



Clinical Concerns in Counseling Clients with Traumatic Brain Injury

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Authors' contributions

This work was carried out in collaboration among all authors. Author MFS conceptualized the paper and recognized the need for work and information to be disseminated. Author AJ contributed to the literature review as did the author LR also proof read and approved the final draft.

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ABSTRACT

Counseling clients who have experienced an open or closed head injury can be quite problematic and present challenges in different realms. This paper explores some of these disparate realms and offers some insights as to counseling strategies that may need to be explored and examined. Realistic goals and objectives are needed and attention to specific areas of concern are examined.

Keywords: Traumatic brain injury; head injury; recovery; counseling; rehabilitation.

1. INTRODUCTION

All too often, individuals who have sustained a head injury or brain trauma attempt to return to school or work prematurely and encounter difficulties. They may still be in recovery and may

need additional time to recover and regain some emotional, physical and even psychological balance and equilibration. This paper will attempt to review some of the main concerns in terms of counseling clients or patients who are in recovery and who seek treatment or who have been

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referred for some specific reason. Overall, the mental health worker or counselor needs to understand the impact of a head injury on cognition and thinking. The person recovering from either an open or closed head injury may have difficulty with many realms of cognition—such as memory, attention and concentration, learning, memory, reasoning, planning, executive functioning and problem solving as well as navigating a learning platform in a college or university. The purpose of this paper is to explore this realm in depth and provide some overarching guidelines and information for clinicians working with this population.

Traumatic brain injuries affect more than 5.3 million US citizens, and due to that, they need lifelong care as a result. Many of those who are affected seek counseling to help them regain control of their life. They also turn to counseling as a way to talk about how their injury affects them, and to learn healthy coping mechanisms for living life with a TBI. In addition, as of now, TBI is not well understood by mental health counselors, which is why it is urgent for more counselors to be trained in how to approach these concerns.

TBI is defined as a blow to the head that impairs brain function. A few of the causes of TBI are falls, assaults, and car accidents. They are also common among those in the military who have PTSD and have been injured in war. There are also different classifications of TBI, which include whether or not the injury is open or closed. A closed injury is more dangerous because the trauma force goes straight into the brain rather than being deflected by the brain tissue. Another classification includes the severity of the brain injury. The four categories include mild, moderate, severe, and catastrophic. Symptoms of these brain injuries can include behavioral, psychological, cognitive, and physical issues.

A person with a mild head injury might appear to be unimpaired, but they can possess physical symptoms such as vomiting, migraines, fatigue, blurred vision, and numbness in the feet and hands. A few of the psychological symptoms include anxiety, depression, mood swings, irritability, and sleep disturbances. A moderate brain injury is defined as a person being unconscious from 15 minutes to 24 hours. They may also experience balance issues, tremors, memory deficits, language issues, difficulty with emotional expression, and lack of coordination.

Those with a severe brain injury possess the same symptoms as those with mild and moderate brain injuries, but to a more severe degree. Lastly, those with a catastrophic brain injury are in a coma for an unknown amount of time. They cannot speak, may show primitive reflexes, and do not exhibit any awareness of their surroundings. Some do eventually wake up from their coma, but if they do their lives are severely affected and most of them will need assistance with daily living.

Existential therapy has been applied to cases of individuals with TBI. The human condition is described as isolation, freedom, death, and meaninglessness. Several clients with TBI are left with a loss of control over their lives. Many of them try to make sense of their injury, and come to the conclusion that it makes them unique and able to connect with others better. Some of them also dwell on how lucky they are to have survived their injury, but still engage in self-destructive and unhealthy behaviors. Many of them also turn to religion to make sense of their injury. Some of them view it in a positive light, as if they are closer to the creator after obtaining their injury, but another portion of them try to say that the injury is their punishment from God for wrongdoing in the past. Lastly, cognitive behavioral therapy has been shown to yield positive results when counseling clients with TBI. [1].

After experiencing a Traumatic Brain Injury (TBI) one's life can change immeasurably. Survivors report feelings of worthlessness, loneliness, frustration, even depression in individuals who have had a TBI in the past. With these feelings comorbid with the brain injury may produce challenges within a therapeutic setting in Counseling [2].

Additionally, people who have experienced a TBI may come in contact with anxiety, difficulty controlling emotions, changes in relationships with family and friends; for example, a family member turning into a caregiver. Individuals may also have to adjust to the changes in work, school, home life, social life and the financial burdens the injury creates [2]. It sounds as though individuals must restart their life and restart what they once knew to grow again after experiencing a TBI. Three recent articles have produced findings that let researchers know how to navigate TBI's; especially, treatments and recovery.

In the article titled "Treatment Efficacy: Cognitive-Communicative Disorders Resulting from Traumatic Brain Injury In Adults" by Coelho, the researchers discuss how TBI can cause communicative disorders [3] which follows other research finding that some TBI involve damage to the Frontal lobe of the brain responsible for problem solving, spontaneity, memory, language, initiation, judgment, impulse control, and social and sexual behavior [2]. Any damage to these functions would have any individual relearn a certain part of themselves, which sometimes is the hardest part in changing behavior willingly.

Coelho's article focuses on the damage to the functioning of language and what happens when one experiences a TBI. Coelho states that difficulty or failure with any of these expressive-receptive abilities or with any aspect of cognition may cause a breakdown in communication and thus the inefficient exchange of information [3]. The effects that TBI have on an individual are costly and if language is disrupted, then their life becomes drastically transformed.

Coelho [3] share our sentiments for TBI when he says "Perhaps the most disabling and handicapping effect of TBI is a reduced capacity to pursue pre-injury interests and daily activities at the same functional level." (Pg. 3) The significance of that is paramount because it sheds light on the effects of what counselors are facing, and what therapists need to be prepared to do when treating someone who has had a TBI. Another effect TBI may have on an individual are difficulty concentrating under distracting conditions or problems managing tasks involving multiple demands. Areas disrupted are attention, memory, and executive functioning [3]. These symptoms do not exclude Minor brain injuries, which create their own set of problems. However, this author has found that interventions directed at specific cognitive deficits are important. Clinicians must address broader issues of social skills retraining, timing of treatment during recovery, treatment location and its effectiveness (e.g., hospital, home, school, work) [3]. Many find this most interesting because if someone could find what part of the TBI affected which part of the brain, then technically, they can start with the resources to get that individual back to pre-accident functioning via cognitive rehabilitation, physical therapy and occupational therapy as well as speech therapy.

Whiting, Deane, Simpson, McLeaod and Ciarrochi [4] considered a review of cognitive and

psychological flexibility in treatment for psychological distress after traumatic brain injury, with a focus on acceptance-based therapies [4]. The authors define psychological flexibility as a factor to health and wellbeing and is under the same umbrella as acceptance and commitment therapies (ACT) [4]. The nature of the relationship between cognitive and psychological flexibility may have important clinical implications for interventions that promote psychological flexibility to address adjustment issues after a TBI. (Pg. 264) This paper indicates its importance by explaining how there needs to be research done if we are to understand any adjustment issues after a TBI. One way to combat the adjustment issues was to provide Acceptance Commitment Therapy (ACT) on clients.

Acceptance Commitment Therapy (ACT) and Cognitive behavior therapy have been coined some of the best techniques to use for TBI. The goal for ACT is for helping people accept difficult experiences and engage in committed behavior, in values-guided life. While CBT focuses on challenging thoughts and replacing negative thoughts with positive thoughts about oneself [4]. The author also talks about how ACT could be used for TBI and how there is a growing interest towards the practice. Whiting, et al. give the example of how ACT might facilitate adaptation and acceptance of changed functioning and life circumstances following a severe TBI. [4] However, the authors state that psychological flexibility and cognitive flexibility must be stated before utilizing the treatment. This would be ACT's drawback for usage.

Whiting, and his co-workers [4] found there is a significant definitional and conceptual overlap. There is also preliminary evidence of overlap in terms of associations with neurological functioning and the location of brain activity associated with tasks that demand cognitive and psychological flexibility. Impairments in both constructs have showed a complex relationship with psychopathology. Extant measures have overlap, particularly the self-report measures of cognitive and psychological flexibility but less so the neuropsychological measures. Finally, variables that have been associated with important outcomes following TBI have both theoretical and some empirical links to both constructs [4]. Many feel this research to be relevant and interesting because ideally, cognitive and psychological change happens when someone is involved with a TBI. Either the

individuals will have disrupted thinking or thoughts, or the person won't be able to function the same and perform tasks as they used to in the past. These researchers shed light on the many factors that involve TBI and the treatments that are best tailored to help the person. They also show that people with a TBI often suffer from cognitive inflexibility because of damage to their executive processes but research also shows that they respond positively to different forms of psychological therapy [4]

The general public is becoming more and more aware of concussions, traumatic brain injury and sports related TBIs and medical personnel and emergency room physicians are now examined more extensively and more attention is given to post E.R. visits and follow up [5].

Evans [6] has specified that in terms of the military, there are three specific types of injuries resulting from various types of blasts:

“A primary blast injury is the direct result of a blast wave-induced change in atmospheric pressure (barotrauma). A secondary blast injury is objects put in motion by the blast hitting people (ballistic trauma) A tertiary blast injury is people being forcefully paced in motion by the blast” (p. 1216). Glang, Tyler, Pearson, Todis & Morvant [7] have indicated the need for teachers to be vigilant and alert as there may be children who have suffered a head injury and may not be receiving adequate services in the public schools due to inexperienced teachers, lack of training, and lack of in-servicing and appropriate workshops.

One final major recent article investigated the construct of fatigue and associated factors that have been associated with Traumatic Brain Injury and other resultant concerns such as insomnia and depression. This article indicated that fatigue has been cited as one of the most common symptoms of a brain injury [8].

The authors then went on to explore any correlation insomnia and depression since fatigue has been linked to those disorders. With 100 patients, the authors found that the prevalence of depression was in 84%, while fatigue and insomnia was 50% and 49% respectively [9].

The findings were concrete as in fatigue is common in post TBI patients. Insomnia and

depression are closely associated with fatigue. Clinical and research investigations of fatigue in post-traumatic brain injury should include screening for treatable depressive symptoms and sleep disorders [9].

These cursorily reviewed articles indicate some of the affects and symptoms of what TBI's can do. There is still more research to do, according to the implications, it warrants research on efficacy of treatment, effects and symptoms. There is increasing interest in this subject as more and more individuals will begin to self-report a head injury or concussion and information will continue to grow with continued investigation and because of the many parts of the brain that could be affected by a TBI. The following section will hopefully sensitize clinicians to the various realms with which they need to investigate, be sensitive to and adjust their counseling style and techniques and intervene where appropriate.

2. MEMORY

In terms of memory, clinicians need to be aware that both short term and long term as well as working memory may be hampered or impacted by the head injury. Therefore, the counselor may want to repeat certain key statements or phrases to ensure that the client recalls important interventions. One of the most important things for a person with a head injury to understand and grasp is that if they become frustrated, they either need to ask for help or assistance and if assistance is not forthcoming, they need to stop the activity and then re-attempt whatever task the next day. This is important in terms of fine motor activities that often are exasperating and frustrating for the individual.

In terms of long term memory, the client may or may not remember their pre-accident functioning or they may have forgotten key aspects of what transpired before the accident, or may even have forgotten, for whatever reason, the names and faces of loved ones or even have difficulty retrieving the names of family member or friends.

Obviously, the person with a head injury may experience much difficulty when asked to perform multiple tasks at work, and may need to only attempt simple one step rote repetitive tasks. The client may also have forgotten simple smells or a perfume or fragrance that a mate or spouse wears. While this may not seem like a major issue, it does reflect some of the very

subtle nuances that individuals who have experienced a head injury face during their recovery which can last from six months to two years depending on the extent of the injury and the rehabilitation process.

3. ATTENTION

Obviously, a client who has had a head injury may have difficulty processing or paying attention to a counselor for 45-50 minutes. Their attention may wander and they may have difficulty with focusing on a specific issue that needs to be addressed. Some individuals may have difficulty in terms of school- and may attempt to return to school too soon, and thus experience failure.

In some instances, a phenomenon known as "neuro-fatigue" is seen, meaning the individual falls asleep during a class or lecture presentation. It is presumed that this is a part of the recovery process. Teachers however may be exasperated and believe that the student should be at the very least be home recuperating rather than sitting in a classroom, falling asleep.

In such instances, it is imperative that the person who has experienced the head injury or brain damage receive a fairly comprehensive evaluation before deciding to return to school. Further, depending on their vocation, it may be quite difficult for that person to return to work if his or her position or occupation relies heavily on extended attention for long periods of time.

In terms of inter-personal issues, a client with a head injury may have difficulty paying attention to a spouse or mates conversation or questions for long periods of time.

4. CONCENTRATION

Certain activities do require a good deal of sustained attention. For example, driving a motor vehicle in a large city is a task that demands a good deal of sustained visual attention- both to the front of the road and on certain instances to the rear and to the sides of the vehicle.

Accidents can occur, and some may be due to lack of concentration, while others may have been caused by a delayed reaction time. Many individuals attempt to return to their previous occupation too soon, and they need to be cautioned about the dangers also, of attempting to operate machinery.

5. LEARNING

New tasks may present with a great deal of difficulty for the individual who has sustained a head injury. These new tasks could range from things as simply as adjusting to a new microwave in the home to adjusting to a new Calculus class in college or a new instructor. Often skills such as operating a vacuum cleaner may have been lost, but even learning a new person's name can result in some frustration. Those who have a low frustration tolerance may need additional help in terms of coping with new individuals, new physicians and new personnel, for example a new physical therapist if they have had a physical issue or trauma.

6. REASONING

For some individuals their logical, rational, reasoning abilities may be impacted by a head injury. A person who was once the most systematic, organized person in their workplace suddenly becomes an individual who is driven by emotions- fear, anger, frustration and other negative emotions. Depending upon what part of the brain has been damaged, this could prove quite problematic. Some individuals might try to self-medicate with alcohol or other over the counter drugs. A wife may need to know that her loving, caring, nurturing husband may be irritable, cranky and agitated at times.

7. PLANNING

For some individuals, they may only be able to plan ahead to their next meal. They do not conceptualize as to what is going to transpire next week, next month or next year. They are in survival mode and are attempting to cope with their new identity as a "brain damaged" individual as best they can. Further exacerbating the issue is the fact that others see no physical damage- no arm in a cast, no ankle or arm being supported by a sling, and no neck brace. Thus, people expect that the person is "fully recovered" although they may have pretty serious limitations.

8. EXECUTIVE FUNCTIONING

For some people, their lives revolve around major events to come. As I type this, this author is approaching Christmas with all of the parties, presents to buy and things to do in terms of cards and phone calls and the like. In order to

keep up with all of the required necessities, one must have a good deal of skills to cope with multiple priorities- as well as the daily or monthly priorities such as paying the gas and water bill or electricity or car insurance payment. Often it may be necessary for another individual to take over those tasks and deal with the family checkbook, and make sure that it is balanced and that there is sufficient funds to cover all checks written.

9. PROBLEM SOLVING

Every day, we all encounter certain difficult situations or problems For the person with a head injury navigating from one room of the house to another is a difficult problem. Remembering where one placed their purse, wallet or keys is another task to be managed.

9.1 Language and Communication Problems

Depending on the part of the brain that has been damaged, and the type of injury (gunshot wound or baseball bat), the person may have severe expressive or receptive language difficulties. They may seem perplexed at this dilemma and become agitated, or may want to withdraw from all verbal activities.

9.2 Retrieval Problems

Recalling a specific name or a person of interest from the past is often a key “tip of the tongue” difficulty for some individuals. They are able to “see” the person visually in their, minds but are not able to retrieve the person’s name. They may be able to recall where and when they met- but not recall their occupation or name.

10. LEARNING NEW INFORMATION

In terms of learning new information, the individual who has just experienced a head injury may be eager to return to school or to work- where new tasks confront them. They may appear disoriented and confused and may need to have directions written down for them, and rote repetitive tasks demonstrated several time before they are able to complete said tasks. Exasperation and frustration invariably follow. It may be necessary to video tape said directions with demonstrations or to rehearse new procedures several times. In terms of returning to a college class, it would be wise to ascertain their

pre-return function at least with some minimal academic screening.

11. FAMILY / MATE / SPOUSE / PARTNER ISSUES

The children of said individual who has had a head injury need to understand that the recovery period for a head injury may be between 12- 18 months, depending on the person’s age and pre-accident functioning. While the child may see an ambulatory parent, that parent is still in the process of recovery and they may be having difficulty sleeping or even eating or interacting.

12. SEXUAL FUNCTIONING

Depending on the location of the head injury and age and amount of brain damage, all too often the individual’s sexual functioning is either diminished or in some cases even increased. Spouses and partners need to be aware of the impact of a head injury on survivors and attempt to understand the daily functioning and drives and desires of their significant other. With some individuals there may also be physical pain and a significant other needs to understand the issues with pain management and whether the pain is chronic or acute. There may also be sleep issues- perhaps due to pain and on the other hand, neuro-fatigue is often seen in youth and adolescents as they sleep quite a lot during the day, and this causes consternation to teachers and guidance counselors in the schools.

13. JUDGMENT

Often a person with a head injury may arrive at counseling in the middle of the winter wearing shorts and a t-shirt and be oblivious to the weather and the elements. Such individuals need to be prompted for the weather and caregivers need to recognize that they may be so focused on not being late to their counseling session, that they forget the rain, the snow and the wind and other things. Said individuals may be in denial and may also say hurtful, harsh, acerbic things (such as you are really fat or ugly or something vitriolic and derogatory) and may also have difficulties with social boundaries. Often this is reported by a caregiver or significant other.

Rehabilitation is often a problematic endeavor as the person with a head injury may present with multiple concerns, thus making rehabilitation,

and recovery difficult and problematic [10]. This paper has attempted to provide more in depth analysis and build on the work of Maucieri [11] in attempting to assist counselors working with individuals with open or closed head injury or perhaps severe concussion.

14. CONCLUSIONS

This paper has reviewed some of the recent salient literature on the treatment of open and or closed head injury and has attempted to provide an overview of some of the clinical and cognitive and counseling concerns counselors will encounter when working with an individual who has experienced a head injury.

CONSENT

It is not applicable.

ETHICAL APPROVAL

It is not applicable.

COMPETING INTERESTS

Authors have declared that no competing interests exist.

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