



**BRAIN INJURY
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No Brain Injury is
Too Mild to Ignore,
or Too Severe to
Lose Hope

What Families Need to Know About Community Mental Health Centers

By Carolyn Rocchio

Introduction

Life after brain injury can be very difficult for individuals and their families. The relief of a life sustained and the restoration of physical abilities often is diminished by the changes in personality, substance abuse and/or behavioral problems that may not develop until months or years post-injury. Many individuals leaving rehabilitation settings lack adequate discharge planning and, returning to the community with expectations that life will pick up where it left off prior to the injury. That expectation is seldom realistic and individuals with TBI and their families usually are unaware of the impact that impaired cognition has on day-to-day functional capabilities.

Without adequate structure and reinforcement, skills learned in rehabilitation may not generalize into real life settings. Over time, life may become chaotic for the individual and family members. These families in crisis often are directed to community mental health centers for help. Although these centers are staffed by licensed professionals, mental health counselors typically are not prepared or experienced in managing individuals whose cognitive and behavioral problems are a residual of traumatic brain injury (TBI).

Children and adolescents particularly are vulnerable to misdiagnosis when referred to community mental health centers for behaviors not readily associated with a blow to the head or a fall sustained earlier in life. It once was believed that the resiliency of the developing brain would allow children with brain injury to “outgrow” the problem and develop normally. Among others, Dr. William D. Singer, of the Department of Pediatrics at Harvard Medical School, has found that not only are children as vulnerable as adults to brain injury, but that it takes much longer for the effects of the trauma to be seen in a child. When a child advances through elementary school—even at a rate a little slower than his/her classmates—maturation creates greater stress and demands more responsibility for appropriate age-related behavior which the youngster may be unable to master. This often is the point at which parents reach out for assistance.

Once reaching puberty and beyond, many unwanted behaviors can become troublesome. Most professionals inexperienced with TBI or unfamiliar with the child’s history assume the behavior is typical teenage rebellion and treat it as such. Increased social and psychological pressures in the middle stage of adolescence come at a time when society expects the youth to behave in a more adult fashion (Nosphitz, 1979).



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Another complicating factor when counseling teenagers with problems—particularly those counseled by inexperienced professionals—is that the teenage years ironically coincide with the age in which schizophrenia appears in vulnerable adolescents. It is very important that treating counselors are aware when there is a history of brain injury, rather than basing treatment solely on the behaviors observed. It has been estimated that up to 15% of schizophrenics have had significant brain injury that preceded the first psychotic episode (Lishman, 1978). Although the IQ usually remains in a normal range and the CT scans can be negative, neuropsychological evaluation is more likely to determine the extent of focal deficits. Appropriate treatment options should include rehabilitative efforts to improve cognitive and psychosocial skills and/or a pharmacological and psychotherapeutic approach.

Frequently, adults with brain injury, whether voluntarily or involuntarily, are referred to community mental health centers for behaviors that are judged bizarre, socially inappropriate, combative and/or self-destructive, as well as for treatment of substance abuse. In the absence of appropriate evaluation, treatment and support by families and employers, adults with mild brain injury also seek help from community mental health agencies. They often describe their feelings as “going crazy” when those around them fail to understand the changes that affect the way they think and act.

Resolving Issues

Although solutions are limited, mental health counselors need to: (1) know how TBI differs from psychiatric disorders, (2) possess good intuition and (3) have the cooperation of the family. One of the first principles in working with individuals with brain injury is understanding and accepting that no two brain injuries ever are the same. Naturally, there are commonalities, but each individual presents with his/her own strengths and weaknesses, all which must be determined before substantive gains can be made. Secondly, individuals with TBI know the person they were before the injury but may lack awareness and insight about ways they have changed.

Damage to the frontal and temporal lobes of the brain (most common to vehicular crashes) creates persistent cognitive difficulties which, without therapy to develop compensatory strategies, ultimately creates psychosocial dysfunction. The family is a very important support component. Individuals with TBI cannot be treated in isolation, and family input about premorbid personality, characteristics and level of functioning is critical. There is no “fix” for brain injury; however, support systems make a difference in quality of life.



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It is difficult to discriminate between those behaviors that are organic in nature and others that are functional and usually represent a response to disability. Many of the organic disorders usually are not improved with traditional psychotherapy because learning and insight do not support new learning (Blanchard, 1984). Additionally, addiction programs seldom provide the necessary assistance in eliminating substance abuse due to the impaired memory and cognition seen in most individuals with brain injury. It is helpful for the Alcoholics Anonymous (AA) sponsor to become familiar with the specialized 12-Step Program for individuals with brain injury. Structured environments enforced by families are vitally important for individuals unable to organize their day productively.

Seizures originating in the temporal lobes of the brain are common after TBI and often develop as long as three and five years post-injury. Families need to be alert to the symptoms of seizures (i.e., behavioral changes, complaints of smelling foul odors, light sensitivity, hallucinations, random and restless activity). If an individual reports any of these symptoms, he/she should be evaluated by a neurologist. Most seizure activity can be controlled well with medication.

Counseling Persons with Brain Injury

Some counseling techniques used with clients with TBI include behavior modification, Rational Emotive Therapy (RET) and reality therapy. Of these, reality therapy offers the best opportunity for mental health counselors because of its use in a wide variety of settings and its emphasis on problem solving. Some aspects of RET (i.e., role playing, modeling and skill training) may be useful with clients with TBI, but critics argue that it is an over-intellectual approach. Behavior modification is more useful in the earlier stages of recovery and rehabilitation where there is consistent reinforcement. Regardless of which method is used, all individuals with TBI present a unique challenge to the counselor (Blanchard, 1984). Group counseling particularly is helpful because it provides socialization and peer interaction that can offset some of the isolation and loneliness universally experienced by people with TBI. It gives them an opportunity to practice interpersonal and functional skills in a supportive and structured setting.

Conclusion

In summary, families often must work cooperatively with community mental health counselors to bring about satisfactory outcomes for their family member with brain injury. Counselors can be sounding boards for individuals in need of an empathic listener.

Counselors also can suggest ways for improving the atmosphere in a home in which uncontrollable behavior may be causing chaos. Psychosocial behavior is a common residual of TBI and can be managed utilizing a



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combination of: (1) strategies to compensate for deficits, (2) structure to decrease anxiety and (3) meaningful activities to increase self-esteem. Families should work in concert with mental health counselors to reinforce behavioral strategies and monitor performance which, in turn, should create a more harmonious home atmosphere.

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