

Social communication interventions for individuals with traumatic brain injury



**ASSIGN
BUSTER**

In the scope of acquired disorders there are multiple treatment approaches and intervention that utilize restorative and/ or compensatory strategies to help the individual attain a higher quality of life. Many acquired disorders treatment approaches focus on interventions for cognition, language, social communication, dysphagia and physical deficits (Papathanasiou & Coppens, 2017). These treatment approaches can be given in a variety of ways (individual therapy, direct group therapy, indirect group therapy, social linguistic therapy) and settings (inpatient, rehabilitation center, home-based) (ASHA 2018). For this paper, the focus will be on the social communication skills intervention of TBI Express, for individuals with Traumatic Brain Injuries.

ASHA defines a Traumatic Brain Injury (TBI) as “ a form of nondegenerative acquired brain injury resulting from an external physical force to the head or other mechanisms of displacement of the brain within the skull.” (ASHA 2018). The most common causes of TBIs are collisions, blast injuries/military combat injuries, falls and violent assaults. The severity of a TBI ranges from mild to severe and is based on the Glasgow Coma Scale, the length of unconsciousness and the length of posttraumatic amnesia at the time of injury. A mild TBI is described as a brief loss of consciousness (less than 30 minutes), memory loss of less than an hour and a change in mental status for less than 24 hours. Many mild TBIs go unreported because they are associated with concussions (Williams 2018). A moderate TBI is characterized as loss of consciousness and memory for 1 to 24 hours. With a moderate TBI there are also abnormal brain imaging results. A severe TBI on the other hand is a loss of consciousness and or amnesia that lasts more

than 24 hours. Many people who suffer from a severe TBI may be in a coma or vegetative state for an extended period of time (ASHA, 2018).

TBIs are broken down into two types: open/penetrating head injury and closed/ nonpenetrating head injury. The first type of TBI, open head injury, is an open wound from a foreign object (ex: bullet) with focal damage at the site of the injury. With an open/ penetrating head injury, the skull fractures and the meningeal layers of the brain are penetrated. The second type is a closed/ nonpenetrating head injury, is an indirect impact to the head, which causes diffused damage, instead of focal damage, to the brain. In closed TBIs the skull may or may not be fractured but the meninges are not penetrated (Papathanasiou & Coppens, 2017). There are two subcategories of closed/ nonpenetrating head injuries these are acceleration injury and non-acceleration injuries. Acceleration injuries happen when there is movement of the brain within the skull caused by a whiplash/ coup-contrecoup movement. With an acceleration injury there will be a contusion at the site of impact as well as the opposite side of the skull(ASHA 2018). A non-acceleration injury is usually caused by blow to the head and due to the restrained nature of the head at time of incident there is no acceleration or deceleration of the brain. Since there is no acceleration or deceleration, the damage is usually localized to the point of injury and may also cause damage to the meninges if the skull is fractured (Papathanasiou & Coppens, 2017).

Traumatic Brain Injury Deficits and Considerations

In the United States it is estimated that 3.2- 5.3 million individuals are living with long-term deficits from a traumatic brain injury (ASHA 2018). The long-term deficits of a TBI will vary depending on the severity (size/location) of the injury. These deficits can include physical, neurobehavioral, and cognitive-communication deficits. The most common physical deficits of a TBI include: headaches, fatigue, dizziness/vertigo, tinnitus, hearing loss, dysphagia, visual neglect/visual field cuts and changes in muscle tone (Williams, 2018). Neurobehavioral deficits often found in individuals with TBI include: depression, anxiety, flat affect, overt emotions, impulsivity, disorientation, agitation/combativeness and stress disorders. Examples of cognitive-communication deficits include: difficulty attention, perception, memory, executive functioning, and verbal/nonverbal communication (ASHA 2018). These deficits take a toll on the individual's everyday life in many ways including their ability to return to gainful employment, maintain or develop relationships, and engage in meaningful activity (Togher, McDonald, Tate, Rietdijk, & Power, 2016).

Besides type and severity of a TBI, the recovery and prognosis for individuals with TBI are affected by several other variables. The first variable is duration of coma/unconsciousness; the longer the individual is unconsciousness, the more damage and deficits they will have. The second variable is age, the younger the individual is the more likely they are to have less deficits, and the recovery will be swifter. The final variable is alcohol and/or drug use at onset; if the individual had alcohol or drugs in his/her system when he/she acquired the TBI, the extent of damage will be more because of the higher likelihood of hemorrhage, edema and cerebral hypoxia.(Williams 2018). Due

to the variability of these variables, the location and extent of the injury and other known deficits; a full evaluation by an interdisciplinary team (to include an SLP) is conducted to determine the client's prognosis and treatment.

Traumatic Brain Injury Evaluations

Before choosing a treatment approach or intervention to focus on with a person with a TBI it is important to do a full evaluation. This full evaluation should not occur until the later stages of recovery, although a TBI screening may be done in the earlier stages of recovery (Papathanasiou & Coppens, 2017). TBI evaluations should include a formal assessment tool like the Scales of Cognitive Ability for Traumatic Brain Injury (SCATBI) or the Functional Assessment of Verbal Reasoning and Executive Strategies (FAVRES), to help determine specific deficits. Another component of a TBI evaluation is the caregiver/client interview, with questions that address the client's premorbid verbal skills, literacy, interests, employment, education level, and medical issues. The SLP may also ask the client their areas of concerns/ deficits they have seen (Williams 2018). Reviewing the client's medical history and chart is also an important part of the evaluation, as it can give a lot information about the incident that caused the TBI, the length of unconsciousness, if they have hearing, vision, swallowing or other medical issues, etc; which can affect a client's prognosis/treatment plan. The last part of the evaluation should be an informal observation of the client, to see what deficits or abnormal behaviors the client displays (Papathanasiou & Coppens, 2017). During the evaluation it may become apparent that several interventions are needed to address an individual's deficits. Interventions for TBIs are either restorative or compensatory in nature. An intervention that is <https://assignbuster.com/social-communication-interventions-for-individuals-with-traumatic-brain-injury/>

used frequently with clients who have TBIs are social communication skill interventions.

What Are Social Communication Interventions?

Social Communication interventions are administered by Speech-Language Pathologists, with a focus on improving the client's conversational and social pragmatic skills. Common elements of social communication treatments are: educating communication partners on client's deficits, practicing social behaviors in daily social situations, coaching for challenging situations prior to the event and setting personal goals in relation to the individual's deficits (ASHA 2018). Some specific skills that may be targeted under these elements include: initiating conversations, using appropriate tones of voice, interpreting feelings/emotions, interpreting nonverbal communication, turn-taking, topic maintenance and topic selection (Papathanasiou & Coppens, 2017). Interventions that target Social Communication can be administered in a group, individually centered or a combination of the two. Many interventions also involve the caregivers/communication partners during the therapy session or as a practice partner in the home setting (Togher)

TBI Express Partner Training

A social communication treatment approach that involves the client and their communication partners is TBI Express Partner Training. The focus of TBI Express is to increase shared understanding/ communication between the individual with the TBI and their caregiver/ daily communication partners. TBI Express Partner Training is a 10-week program that was developed during a clinical trial in Australia. The results of this clinical trial showed that partners <https://assignbuster.com/social-communication-interventions-for-individuals-with-traumatic-brain-injury/>

who were trained on TBI Express experienced better interactions following the training (Togher, 2014). TBI Express can be utilized in both individualized therapy sessions and group therapy sessions. A study by blank showed how effective TBI express can be in both individual and group therapy. In this study...(Togher, Mcdonald, Tate, Rietdijk, & Power, 2016).

Benefits and Limitations of TBI Express

There are many benefits of implementing TBI Express in lieu of other social skill therapy groups. The first benefit is that the communication partner is involved in the entire therapy process instead of only being involved with the client's social skills homework. Another benefit of TBI express is that the SLP/clinician is able observe and assess how the client and their caregiver are communicating and can give suggestions based on what he/she sees during each session. The ability to observe the client and communication partner can also help the SLP to instill positive(think of word) and cut down on the client's abnormal social communication behaviors on the spot. The SLP can also let the client roleplay scenarios with their communication partner that they can implement at home and in real world situations. Through TBI express the client and their communication partner can find a common ground and come up with strategies to understand each other much quicker than when the communication partner is not involved with the therapy. The last benefit of use TBI Express as a social communication intervention, is the ability of the caregiver to hold the client accountable and give the client gentle reminders of the strategies they learned in therapy.

Although there are many benefits to TBI Express there are some limitations to consider. The first limitation being the time commitment for the communication partner. As stated previously, TBI express is a 10-week program, which involves the client and communication partner practicing consistently throughout the day. Not to mention that the program also involves having both the client and communication partner participate in therapy sessions 2 -3 times a week (Togher, McDonald, Tate, Rietdijk, & Power, 2016). For communication partners that do not have the ability to take time off work, due to financial burden or other reasons, the implementation of TBI Express for a client would not work. Another limitation of TBI Express is that the communication partner may not agree with the SLP's suggestions during therapy sessions. Or the communication partner may get frustrated with the client's slow progress and decide that the therapy is not working. A way to mitigate this limitation is to make sure that the client and their communication partner all understand the severity of the client's social communication deficits, how TBI Express works and that they understand the rationale behind the suggestions that the SLP gives during the therapy sessions (Togher, 2014). The last limitation of TBI Express is that it requires the client to have a communication partner. If the client does not have a support system or communication partner that they talk to very frequently, TBI Express will not work for the client. If a client does not have a support system, other group therapies that focus on social communication interventions would be a better fit for the client.

Conclusion

Traumatic Brain Injuries are very prevalent acquired disorder in the United States. Depending on the type and severity of the TBI, there are many long-term deficits that can impede on a person's quality of life. One long-term deficit that is present with a TBI is a deficit in social communication skills. Many interventions can be used to treat social communication skill deficits to include metacognitive strategies intervention, errorless learning, explicit training techniques and TBI Express that can be conducted in individual and group settings. TBI Express has been a clinically proven method of improving social communication skills between clients with TBIs and their communication partners (Togher, McDonald, Tate, Rietdijk, & Power, 2016). There are many benefits and a few limitations to using TBI Express partner training, but overall TBI Express is a good intervention to use for social communication skills intervention. As with any intervention, it is best to look at the client's goals, support system, other deficits, and secondary disorders before making a clinical decision. It is also important to implement functional and client-specific treatment goals, to include communication partners, to simplify tasks and then increase the complexity as the patient improves and to choose activities that resemble real-life activities for whatever intervention is chosen (Williams, 2018).

Citations

- American Speech-Language- Hearing Association (ASHA). (n. d.-a) TBI: Overview. *American Speech-Language-Hearing Association*. Retrieved November 19, 2018.
- Braden, C., Hawley, L., Newman, J., Morey, C., Gerber, D., & Harrison-Felix, C. (2010). Social communication skills group treatment: A <https://assignbuster.com/social-communication-interventions-for-individuals-with-traumatic-brain-injury/>

feasibility study for persons with traumatic brain injury and comorbid conditions. *Brain Injury*, 24 (11), 1298-1310.

- Papathanasiou, I., & Coppens, P. (2017). Aphasia and related neurogenic communication disorders. Burlington, MA: Jones & Bartlett Learning. 421-441.
- Togher, L. (2014, May 15). TBI Express Partner Training introduction. Retrieved November 18, 2018, from <http://sydney.edu.au/health-sciences/tbi-express/index.shtml>.
- Togher, L., McDonald, S., Tate, R., Rietdijk, R., & Power, E. (2016). The effectiveness of social communication partner training for adults with severe chronic TBI and their families using a measure of perceived communication ability. *NeuroRehabilitation*, 38(3), 243-255.
- Williams, M. (2018) TBI Student Handout powerpoint. Retrieved November 05, 2018, from <https://d2l.sdbor.edu/d2l/le/content/1097013/viewContent/6497793/View>.