialist can be very helpful.
- Journaling can be helpful for patients with motor-based language difficulty

Modifications: Nonverbal Communication

Language deficits derived from right hemisphere damage can be overlooked but are critical since nonverbal aspects of language contribute significantly to overall comprehension.

Modifications: Frontal Lobe Characteristics

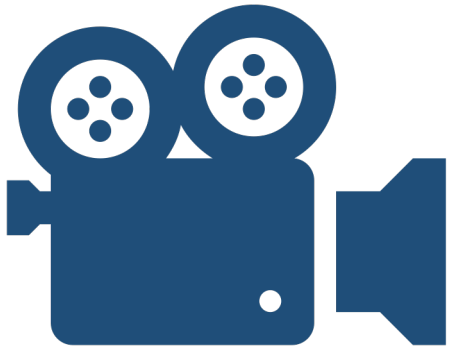


- Patients manifesting deficits in motivation, initiation of behavior, abstract reasoning, insight, planning, problem solving, or impulse control can present the most challenging situations.
- Structure, goal, and action-based therapeutic strategies are necessary.

Modifications: Discussing Behavior

- The significance of current behavioral problems should be emphasized to help the patient see the importance of productive therapeutic work
- Discussing the impact of negative behaviors on family members or a significant other can increase the patient's motivation for treatment

Modifications: Benefits of Video Feedback



- When motivation for treatment is compromised by decreased awareness or insight that a problem exists, the use of video technology makes abstract issues of therapy more salient for the patient.

- Videotaping group setting reveals issues related to social interaction that a TBI survivor might not have recognized just from the subtle reactions of people in natural social situations

Modifications: Modeling Behavior

Modeling of desired behavior is important

Combining modeling and videotape technology shows objective and salient examples of behaviors to be targeted for treatment

Additional structuring and rule setting within the context of therapy may be required for patients who have sustained orbital frontal damage and therefore, experience increased impulsivity and reduced self-regulatory capacities

Modification: Awareness

- Awareness and Denial
- Diminished insight and awareness of self are common sequelae of TBI and other neurological illnesses
- Three levels of awareness are: Information, Implication and Integration

Modifications: Need for Accurate Information

Problems perceiving information about their disorders and can even be completely unaware of any impairment (anosagnosia)

Difficulty understanding medical information and material related to the diagnosed condition also is classified as reduced awareness at the information level

Modifications: Implications and Integration

Implication Level

- When patient's perceive information but are incapable of appreciating the implications or long-term consequences of their conditions, deficits, or life situations.

Integration Level

- Patient accurately perceives their condition and are aware of the implications but are unable to absorb emotionally the gravity or meaning of their situation. Defense mechanisms such as denial may appear when deficits of awareness occur at the integration level.

Traditional Treatment-Oriented Approach vs. Recovery-Oriented Approach #1

Traditional Treatment Strategies	Recovery Strategies
Promote clinical stability, managing illness	Promote quality of life and recovery
Focus on illness, disabilities and deficits	Focus on wellness/health, abilities and choices
Value Compliance	Value active participation, empowerment
Only professionals have access to information	All parties have access to the same information
Link to professional services only	Link to diverse supports, including professional services, non-traditional services, and natural supports

Traditional Treatment-Oriented Approach vs. Recovery-Oriented Approach #2

Traditional Treatment Strategies	Recovery Strategies
Relies on facility-based settings and professional supporters	Integrated settings and natural supporters are also valued
Self-determination comes after a person achieves clinical stability	Self-determination and community inclusion are fundamental rights of all people
Emphasize avoidance of risk	Emphasize responsible risk-taking and growth

The Bottom Line

Successful treatment and recovery requires a respectful approach to the person with SUD that takes into account the whole person and all the influences that might either enhance or ruin the recovery effort and long-term success

Understanding of the role of the brain and the long-term impact of substance use (and TBI) on the thinking process and how that impacts the recovery process is an essential component to a successful recovery

Traditional treatment-oriented approach and the recovery-oriented approach are both necessary in the long and difficult battle to return to homeostasis and a life without substances

Behavioral Assessment: Knowing the Client

- Psychological considerations are integral to the treatment of persons with brain injury
- Coping skills may decline and behavioral dyscontrol may increase due to alterations in cognition
- Programs that emphasize psychological status are more likely to succeed than programs that de-emphasize psychological status
- It is a mistake when TBI or SUD professionals, families, the insurer and/or the client downplay psychological variables.
- Psychosocial sequelae may be a better predictor of outcome than physical symptoms.

Behavioral Assessment and Intervention: Barriers

- Clinicians and their supervisors ought to predicate treatment on thorough assessment. Psychological assessment dovetails with evaluations by all other disciplines because psychological variables affect the outcome of their treatment
- For example, low effort due to depression can contaminate the findings and outcomes of physical therapy
- Hopelessness can interfere with the educational efforts of nurses leading to poor reliability in the self-administration of medications
- The beliefs of a client with cognitive and physical disability can impact compliance with physician's recommendations

Domains of Behavioral Assessment and Intervention

Psychological assessment covers 3 domains:

- Emotional status
- Behavioral status
- Functional status

Behavioral Assessment and Intervention: Behavioral Techniques

Intervention for behavioral difficulty can occur using varying techniques:

- Contingency Management
- Modeling
- Environmental
- Counseling/Psychotherapy

Behavioral Assessment and Intervention: Dealing with Aggression

Aggression: The most distressing of all brain injury and SUD symptoms. When aggression occurs, it commands attention.

- Contingency techniques can be used after physical aggression, although they may prove to be more useful as an adjunct to antecedent control.

- Counseling the individual can be essential to facilitate interpretation of the antecedent and contingency changes, the utilization of skill-based techniques for anger management, cognitive restructuring of frustrating events and preparation for future stressful events.

Behavioral Assessment and Intervention: Impulsivity

Impulsivity can be a particularly frustrating behavior for professionals and family and even for the individual with the problem.

2 ways to perceive impulsivity:

- Person may behave too intensely or too quickly (prematurely): "too much too soon." Overly activated responses.
- Person may fail to stop inappropriate behavior, acts that should not occur at all. Professionals may call these risky or dangerous behaviors. There is a failure to inhibit impulses toward aggression, elopement, suicide, etc.
- Uncontrolled behavior.
- Impulsivity can represent over-activation or under control

Ways to Improve Your Memory

Organize

Organize your world

- Keep information in a central location
- Use a day planner or calendar

Use

Use “word association”

- Names, faces, grocery list

Repeat

Repeat things out loud

- Say it multiple times

Communication Ideas: A Client's Perspective

1

Ask people to get your attention before starting to talk to you

2

You need time to shift your attention and focus on them

3

Ask people to be brief, simple and to the point

4

Encourage people to take notice of the speed they talk and how much they say

Communication Ideas: Tricks and Techniques

- Repeat back information to make sure you understood it
- Keep background noise as low as possible
- Turn off music/TV
- Avoid large groups of people with a lot of talking
- Stand or sit in a corner so that noise is not all around you

Communication Ideas: Remembering

- Reading a letter or notes gives you more time to think.
- Ask Family and friends to write things down
- Decide on what you have to remember and focus only on that
- Do not try to remember **everything**

Family Issues

A Way to Understand Family Involvement and Support

	Uninvolved	Involved
Supportive	Often results in resentment	Common in TBI early rehab
Unsupportive	Common in SUD-usually at point of substance misuse reoccurrence	Often results in ongoing conflict

Goals of Family Treatment

- Acceptance by all family members, as well as by the client, that addiction and/or TBI are treatable illnesses, and the occurrence of addiction or substance misuse is not a sign of moral weakness.
- Establishing and maintaining a family system without substances
- Developing a system for family communication and interaction that reinforces the client's recovery process by integrating family therapy into addiction treatment as well as psychosocial rehab for TBI
- Processing the family's readjustment after cessation of drug and alcohol use/misuse

Complexity of Family Issues: Individual Reaching Greater Independence

- In early approaches to TBI rehabilitation, SUD problem is relatively easily handled by both family and professionals.
- Complexity begins as the TBI survivor reaches greater independence and less oversight by family or professionals.
- Family must be vigilant for signs of substance use which can stimulate resentment and avoidance by the survivor
- Outpatient rehab professionals must also be vigilant and be able to share information with a survivor's family
- Family members may have to examine their own use of substances and make changes so as to continue with the message that substance use following TBI is a major risk factor for another TBI, as well as, other psychosocial difficulties and vocational difficulties

Complexity of Family Issues: Individual Transitions

- Difficulty in transitioning from Rehab to home
- Difficulty in transitioning from home to independent living
- Family influence on re-establishing friendships
- Is ‘tough love’ an option for families when there is a TBI and SUD?
- While there are differences in family approaches to TBI and SUD as separate disorders, there is opportunity to learn from each other

Different Family Approaches: Family Systems/Behavior

Family Systems Approach: This model explores and recognizes how a family regulates its internal and external environments, making note of how these interactional patterns change over time.

- Major focus areas are: daily routines, family rituals (e.g. holidays), and short-term problem—solving strategies.

Family Behavioral Approach: This model is based on the theory that interactional behaviors are learned and perpetuated by reinforcing the behavior.

Variety of Family Approaches

Family Functioning Approach: This approach classifies the family system into one of four types and uses the therapeutic intervention that is best suited to the functioning of that family system.

Functional family systems: The family and the client have maintained healthy interactions

Neurotic or enmeshed family systems: This approach usually requires intensive family treatment aimed at restructuring family interactions

Disintegrated family systems: This approach calls for separate yet integrated treatment of the client and the family.

Absent family systems: Unavailable family members. Clients estranged from members of their family often develop a family of choice with people with whom they spend the most time. Identifying and clarifying the roles of these extended family members is important, and clinicians encourage their participation.

Social Network Approach

Focuses primarily on the treatment of the client and also establishes a concurrent and integrated support network for family members to assist with problems caused by the addiction.

Substance Misuse Prevention

Reoccurrence of Substance Misuse Prevention: Part I

- Recurrence of misuse after treatment or after a sustained period of remission is a characteristic of all chronic persistent medical disorders (e.g. diabetes, asthma, hypertension); but when it occurs with a SUD, it is often met with a heavy stigma that causes shame, guilt and feelings of hopelessness.
- Relapse must be accepted but not excused in recovery.
- Client should not be made to feel shame after relapse and should be welcomed back into treatment
- Reoccurrence of misuse must be aggressively analyzed by the individual and his/her counselor so that causes can be identified, and strategies developed to avoid future slips (lapses) or relapses.

Reoccurrence of Substance Misuse Prevention: Part II

- Harm reduction education and alternatives should be part of this process.
- It is easier to address a slip after the first use than trying to arrest continued use after a slip.
- Treatment of a substance use disorder is incomplete unless a full reoccurrence of substance misuse prevention plan is developed that identifies and addresses cognitive deficits, PAWS, cravings (endogenous and environmental triggers) and prevention strategies.

Two Types of Triggers

Endogenous triggers having the greatest impact on drug craving and relapse are negative emotional and physical states or internally motivated attempts to regain control in order to use again.

- Treatments include counseling, education, discussions with recovery sponsors, stress reduction therapies, biofeedback, participation in 12-Step Meetings, nutrition and medications

Environmental triggers often precipitate drug cravings.

- Also known as external influences or interpersonal factors, pressures, lack of support systems, negative life events, people, places and things

Cravings and the Environmental Factors

- Sensory stimuli (odor, sight, noise or anything related to a person's past drug use) can also trigger memories that evoke cravings

- Drug craving caused by an environmental cue results in true psychological responses that are manifested by actual physiological changes of increased heart rate, pulse rate, blood pressure; sweating; dilation of the pupils; specific electrical changes in the skin and EEG scans; increased peristalsis activity; and an immediate drop of 2 degrees or more in body temperature.

Indicators of Potential Reoccurrence of Substance Misuse

Signs of Pending Reoccurrence of Substance Misuse

- Romanticizing past substance use
- Discussing about and believing that substance use can occur again without negative impact
- Sudden change in behavior
- Not using cognitive rehab strategies
- Isolating
- Evasiveness and difficulty with eye contact

Other Triggers

- Depression
- Stress
- Feeling disappointed in TBI recovery or defeated by the TBI
- Exhaustion
- Isolating
- Memories
- Physical cues
- Exogenous cues

Reoccurrence of Substance Misuse Prevention Strategies #1

- An individual addicted to a substance must understand the nature of relapse and learn to recognize their personal triggers.
- The individual must develop behaviors to avoid external triggers. They include staying away from old neighborhoods, dealers, and bars or gatherings where substances are readily available; avoiding certain friends; and carrying only a limited amount of cash.
- The individual must be prepared with an “automatic reflex strategy” that will prevent them from using when their craving is activated by internal or external cues. In essence, strengthening the frontal output to maintain control

Reoccurrence of Substance Misuse Prevention Strategies #2

- These include engaging their support system, going to a 12-step meeting, using coping skills for negative emotional states and cognitive distortions, remembering the damage caused by their addiction, reminding themselves of the reason for wanting to stay clean, remembering their last binge, creating a balanced lifestyle, and, in some cases using anti-craving medications.

Outcome and Follow-up

Tracking client outcome and preparing follow-up evaluations have become a major activity for treatment programs. Indicators most often used to determine successful treatment of substance use disorder include:

- Prevalence of reoccurrence of alcohol/drug use
- Retention in treatment
- Completion of a treatment plan and its phases
- Family functioning
- Social and environmental adjustments
- Vocational or educational functioning; including personal finance management
- Criminal activity or legal involvement

Continuing Education Credit - Please Note!

- You must miss no more than 10 minutes AND complete the CE Evaluation Survey in order to be eligible for continuing education
- You will receive an email at the email address you used to register that will contain a link to a required survey
- You will have 72 hours from the date/time you receive the email to complete the survey
- You will receive your CE Certificate in approximately 4-6 weeks

GPRA Link (SAMHSA Required Evaluation)

This is a shared event of the Mid-America and Mountain Plains ATTC

ttc-gpra.org/GPRAOnline/SG?e=135570