THE ROLE OF PSYCHOTHERAPY IN NEUROREHABILITATION

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Understanding the Need
Four Forms of Psychological Issues Seen Following Brain injury

1. Direct result of injury – neuropsychologically based
2. Reactions to the injury and its effects
3. Reaction to changes in life spheres
4. Pre-existing psych disorders – may be exacerbated
Psychosocial Outcomes Following TBI

Multi-determined:
1. Severity and site of the injury
2. Pre-injury behavior and personality
3. Psychosocial adversity
4. Presence of post-traumatic seizure disorder
Ruff’s Patient-Based Model

1. Social Domain
   - loss of relationships and isolation

2. Recreational Domain
   - loss of outlets, connections and identity

3. Financial Domain
   - loss of income, added expenses, uncertain future

4. Vocational Domain
   - identity, sense of competence, capacity to support

5. Self-Image and Meaning
SELF-IMAGE AND MEANING

WORK

FINANCIAL

PHYSICAL

COGNITIVE

EMOTIONAL

SOCIAL

RECREATIONAL

Ruff & Chester, 2014
Real Psychotherapy?
LIMITATIONS OF TRADITIONAL PSYCHOTHERAPY APPROACHES WITH TBI

- Reliance on insight/ self-awareness
- Reliance on memory/continuous processing
- Reliance on linguistic capabilities
- Concern about “organic” basis of distress
- Reliance on self-referral/motivation
- Other factors
PSYCHOTHERAPY IS:
An interactive process through which one is enabled to:

1. Remove obstacles or build skills that empower one to engage in life effectively.
2. Gain a clearer understanding of one’s unique self, including one’s strengths and limitations.
3. Gain a compelling sense of personal meaning and purpose in life.
Toward a Propositional Model

A. Initial Considerations
   1. The big questions
   2. Death to the false gods (Prigatano)
   3. The pre-injury / post-injury dualism (Ruff & Chester)

Neurosis is always a substitute for legitimate suffering.
Carl Jung
B. An Initial Formulation of the Role of Psychotherapy in Rehabilitation

1. Help the pt engage the rehab process more actively and effectively

2. Help pts cope with their “wounded soul” (Prigatano, 1991) or altered sense of self

3. Help pts resolve the question, “How can life be worth living after brain injury?” – needs to deal with work, love, and play (Freud; Ruff)
C. **Key Issues in Adjustment Post-ABI**

1. **Impaired Awareness of Deficits (IAD)**
   a. studies consistently support the importance of self-awareness in treatment outcomes
   b. inversely correlated with tx adherence (Trahan et al, 2006)
   c. inversely correlated with psych functioning
   d. poor self-awareness does not protect from adjustment issues – it’s a risk factor (Hoofien et al, 2005)

   **Levels of Awareness**
   a. anosagnosia
   b. intellectual awareness
   c. emergent awareness
   d. anticipatory awareness
Biopsychosocial Model of Awareness

Neuro-Cognitive

Awareness of Deficits

Psychological

Socio-Environmental

Ownsworth, Clare, & Morris, 2006
Self-Awareness
• Self-awareness of deficits
• Self-awareness of consequences of deficits
• Realistic Goal setting

Motivation
• Participation in rehab
• Compliance w/ tx
• Compensation
• Behavioral change

Emotional Reaction
• Depression
• Anxiety
• Catastrophic reaction
• Suicidal tendencies

Outcome

Fleming & Strong, 2010
2. **Depression** - associated with:
   a. poor psychosocial functioning
   b. poorer rehab outcomes
   c. increased functional disability
   d. reduced participation in ADLs
   e. reduced employment potential
   f. elevated divorce rates
   g. increased caregiver burden
   h. poorer community integration

(Cantor et al, 2005)
Incidence of Post-TBI Depression
1. Consistently exceed community base rates
2. Exceed intra-individual comparisons (Fann et al, 1995)

Causes of Post-Injury Depression
1. Increased disposition to TBI among those already depressed
2. Function of neuro injury (especially left frontal injury)
3. Reactive response to ABI effects (increases over time)

Impact of Post-ABI Depression
1. Diminished motivation for treatment
2. Diminished focus/attention
3. Increased irritability and other behavioral issues
3. Isolation/Disengagement
   a. Social isolation is a common long-term effect of disability
      1. mutuality shifts
      2. loss of skills and abilities to participate in life activities
      3. isolation from friends, work, and community
      4. isolation is enforced by difficulties preventing access

      1. 454 Canadians, average 13 yrs post-injury
      2. 75% not working
      3. 90% dissatisfied with social interaction
      4. 47% not talking with others by phone
      5. 20% never visit others
D. **Key Goals of Psychotherapy in Neurorehabilitation**

1. Preliminary Considerations
   a. need to harness intrinsic motivation (van den Broek, 2005)
   b. importance interacts with confidence in determining drive for change (Miller & Rollnick, 2002)
   c. method of interaction needs to account for deficits/characteristics of person served
   d. must consider how to measure outcomes
2. Acceptance of “Life as it is Now”

Driven by the “why me?”, “what now?” questions, some will see the search for meaning as central focus of therapy

a. Importance of self-awareness and acceptance of deficits in long-term outcome

b. Acceptance of disability as non-devaluing requires significant change in personal values
I am not what happened to me. I am what I choose to become.

—Carl Jung
c. Acknowledgment of problem ≠ agreement to work on it – must move toward commitment

d. As self-awareness increases, so may distress, along with various coping mechanisms

e. Individuals who present with defensiveness are more likely to respond to interventions that emphasize:
   - Building the therapeutic alliance
   - Non-confrontational approaches
   - Teaching adaptive coping strategies before changing
   - Using therapy to explore loss and promote acceptance
3. Management of Depression
   a. Exploration and resolution of the pre-post injury dualism
   b. Finding meaning and purpose in current life sphere
   c. Committing to activities that involve engagement and utilization of capabilities
   d. Focus on what is within their control
4. Optimization of Functional Independence
   a. Not about happiness but about power and self-control (Peck; Prigatano, 1991)
   b. Independence involves a realistic grasp of both strengths and weaknesses (see model)
   c. Once pt is aware and invested, can train compensatory strategies
   d. Selecting a treatment focus
      • subjective importance to pt
      • relevance to pt’s community reintegration and independence
      • likelihood of change via pt’s own actions
CONCEPTUAL MODEL OF FUNCTIONAL INDEPENDENCE

SELF - AWARENESS

AWARENESS OF LIMITATIONS
- SUPPORT

AWARENESS OF CAPABILITIES
- SUPERVISION
- SERVICE
- SELF-CARE

FUNCTIONAL INDEPENDENCE
e. Positive engagement in life & society (work, love, play)
Definition of Success