Lessons Learned Related to the Interface of Acquired Brain Injury and Developmental Delay

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Outline

• Theoretical Considerations:
  • Normal Development
  • Moral Development
• Brief Literature Review of Acquired Brain Injury (ABI) in Children and Adolescents
• Psychosocial Factors:
  • Personality Disorders
  • Digital Communication
  • Victimization and Cyber Aggression
• Clinical Observations of Patients with ABI and Families in Post-Acute Neurorehabilitation
• Lessons Learned and Treatment Interventions for Patients and Families
Theoretical Considerations:

Normal Development

Moral Development
Normal Development

• Children are not small versions of adults
• Need to understand child development to appreciate cognitive, emotional, physical, social, and educational growth
• Are many theories, including:
  • Sigmund Freud: Stages of Psychosexual Development
  • Erik Erikson: Stage Theory of Development
  • Behavioral Child Development Theories: How experience shapes who we are
Normal Development: Theories (cont’d)

• Piaget: Stage theory of cognitive development

• Social Child Development Theories: How social influences impact development

• John Bowlby’s Attachment Theory: Role of early relationships with caregivers

• Albert Bandura: Social Learning Theory

• Vygotsky Sociocultural Theory

(Cherry, 2016)
Normal Development: Relevant Constructs

• **Ego identity** (beliefs, ideals, and values) develops through social interactions and provides an integrated and cohesive sense of self (Erikson)

• Stages of development require **competence and mastery** (Erikson)

• Intelligence grows and develops through a series of stages using schemas, assimilation, accommodation, and equilibration (Piaget)

• There are “**critical windows**” of brain development related to brain organization and white matter growth (Cherry, 2016; 2017; Compas et al., 2017; Haarbauer-Krupa et al., 2017)
## Erikson’s Stages of Development

<table>
<thead>
<tr>
<th>Stage</th>
<th>Psychosocial Crisis</th>
<th>Basic Virtue</th>
<th>Age (yrs)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Trust vs. Mistrust</td>
<td>Hope</td>
<td>0-1.5</td>
</tr>
<tr>
<td>2</td>
<td>Autonomy vs. Shame</td>
<td>Will</td>
<td>1.5-3</td>
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<tr>
<td>3</td>
<td>Initiative vs. Guilt</td>
<td>Purpose</td>
<td>3-5</td>
</tr>
<tr>
<td>4</td>
<td>Industry vs. Inferiority</td>
<td>Competency</td>
<td>5-12</td>
</tr>
<tr>
<td>5</td>
<td>Ego Identity vs.</td>
<td>Fidelity</td>
<td>12-18</td>
</tr>
<tr>
<td></td>
<td>Role Confusion</td>
<td></td>
<td></td>
</tr>
<tr>
<td>6</td>
<td>Intimacy vs. Isolation</td>
<td>Love</td>
<td>18-40</td>
</tr>
<tr>
<td>7</td>
<td>Generativity vs.</td>
<td>Care</td>
<td>40-65</td>
</tr>
<tr>
<td></td>
<td>Stagnation</td>
<td></td>
<td></td>
</tr>
<tr>
<td>8</td>
<td>Ego Integrity vs.</td>
<td>Wisdom</td>
<td>65+</td>
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<td>Despair</td>
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(Cherry, 2017; McLeod, 2013)
Normal Development: Relevant Constructs (cont’d)

• Learning occurs by observing the actions of others, and requires attention, retention, reproduction, and motivation (Bandura)

• Intrinsic reinforcement = internal reward (pride, satisfaction and a sense of accomplishment) and development of self-efficacy (Bandura)

• Parents, caregivers, peers, and the culture influence higher order functions (Vygotsky) (Cherry, 2016)
Theoretical Considerations: Moral Development

• Definition of morality: a code of values and conduct, including empathy, gratitude, a sense of fairness, feelings of reciprocity, consolation, righteousness, and group loyalty (Mendez, 2009; Pascual et al., 2013)

• Guilt, shame, gratitude, compassion, humility, pride, fear of negative evaluation; strong motivators; and decisions about right and wrong (Eslinger et al., 2009; Marazziti et al., 2013; Mendez, 2009; Young & Koenigs, 2007)
Theoretical Considerations: Moral Development (cont’d)

- A biology X environment interaction can emerge when a child with impaired social-emotional functioning (early prefrontal lesions) in combination with dysfunctional peer and caregiver interactions → failure to build appropriate scaffolding for the child’s moral development (Taber-Thomas et al., 2014)
Kohlberg’s Stages of Moral Development: Pre-Conventional Morality

- Stage 1: Obedience or Punishment Orientation
  - Young children: Rules are fixed and absolute
  - Obey rules to avoid punishment

- Stage 2: Self-Interest Orientation
  - Older children: Others have goals and preferences
  - Can negotiate
  - “What’s in it for me?”
Kohlberg’s Stages of Moral Development: Conventional Morality

- Stage 3: Social Conventional Orientation

- Stage 4: Law and Order Orientation

- Stage 4.5: The Cynic

- Adolescence: live up to social expectations (what good boys and nice girls do)

- Adulthood: look at whole society to make judgments
  - Follow rules; respect authority
  - College students: “do your own thing”
Kohlberg’s Stages of Moral Development: Post-Conventional Morality

• Stage 5: Social Contract Orientation
  • Differing opinions about right and wrong
  • Majority decision and compromise
  • Fight to have “bad” rules change
  • Abstract reasoning
  • Put oneself in others’ shoes
  • Conscience; follow universal ethical principles

• Stage 6: Universal Ethics Orientation

Stages of Moral Development:
Integrated Model by Piaget (1932); Kohlberg (1975); Rosen (1980)

- Stage 1: Respect for Power and Punishment
- Stage 2: Look Out For #1
- Stage 3: Be a “Good Boy”/“Nice Girl”
- Stage 4: Law & Order Thinking
- Stage 5: Justice Through Democracy
- Stage 6: Decide Personal Basic Moral Principles

(Tucker-Ladd, 2010)

- Ages: 1-5 yrs.: do what you want; avoid punishment
- 5-10 yrs.: self-serving
- 8-16 yrs.: seek approval; conform to others
- >16 yrs.: have internalized society’s rules
- >Mid 20’s: live by law; change if necessary
- Rare: decide life philosophy to guide life; true to their values
Developmental Milestones: School Aged Children

Cognitive/Social/Emotional
- Developing perspective taking
- Logical thought/concrete
- Developing coping skills
- Understand how behavior affects others
- Self-esteem based on performance

Maltreatment Effects
- Poor social adjustment
- Easily frustrated/emotional outbursts/anxiety
- Poor impulse control/immediate gratification/give up easily
- Emotional extremes
- Acting out (e.g., aggression)

### Developmental Milestones: School Aged Children (cont’d)

#### Cognitive/Social/Emotional
- Understands right and wrong
- Need rules to guide behavior
- Begins to understand social roles
- More team play
- Avoids punishment

#### Maltreatment Effects
- Mistrustful/attachment problems
- Manipulative/conduct disorders
- Unrealistic
- Unable to initiate/participate in activities
- Difficult peer relations
Developmental Milestones: Adolescents

Cognitive/Social/Emotional
- Think hypothetically, abstractly, and logically
- Self-assess and problem solve
- Insight and perspective taking
- Identify with peer group
- Golden Rule morality
- Identity formation
  - Younger: rely on peers
  - Middle: examine others’ values and beliefs

Maltreatment Effects
- Possible identity confusion
- Poor self-esteem
- Unrealistic
- Self-defeating, impulsive, or aggressive behavior
- Labile with mood swings
- Difficulty forming peer relationships
- Depression, anxiety, PTSD; attachment problems; conduct disorders

Theoretical Considerations: Neurobiology of Moral Development

• Healthy adolescents undergo neurological changes with synaptic pruning/gray matter density changes; myelination/white matter volume and density changes; development of the prefrontal cortex and improved communication with other brain regions (Kambam & Thompson, 2009)
Neuroanatomy of moral behavior implicates the orbitofrontal and ventrolateral frontal lobes; dorsolateral prefrontal cortex; amygdala; insula; subcortical limbic area; anterior temporal lobes; and multiple connections with the thalamus and brainstem (Eslinger et al., 2009; Marazziti et al., 2013; Mendez, 2009; Pascual et al., 2013; Young & Koenigs, 2007)

Specific brain structures invoke both “emotional” and “cognitive” areas (Pascual et al., 2013; Young & Koenigs, 2007)
The possible circuits of the “moral” brain, with the ventromedial prefrontal cortex (VMPFC) representing the main integrating centre with all its connections to other cortical, limbic, hypothalamic and brainstem areas. (Marazziti et at., 2013).
Theoretical Considerations: Developmental, Socialization, and Cultural Factors in Moral Development

- Social-emotional development is affected by attachment, emotional competence, social competence, self-perceived competence, and temperament/personality (Denham et al., 2009)

- Young children show evidence of preliminary moral reasoning and decisions (e.g., sharing and sympathy) (Lapsley & Carlo, 2014; Malti et al., 2012)
Theoretical Considerations: Developmental, Socialization, and Cultural Factors in Moral Development (cont’d)

- **Demographic risk** (e.g., financial problems), maternal mental health problems, poor parenting interactions, low resilience, and low parenting morale increase child behavioral problems (Cabaj et al., 2014)
- A socialization model suggests that “moral agency” emerges from moral failures and social input (e.g., mother’s guidance) (Lapsley & Carlo, 2014)
- **Cultural norms** affect moral development and expression (Lapsley & Carlo, 2014)
Brief Literature Review of ABI in Children and Adolescents
Literature Review For Acquired Brain Injuries at a Young Age

- **TBI**: leading cause of disability in children and adolescents in the U.S. (Center for Disease Control and Prevention)
- 17,321 Arizona children sustained a TBI in 2008 (AZ Dept. of Health Svcs.)
- Outcome and quality of life are worse for more severe diffuse + focal damage, especially involving the frontal lobes (neurodevelopment of executive functions) and corpus callosum (Anderson et al., 2012; Compas et al., 2017; Di Battista et al., 2012; Ewing-Cobbs et al., 2008; Li & Liu, 2012; Rosema et al., 2012)
- The “theory of vulnerability:” earlier brain injuries affect the developing brain more (Li & Liu, 2012), including a lack of cortical thickening in the grey matter of the frontal and temporal lobes (Wilde et al., 2012)
- Brain damage → “arrested development” (Ewing-Cobbs et al., 2008)
Literature Review For Acquired Brain Injuries at a Young Age (cont’d)

- Consequences include **cognitive problems** (i.e., attention, language, intellect, memory, speed of thinking, and executive functions), substance abuse, violent crimes, and jail (Anderson et al., 2012; Beauchamp & Anderson, 2013; Chevignard et al., 2017; Compas et al., 2017; Garcia et al., 2014; Gordon et al., 2017; Horton et al., 2010; Hung et al., 2017; Li & Lui, 2012; Pearson, 2014)

- **Academic achievement** is affected, including school readiness and learning capacities (numeracy and literacy) as well as insufficient school resources (Compas et al., 2017; Foy, 2014; Gabbe et al., 2014; Prasad et al., 2017)

- Behavioral, psychological, psychiatric, social, developmental, and functional problems abound and also affect family, home, school, community, and work environments and **quality of life** (Anderson et al., 2012; Beauchamp & Anderson, 2013; Di Battista et al., 2012; Foy, 2014; Ilie et al., 2014)
Externalizing behavior problems include:

- Outward manifestations (e.g., hyperactivity, aggression, conduct and oppositional-defiant disorders, bullying, risky behavior; also substance abuse)
- Poor social communication (Ilie et al., 2014; Kennedy et al., 2017; Ryan et al., 2013)

Internalizing behavior problems include:

- Inward manifestations (e.g., anxiety, depression, low self-esteem, and suicidality)
- Depression is related to limitations in activities, lost opportunities, loneliness, and grief and loss (Di Battista et al., 2014; Ilie et al., 2014; Königs et al., 2016; Li & Liu, 2012; Rosema et al., 2012)
Social dysfunction (e.g., exclusion and rejection) includes poorer adaptive behavior, reduced self-regulation, fewer friendships, and lower social cognition (emotion perception, social competence, social problem-solving, and communication pragmatics) (Anderson et al., 2012; Rosema et al., 2012; Ryan et al., 2013).

Most patients experienced peer victimization, in-person/cyber bullying, rejection, and stigmatization at school, resulting in depression, loneliness, and social isolation (Hung et al., 2017; Ilie et al., 2014).

There is diminished earning potential and a need for income supplementation (e.g., disability) (Compas et al., 2017).
Literature Review For Acquired Brain Injuries at a Young Age (cont’d)

• Youngsters show impaired generalization of learning to novel contexts (Königs et al., 2016)

• Psychiatric disorders (e.g., anxiety, mood), substance abuse, and overall poorer functioning can persist long-term (Alway et al., 2016; Chevignard et al., 2016; Wade et al., 2016)

• Environmental stresses and maladaptive parenting styles, poor family cohesion, parental distress, poor awareness, permissiveness (e.g., less supervision and structure), low socioeconomic status, and lack of a parent leader negatively affects outcome (including self-regulation and other executive functions) (Anderson et al., 2012; Compas et al., 2017; Di Battista et al., 2014; Li & Liu, 2012; Potter et al., 2011; Rosema et al., 2012; Wade et al., 2016)
Psychosocial Factors:
Personality Disorders
Digital Communication
Victimization and Cyber Aggression
Theoretical Considerations: Personality Disorders

- **Personality disorders** emanate from dysfunctional beliefs (schemas) and maladaptive strategies (Beck, 2014)
- Brain injury at a young age contributes to this due to the nature of the traumatic event and disruptions in perception, speed of information processing, affect, and internal controls (Beck, 2014)
- **Antisocial Personality Disorder:** (Beck, 2014)
  - Pervasively irresponsible
  - **Self-view:** feel victimized by society
  - **Beliefs:** feel entitled to break rules
  - **Overdeveloped strategies:** deception and thrill seeking
  - **Underdeveloped strategies:** responsibility, empathy, rule adherence, and behavioral inhibition
Theoretical Considerations: Personality Disorders (cont’d)

• Narcissistic Personality Disorder: (Beck, 2014)
  – Self-view: special and entitled to favorable treatment
  – Beliefs: deserve special privileges and am above the rules
  – *Underlying covert belief that he/she is unlovable and helpless
  – Overdeveloped strategies: transcend rules and ordinary limits
  – Underdeveloped strategies: show empathy and consideration, inhibit impulses, and social reciprocity
Theoretical Considerations: Digital Communication

• Digital Communication:
  - Texting: 88%
  - Instant messaging: 79%
  - Social media: 72%
  - Video Chat: 59%

• Developmental need for peer connections
• Imaginary audience comes to life
• Intermittent reinforcement schedule (sporadic rewarding messages)
• A way to see how they fit in.....
  but can be a source of social pain

(Underwood & Ehrenreich, 2017)
Theoretical Considerations: Victimization and Cyber Aggression

- **Cyber aggression**: behavior aimed at harming another person using electronic communications and perceived by the target as aversive.
- Up to a 40% report rate.
- Strong overlap between traditional and cyberbullying.

Causes depression, low self-esteem, anxiety, low academic achievement, loneliness, poor life satisfaction, substance use, somatic symptoms, and suicidal ideation. (Underwood & Ehrenreich, 2017)
Clinical Observations of Patients and Families after ABI in Post-Acute Neurorehabilitation
Post-Acute Neurorehabilitation: Clinical Observations of Patients

- School system is primary treatter and educator about ABI and has shaped the youth’s and family’s expectations and experiences.

- Limited therapy, education, and support results in poor awareness and acceptance of the disability.

- The school system’s limited resources can result in insufficient study skills, and decreased accountability and life skills.

- Lack of “real life” experience (including work) affects receptivity to neurorehabilitation recommendations.
Patients present with substantial behavioral, emotional, and communication pragmatic problems:

- Immaturity
- Poor self-regulation (e.g., impulsivity, poor safety awareness)
- Anxiety
- Poor social skills (e.g., clingy, overbearing, shy, withdrawn, poor choices/dangerous behavior)
- Attentional problems
Post-Acute Neurorehabilitation: Clinical Observations of Patients (cont’d)

• Emotional distress because they:
  – Are different than their peers
  – Need intensive neurorehabilitation
  – Have to use compensations that others do not (e.g., datebook, checklists, text to speech apps, etc.)

• Positive attributes:
  – Motivated to engage in an intensive therapy regimen
  – Motivated to attend school and work
Post-Acute Neurorehabilitation: Clinical Observations of Patients (cont’d)

• Depression:
  – Sleep disturbance/weight changes
  – Low energy/cognitive changes affecting concentration and memory
  – Crying
  – Social withdrawal
  – Low self esteem
  – Self-deprecation
  – Apathy
  – Guilt
  – Lack of motivation, joy, and pleasure
  – Hopelessness, helplessness, worthlessness, suicidal thoughts

• Fear and anxiety
• Embarrassment
• Irritability (snarky)
• Catastrophic Reactions

(Klonoff, 2014)
Post-Acute Neurorehabilitation: Clinical Observations of Patients (cont’d)

- Patients are using Internet dating sites to find a significant other.
- Patients and family members have greatly inflated work goals relative to their cognitive, language, psychosocial, emotional challenges.
- Neurorehabilitation oversight is seen as “micromanaging” relative to the “hands off” approach of school (1:1 at CTN vs. 1:100’s supervision at school).
Neurorehabilitation Challenges: Clinical Observations of Patients (cont’d)

- Slow learning curve in adopting compensations
  - Insufficient detail in note taking in their datebooks
  - Fluctuating scores on their Home Independence Checklists (HIC)
  - Difficulty setting priorities and problem solving (homework vs. social events)

- Inconsistency: hallmark of performance

- Difficulty with honesty and integrity

- Poor “professional behaviors” in group settings

- Trouble generalizing compensations to school/work environments

- Disinhibited social/sexual behavior
Post-Acute Neurorehabilitation: Clinical Observations of Parents

- Parents have unrealistic knowledge and expectations:
  - Overwhelmed after leaving the hospital and cannot absorb realities/resources
  - Do not know how/when to intervene
  - Confused about the capacity to attend college and career aspirations
  - Lack of knowledge of available resources over time
  - What to do when their child turns 18?
Post-Acute Neurorehabilitation: Clinical Observations of Parents (cont’d)

• Parents may be:
  – In denial
  – Do not want their child to fail
  – Engage in excuses making and minimization

• Difficult to “let go” and trust the professionals

• Family dysfunction related to skewed attention to the patient versus the siblings and spouse

• Family’s expectations that their child will “catch up” developmentally, cognitively, and socially and will “be fixed” by neurorehabilitation
Model of the Family’s/Support Network’s Psychological Health after Brain Injury

(Klonoff, 2014)
Lessons Learned: Treatment Interventions for Patients
Beneficial Treatment Interventions For Patients

- Focus on improving:
  - **Awareness**: knowledge about strengths and difficulties
  - **Acceptance**: coping mechanisms for the brain injury
  - **Realism**: good decisions about the future
- Intensive psychotherapy to address “arrested development” and “re-raise” patients through appropriate developmental phases
- Address the grief and loss process
- **Medications** to address distractibility, emotional lability, depression, anxiety, etc.
- **Psychoeducation** techniques (e.g., Patient Experiential Model of Recovery; catastrophic reactions)
Beneficial Treatment Interventions For Patients (cont’d)

- Concrete data-driven expectations (e.g., HIC and datebook scores)
- “Planned Failures” to hone awareness, acceptance, and realism
- Employ fair and consistent expectations and feedback
- Professional Behavior/Communication Pragmatics Logs
- Use of probationary status to teach accountability and to address problems with honesty and integrity
- Meetings with the Clinical Director (“principal”) to reinforce commitment, self-discipline, and follow through
- Recognize progress may be gradual with “peaks and valleys” (Klonoff 2010)
Cognitive Group: Communication Pragmatics Module

• Components:
  – Communication Pragmatics
  – Egocentrism and Perspective Taking
  – Establishing and Maintaining Relationships
Common Communication Pragmatic Difficulties after Brain Injury

- **Nonverbal communication** - inability to “read”/interpret social cues
- **Hyperverbality** - using excessive words and information when speaking or answering a question
- **Tangentiality** - difficulty staying on topic
- **Poor Turn Taking** - difficulty maintaining a balance in discourse and not interrupting conversations
- **Poor Etiquette** - lack of use of polite language
Common Communication Pragmatic Difficulties after Brain Injury (cont’d)

• **Disinhibition** - inability to inhibit or control inappropriate social behavior

• **“Snarkiness”** - irritability, grouchesness, low frustration tolerance

• **Egotistical Behavior** - self-centeredness and difficulty seeing others’ points of view

• **Flat Affect** - decreased facial expression and range of feelings/animation

• **Initiation** - difficulty starting a conversation

(Klonoff, 2010)
Egocentrism

- Compensations:
  - Think about your behavior!
    - Am I talking too much?
    - Am I asking more questions in groups than everyone else?
    - Use a log or keep a journal to track behavior
      - Be open to feedback!
      - Get frequent feedback and review it regularly
  - Make an effort to ask about others and learn more about them
    - If memory is a difficulty, make an effort to remember information and use compensations (i.e., note taking)
  - Get involved with team or community projects
  - Volunteer and give back to society!
Egocentrism (cont’d)

- **Compensations (cont’d):**
  - Make scripts and reminders on how to interact in certain situations
    - “Enough about me, what about you?”
    - “What’s new with you?”
  - Practice responding to someone else’s topic, comment, or question versus bringing up something about you
    - Talk *with* others, not *at* them
      - “Tell me more about that”
      - “What did you like best about...”
  - Don’t start every sentence with “I”
New Relationships

• Always use caution when meeting new people:
  – Let others know where you will be
  – Do not give out too much personal information
  – Do not leave a public space with people you have just met
  – Trust your instincts if you feel unsafe
  – Consider bringing a buddy along
Deepening and Maintaining Healthy Relationships

• Express positive feelings about that person:
  – Tell them what you like or appreciate about them
  – Be genuine

• Ask more information about them:
  – This is useful even with longstanding relationships
  – Ask about their thoughts or feelings about a topic
  – Try to understand more about the person
  – What are their goals or dreams?
Deepening and Maintaining Healthy Relationships (cont’d)

• Gradually disclose more about yourself
• Talk about your feelings/ ask about their feelings
• Generate new activities you can do together
• Offer your help for something that is important to them
• Be there when they need you emotionally or physically
• Compromise
Deepening and Maintaining Healthy Relationships (cont’d)

• What steps could you take to improve your current relationships? Identify a relationship and pick two things you could do to deepen that relationship.

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Beneficial Treatment Interventions For Patients

- Interface with school personnel through Individual Education Plan meetings and collaboration with teachers, counselors, and school personnel
- Work with the patient (and family) to teach them self-advocacy
- Supplement school requirements with clinic-based therapies, especially those that teach compensations for memory and executive functions and communication skills
Beneficial Treatment Interventions
For Patients (cont’d)

• Teach vocational skills through Vocational Group
  – Work modules – Farmer’s Market
  – Psychoeducation – ADA, résumé, job interview and application skills, work behaviors

• Expect longer lengths of stay to allow for intensive in-clinic treatment, at least one situational assessment with substantial hours and duties, and transition to competitive employment

• Educate the team about developmental phases and organic versus characterological factors
Beneficial Treatment Interventions For Patients (cont’d)

• Situational assessments to teach basic work skills and a work ethic

• Regular Work Skill Evaluation feedback by the supervisor with comparison with the patient’s (and therapist’s) ratings

• Monthly meetings with Vocational Rehabilitation (VR) Counselors and Ms. Ann Tarpy with patients’ creation of VR scripts
Beneficial Treatment Interventions For Patients (cont’d)

• Address social/psychosocial/life skill problems through “mini outings,” Friendship Group, Healthy Living Group, and Finance Group

• Enable healthy expression of emotion in Group Psychotherapy

• Learn leadership skills (e.g., Community Outings, lead “Milieu” sessions)
Beneficial Treatment Interventions For Patients (cont’d)

• Address transportation options:
  – Driving (adaptive driving tests)
  – Public transportation training:
    • Bus
    • Light rail
    • Dial A Ride

• Exposure to community groups, leisure, and quality of life
  – Role of Recreational Therapy
Beneficial Treatment Interventions For Families
Beneficial Treatment Interventions For Families

- Family functioning greatly relates to:
  - Early parenting styles
  - Involvement in neurorehabilitation and educational opportunities
  - Compliance with recommendations
  - Openness to psychiatric/psychotherapy interventions
  - Adequate supervision at home
Beneficial Treatment Interventions For Families (cont’d)

• Family functioning greatly relates to (cont’d):
  – Follow through at home with chores, responsibilities, etc.
  – Use of compensations (e.g., datebook)
  – Progress in improving awareness, acceptance, and realism
  – Degree of “burn out” in the parents/family
Beneficial Treatment Interventions For Families (cont’d)

- Intensive psychoeducation and emotional support of family members through meetings with the neuropsychologists, involvement in home visits, and attendance at the weekly Relatives’ Group
  - Improve their awareness, acceptance, and realism about the injury after-effects
  - Address grief and loss, depression, anxiety, frustration, denial, guilt, “catastrophic reactions by proxy,” “chronic sorrow,” identity and role changes, “cure vs. compensations”

(Klonoff, 2010; 2014; Roos, 2002)
Beneficial Treatment Interventions For Families (cont’d)

• Psychoeducation and emotional support (cont’d):
  – Discuss coping techniques (avoid personalization; understand “hurt the ones you love;” pick battles; focus on faith and hope)
  – Delegate responsibilities (tiers of support)
  – Obtain a referral for family psychotherapy for problematic family patterns
  – Utilize social workers for community resources/support
  – Embrace reading materials

(Klonoff, 2010; 2014)
Beneficial Treatment Interventions For Families (cont’d)

- Family Education:
  - Spot the need for close supervision (e.g., Smartphones and the Internet) and monitor cyber aggression/victimization
  - Function as the “frontal lobes by proxy”
  - Undergo compensation training (HIC, datebook)
  - Conduct regular home “milieu meetings”
Beneficial Treatment Interventions For Families (cont’d)

• **Family Education (cont’d):**
  
  – Improve awareness, acceptance, and realism about **attainable** work goals
  
  – Recognize that the **first job is not the last**
  
  – Help the patient find **healthy social outlets** (e.g., church groups, adaptive sports)
  
  – Encourage family members to **take care of their psychological health** (counseling, respite, etc.)

(Klonoff, 2010; 2014)
“Helpful Hints” and Tools for Parents to Cope with a Son or Daughter with an Acquired Brain Injury

• Understand developmental phases
• Watch for doing “too little” or “too much”
• Allow a normal process of separation and individuation
• Consider psychotropic medication, if needed
• Use stress reduction techniques
• Address “ambiguous loss”
• Transform and adapt by finding meaning in suffering
• Embrace the “realism” process
• “Let go” and embrace the “new normal”

(Boss, Roos, & Harris, 2011; Klonoff, 2010; 2014)
References


