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Psychotherapy after acquired brain injury: Is less more?

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Abstract

This paper considers the challenges and dilemmas facing psychotherapists working with neurological patients, and in particular those who work in the context of under-resourced brain injury rehabilitation healthcare systems. Through the subjective process of reflective practice integral to clinical supervision, the author attempts to identify five core aspects of psychotherapy intended to augment post-acute long-term rehabilitation programmes and interventions after acquired brain injury.

Keywords: psychotherapy, traumatic brain injury, clinical practice, rehabilitation

Introduction

Relative to other areas of healthcare, neuropsychological rehabilitation is a relatively young, but established and constantly evolving branch of applied neuropsychology. Clinicians working in neuro-rehabilitation services generally care for patients with many different forms of acquired brain injury, including for example Stroke, Traumatic Brain Injury, Meningitis, Encephalitis and other variants of Cerebral Infections, among many others. Most patients of working age who tend to come to the attention of these clinical services, have probably suffered a Traumatic Brain Injury. Unfortunately Traumatic Brain Injury has a high incidence among younger persons. Younger persons tend to be economically active and hence disability stemming from Traumatic Brain Injury cause significant burden to many countries’ fiscal and healthcare systems. Additional to well-known factors such as risk-taking behaviour among young males or vulnerability to falls among the elderly, Traumatic Brain Injury also has significant socio-political determinants. These include theatres of war and other conflict zones, poorly developed transport infra-structure, socio-economic deprivation and high crime rates, among others. Other forms of acquired brain injury, for example Stroke, may have significant lifestyle components, such as smoking, diet or lack of physical activity, in addition to many other co-determinants, for example age.

Many patients with an acquired brain injury are left with a complex range of impairment spanning physical, cognitive, emotional and behavioural domains. These impairments unfortunately are more often than not associated with significant, long-term disability, representing a dramatic and sudden change from pre-injury levels of functioning. In many cases the resulting disability can often be greater than the sum of the individual impairments. While much of the disability can be accounted for by the organic determinants of patients’ impairments, at least as much is almost certainly the result of additional environmental obstacles such as lack of availability of appropriate rehabilitation, physical barriers, discrimination and remote geographical area to list but a few. Indeed, Truelle, Fayel, Montreuil et al. (2010) highlighted the complex environmental and psychological difficulties many of these patients face every day. A potentially more subtle, but equally devastating socio-political barrier is the much less physical nature of post-acute disability after brain injury, coupled with an ill-informed belief among funders (and sometimes health professionals) that because psycho-social disability tends to be long-term, neuro-rehabilitation interventions do not “work”. This may in some countries perpetuate the problems of service provision, as it provides an “ideal excuse” where there is already a limited pool of available money, not to fund or develop services for patients with acquired brain injury.

There is now reasonably good evidence for the effectiveness of neuro-rehabilitation, and in particular neuropsychological rehabilitation after acquired brain injury (e.g. Caracuel, Cuberos-Urbano, Santiago-Ramajo et al., 2012; Cicerone et al., 2011; Cicerone et al., 2008; Cope, 1995), and even during the much later post-acute community rehabilitation stages (Powell, Haslin, & Greenwood, 2002). Continual developments in the field are likely to further increase the effectiveness of rehabilitation. Wilson (2011) in a recent paper summarised the top ten developments in neuropsychological rehabilitation over the past 3 years, including errorless learning and some of the more important theories underpinning brain injury rehabilitation. Furthermore, it has been argued that in order to continually strengthen the scientific basis for understanding neuropsychological rehabilitation, further research into neuro-plasticity is essential (Berhaechi, 2011) including brain connectivity (Cicerone, 2012). However, it is also very important to consider other factors, such as clinicians and researchers’ values underpinning rehabilitation research and interventions (Cicerone, 2012). Where neuro-rehabilitation interventions have been available, patients have derived at least some benefit. However, while physical and cognitive rehabilitation are emphasised in many neuropsychological rehabilitation programmes, more explicit assistance with emotional problems and the process of longer-term adjustment often do not receive the same degree of attention during a patient’s rehabilitation journey (Morton & Wehman, 1995; Truelle, Fayel, Montreuil, & Chevignard, 2010).
One of the potential problems in this regard is that very little in the line of treatment is on offer, for what can be a less “visible” disability. While physical and cognitive impairments are relatively easily observable, emotional problems and personality changes can be more difficult to detect. A possible further limitation to the allocation of specific resources for the rehabilitation and support of patients with emotional difficulties associated with long-term adjustment after acquired brain injury, is the limited options for a pharmacological “fix” at present. While clearly there is an important role and at least some evidence for the usefulness of medication in managing clinical symptoms of for example depression after brain injury, in isolation medication may fail to comprehensively address long-term behavioural changes, cognitive problems and emotional adjustment (see for example Fleminger, 2008). This is almost certainly due to the real nature of emotional difficulties in the context of acquired brain injury. It is likely that biological, psychological, and environmental factors are all at play (McAllister, 2008) in many patients’ clinical presentation after acquired brain injury. For example, patients’ increasing realisation of impairments and associated disability; lack of realistic opportunities to return to employment; education; financial hardship; loss of family role and social isolation all form part of the complex tapestry that determine and colour emotional problems after brain injury. And at present there are, in the strict sense of the meaning of the word, no “curing” drugs for these difficulties. Are there other options clinicians could potentially consider to help their patients in this area?

To address emotional difficulties in this rather complex context, other avenues are likely for some (but not all) persons with acquired brain injury to have more, or at least additional, potential for effectiveness in comparison to a mono-therapy approach consisting of medication only. However, it should always be remembered that pharmacological therapy can for many patients make it more possible for them to access other aspects of their rehabilitation, by addressing some of the troublesome physical symptoms limiting their ability to participate in these. In fact, in the UK practice guidelines support an integrated medical and neuropsychological approach to rehabilitation (Royal College of Physicians and British Society of Rehabilitation Medicine, 2003). For example, occupational therapy and psychological strategies to facilitate meaningful community integration can have a considerable effect on patients’ sense of wellbeing, but would require patients in the first instance to have the energy and drive to participate and benefit. Social support, including help with, for example, debt and access to suitable housing, often removes at least some of the primary barriers to living a life less trapped in disability and increase overall quality of life. At a more structural or societal level, effective anti-discrimination legislation may help with making re-employment or volunteering in some capacity a more realistic outcome after brain injury for some persons. But at an intra-personal or psychological level, to lay the seeds for these environmental, legislative and social policy initiatives to have lasting effectiveness, the person with brain injury might need something additional to augment their rehabilitation. It is here that psychological therapy appears to be, at present at least, one of the few realistic augmentative inputs which can be offered to make some patients’ rehabilitation more complete. Psychotherapy in brain injury rehabilitation contexts

Psychological therapy in the brain injury context really only started to enter and impact significantly upon the mainstream arena of neuro-rehabilitation following the early work of George Prigatano and colleagues (Prigatano et al., 1986) and others (e.g. Ben-Yishay et al, 1978) who applied the insights of early pioneers such as Kurt Goldstein (e.g. Goldstein, 1959) to develop psychotherapy as an approach within their Holistic rehabilitation programmes. Similarly, psychotherapy approaches as part of comprehensive neuro-rehabilitation also developed elsewhere in the world, including for example the United Kingdom (UK) (Wilson, Evans, Brentnall, Bremer, Keohane, & Williams, 2000; see also Salas & Wilson, this issue) and Continental Europe (Sarajuuri & Koskinen, 2006). Since this early work, more recent developments drawing upon existing theories in psychology - therapies include Mindfulness approaches (e.g. Aniskiewicz, 2007) Generic models and grief experience (Coetzee, 2007), Psychodynamic (Klonoff, 2010), Psychoanalytic (Kaplan-Solms & Solms, 2000), combined (Miller, 1993) and other integrated approaches (E.g. Judd, 1999) among several models adapted and developed for application within brain-injured populations. Cognitive Behaviour Therapy remains a popular approach also, especially in the UK (Wilson, Rous, & Spena, 2008) and probably lends itself to more systemic, empirical research than for example the more psychodynamic models. It is encouraging that more recently preliminary evidence for the effectiveness of psychotherapy with this clinical population has started to be reported (e.g. Bradbury et al, 2008; Doering & Exner, 2011; Hofer, Holfforth, Frischknecht, & Znoj et al., 2010), but further work in this area is much needed.

Can we learn anything from fields outside of psychotherapy? The first question should perhaps simply be if “more” is always the answer to service development. Inevitably a “more” approach risks producing the same answers and outcomes as in the past, and might also fail to advance our knowledge, stifling innovation. Many key developments in theory, technology and research have benefited from cross-fertilisation from other fields. However, this has often not simply been a process of addition (“more”), but rather that of rationalisation (“less”) to define and develop the essential elements constituting a new direction or concept. Following in the line of for example earlier German designers such as Rams who asserted that less is better, Steve Jobs, the late Chief Executive Officer of Apple highlighted that “simplicity is the ultimate sophistication” (Isaacson, 2011). Clearly this implies that resisting automatically resorting to the default reasoning that addition equals progress, instead defining the active ingredients of “what works” may often be more important. This is the opposite process – that of deduction and deconstruction. Applying this principle to psychotherapy, it is necessarily true that the most complex models and techniques, applied in very high intensities, are best for persons with acquired brain injury during the post-acute phase of long-term adjustment? Especially so if we also factor in the view that providing less fr...

quent, but more focussed therapies may reach many more patients than unaffordable (to the majority) high intensity, resource-hungry models.

Interestingly, in a similar vein Veale (2008), reasoning more generally about the clinical application of psychological therapy, and in particular Behavioural Activation as part of Cognitive Behavioural Therapy, pointed out the following. Clinicians need to perform the basic tasks of therapy, and repeatedly, in the course of our everyday psychological therapy work with patients (Veale, 2008). Indeed, this viewpoint may have particular application to psychotherapy approaches for working with brain-injured patients (see also e.g. Coetzer, 2010). While echoing the earlier more theoretical points made above about simplicity, deconstruction and efficiency, Veale (2008) perhaps also touches on an important value. It is potentially important that we (and per implication ultimately our patients) understand within the psychotherapeutic process, what exactly it is we are doing and the outcomes we are together working towards. Might too complex models and techniques have the potential to create a chasm of poor understanding and different expectations between therapist and patient, especially in a population where cognitive difficulties prevail? And do technique and protocols in psychotherapy always equate to certainty or efficiency?

A second value to consider is the question of who our patients are. Do we see only those who can pay for resource intensive post-acute neuro-rehabilitation and psychotherapy, or in publically funded systems, perhaps only those who satisfy very strict or narrow referral criteria? Do we see only very limited numbers of persons with acquired brain injury, because high-intensity, high clinician to patient ratio post-acute neuro-rehabilitation models cannot provide the throughput necessary to cope with the relatively large numbers of patients in society who need rehabilitation? Or, ultimately, is our value to give at least something to all, as opposed to all for some? Our values which underpin clinical practice (Ciccone, 2012) should be considered under these much less than ideal circumstances also. For many clinicians the humane value of reaching as many patients as possible would probably resonate.

We now return to the question of service development where there are severe resource limitations. Perhaps “throwing more money” at the problem of large numbers of patients who have little access to psychotherapy after brain injury is possibly not the most creative, or indeed, only answer. Providing more, as in many other aspects of life, may miss an important point. Indeed, as Spencer (2012), a UK General Practitioner recently put it, sometimes doing nothing is the best intervention in healthcare, and more should not always be seen as a better option. As regards managing more general health systems in the UK, Dr Foster Intelligence advises that less is more and that defining a few critical outcomes and their related process indicators is crucial (Cross, 2012).

From a more psychological or philosophical perspective, money cannot buy happiness, health or fulfilment under normal circumstances and almost certainly has no chance of doing so for brain-injured patients. Interesting, anecdotally, while many benefit tremendously, some patients actually eventually report feeling empty, depressed or disillusioned when they (sometimes after a very long delay) receive financial compensation after brain injury. “Is that the price they pay for my happiness, my ability to suffer?” is sometimes expressed. And ultimately, if a “cure” could be bought, would most patients not use all their compensation to purchase more neuro-rehabilitation input? Should we not instead for our patients simply do the basics well, repeatedly and compassionately, rather than necessarily much more frequently, but time-limited? A central question from this argument is if we can possibly identify some of the core aspects of long-term, “slow stream” psychotherapy provision with this population, which may have some potential to be offered to larger numbers of patients.

Five observations from clinical practice

In the spirit of less possibly being more, for the purpose of this paper I have as part of defining a continuous reflective practice set the difficult task of identifying and defining the five (among many) more personally salient subjective observations made about psychotherapeutic work over the past two decades of employment in state-provided brain injury healthcare systems. These observations relate purely to the techniques in the different psychotherapy models and theories, rather than the pragmatic and specific adjustments made to facilitate the application of these with this group of patients (see for example Coetzer, 2010, and Salas et al., 2013, for more about the latter). Substantial parts of this process of reflective practice have occurred during individual clinical supervision, including regular presentations of long-term cases. However, the five observations briefly described below should by no means be seen as representing anything else but purely subjective individual reflective practice as part of being a clinician. The main purpose is to hopefully initiate and stimulate further thinking and debate about this exciting area of clinical practice within the much broader field of neuropsychological rehabilitation. Undoubtedly there will be many other views and much better suggestions to emerge, should more neuropsychologists consider the not inconsiderable challenge of defining through clinical practice and research what it is that makes up the most basic, or “active” ingredient of psychotherapy with this population.

Cognitive Behavioural Therapy: “To know B or not to know B, is the question in CBT”

Let us first consider Cognitive Behavioural Therapy (CBT). At its heart CBT proposes that some thoughts make us feel bad and, more importantly, prevent us from doing things. An incredibly simple insight which has been around for centuries, for example “it is the view we take of things which disturbs us” as proposed by the philosopher Socrates. Indeed, this forms the foundation for CBT intervention, or cognitive restructuring. Most practitioners would be very familiar with this very basic CBT paradigm or philosophy, even if it is not always completely accurate. While clearly factors other than thoughts can and do affect behaviours and emotions, there is much pragmatic value for psychotherapy, irrespective of approach, in an awareness of our inner language and how this can sometimes affect a person. Perhaps this very basic premise of CBT can where appropriate be applied in the moment, rather than necessarily exclusively as part of “formal” CBT. It is possible that CBT can be especially effective when used in this more experiential way if and when unhelpful or frightening thoughts present in sessions during psychotherapy work with our patients.

Unsurprisingly, CBT is fairly widely used in neuro-rehabilitation settings, but it has been pointed out that it needs adaptation for working with this clinical population (Manchester & Wood, 2001). While certainly CBT can on many levels be complex, at a simple, pragmatic level of application as suggested above, when working with brain-injured persons, it may also have a few other desirable psychological benefits. If kept simple, a thought restructuring intervention may be easy for the person to “hold on to” or remember, and may have the potential to almost function as a mantra. Indeed, using mantras as a technique can be very helpful in brain injury rehabilitation (Klonoft, 2010). Using a strategy for remembering the process of CBT itself can also potentially function as a mantra. For example, some of my patients have reported finding it helpful to refer back to a simple mantra we use in psychotherapy: “Thoughts are thoughts, nothing more, nothing less, facts are facts”. In a metaphorical sense, this can sometimes result in a valuable “pause for thought” strategy outside of the clinical setting, countering for example apathy, impulsivity, worrying or misinterpretation of situations. The use of personally salient metaphors also lends itself to facilitate more complex, dynamic work such as reconstruction of identity after brain injury (Ylvisaker, McPherson, Kayes, & Pellett, 2008).

Acceptance and Commitment Therapy: “You need values to ACT”

Acceptance and Commitment Therapy (ACT) is complex model of psychotherapy, drawing upon different fields within psychology (including behaviourism) and philosophy. As an extension and development of the first point above regarding CBT, the following key principle from this approach may possibly represent one of the primary “active ingredients” for work with brain-injured persons. The component in ACT, or indeed other “Third Wave” therapies that may be most valuable for our patients, is possibly cognitive defusion. In the ACT model, cognitive defusion involves to some degree that the clinician through experiential tasks guide patients to recognise their changing event or changing event. But for our patients views of having suffered a brain injury are entirely reasonable and appropriate (that it is a life-changing event for any person that cannot be rationalised away). Furthermore, persons with brain injury can also sometimes struggle with generating and flexibly manipulate thoughts, and by default acceptance may be a more functional option than changing the way events are thought about.

The ACT model proposes an alternative approach to the classic cognitive restructuring approach often seen in CBT: Facilitating, identifying, undercutting
standing and pursuit of values or goals instead of changing thoughts per se, using for example techniques such as metaphors, represent a core difference from CBT. Where patients are tormented by rumination over thoughts and therapy reaches an impasse, they can be guided to simply be aware of these thoughts and instead identify more strategically how they would like to live their lives. For example, the values in the ACT model may overlap, or augment many aspects and therapeutic goals of Behavioural Activation in CBT, and indeed aspects of Post Traumatic Growth (see for example McGrath, 2011). These couple of aspects of ACT outlined here, as well as the other characteristics represent the main thrusts of Kangas and McDonald’s (2011) paper, as well as an earlier paper by Myles (2004), on the potential for ACT to be a psychotherapy approach well-suited for persons with acquired brain injury. Furthermore, one of the very important other points these authors (Kangas & McDonald, 2011) made was that at some (meta-cognitive) level, while very structured, CBT may actually possibly be too complex to for some of our patients to internalise (Kangas & McDonald, 2011). This may potentially reduce the chances for in-session therapeutic gains to generalise to patients’ everyday lives.

Humanistic therapy: “To be heard, listen”

The key aspect from the Humanistic approaches that we can possibly all be much more aware of, is to listen, and listen more compassionately. This is of course important for many reasons, but perhaps also because listening is possibly one of very few effective and credible vehicles for the expression of compassion between humans. Furthermore, important functions of listening relate to the therapeutic relationship. These include helping to engage those who are sometimes very difficult to “hook” to participate in rehabilitation, including psychotherapy; or as a way to remain in the moment with a patient; or as a simple but very effective compensatory strategy for cognitive difficulties such as poor information processing. We can still learn a lot from the pioneering work of Carl Rogers (see for example Rogers, 1961) in this area. It is through our own active listening, that patients may ultimately become open enough to hear the therapist’s messages as being congruent with their own narrative. In some ways then, we cannot always “talk things right” (convince a person), and perhaps ‘talking therapy’ is possibly more ‘listening therapy’ than we think? Listening effectively to hear what exactly our patients are trying to convey to us, can be complex and require considerable focus in view of the cognitive, emotional and behavioural changes that accompany brain injury. As Prigatano (1991) very eloquently put it, neuro-rehabilitation should not only treat the impaired mind (cognition), but also the soul (emotions). Indeed, it is a basic principle in humanistic psychology that a person has an internal self-knowledge, which through psychotherapy is assisted to emerge, which relies heavily on therapist listening skills. In addition to technical competence, clinicians should also listen with an openness to learn from their patients. Openness is the antithesis of self-centeredness, possibly one of the more problematic obstacles to effective psychotherapeutic work, however subtle or sub-conscious, and can be associated with considerable transference and counter-transference during the psychotherapeutic process.

Interestingly, there is some suggestion that the therapeutic relationship, irrespective of the type of psychotherapy practiced, is one of the more robust factors associated with better outcome (but see also Ardito et al., 2011, in this regard). Let us now return to the point about learning from patients. The author was once engaged in reverse Socratic questioning by one of his long-term patients who had suffered a very severe Traumatic Brain Injury. The questioning started innocently enough and related to trying to identify the wealthiest person in the world. And gradually progressed to the patient’s eventual conclusion that even this person could not at the time of experiencing a terminal illness, buy happiness, nor indeed health. This is a simple enough idea for anyone to understand, and yet again one which has been around since Biblical times, but quite powerful when used experientially on an unsuspecting clinician! It is also an insight that potentially contains many of the ethical and moral questions fundamental to some aspects of the provision of healthcare explored in this paper. Is more always better?

Behaviourism: “Praise is the glue of change”

Within the field of Behaviourism, there are undoubtedly many highly effective key principles for brain injury rehabilitation. But one that stands out as eminently suitable within specifically psychotherapy work with this population is to reinforce desired behaviours through positive reinforcement. For example, if a goal of the overall rehabilitation programme is to increase these target behaviours. This is possibly a strategy that could be particularly helpful for more experiential work in a safe therapeutic environment to address the personality changes that often bedevil patients’ interpersonal relationships. For example when a patient displays inappropriate social skills, or empathy in a session, this could be fertile ground for reinforcing socially valid and very desirable social skills. An extremely explosive and aggressive person, with a history of significant litigation, can be unhelpful. Instead therapists could focus on the experiences, the therapeutic potential of the patient in response to these stresses they may be experiencing, rather than reinforcing what may not be a helpful narrative for their long-term adjustment. Furthermore, providing (even if only perceived) medical, legal, social or other professional opinions constituting a judgement, are not in the remit, nor within the knowledge-base of the neuropsychologist, and can be undermining of other professionals’ important work with our patients.

One of the key aspects of longer term brain injury rehabilitation and adjustment is the process of identity reconstruction (In this regard, see for example Bideman, Daniels-Zaie, Reyes, & Marks, 2006; Graczyk & Ownsworth, 2008; Ylvisaker & Feeney, 2000). This is usually a slow process which can be facilitated through psychotherapists’ careful attention to patients’ narratives, to find clues for present and past identity, and help patients with the psychotherapy processes of exploration, understanding and integration. To try and achieve this, clinicians almost always need to develop a thorough understanding of their patients’ history, development and personality. In this regard some of the Psychoanalytic approaches for example can be helpful to guide the dynamic process of achieving a much deeper understanding of the person and generate hypotheses reflecting the person’s unique internal psychological struggles with reintegration of identity after brain injury. Prigatano (1999) described the fundamental process in psychotherapy as one where it is important to know that persons were before as well as after their acquired brain injury, as this very much colours how they will attempt to cope with their individual personal difficulties. Ultimately the ability to work, love and play may be key to persons’ work through loss after brain injury to attempt to define new meaning in their lives (Prigatano, 1999). Accordingly, to achieve this will involve the development of new personal narratives, among other factors.

Integration of clinical observations

Additional to the above five, hopefully tentatively made points relating to psychotherapy models or techniques, a couple of more general or “back-ground” factors stand out when considering more broadly the provision of psychological therapy for this clinical population. First, and perhaps for some mirroring a meta-cognitive insight and understanding of why one is a clinician, it is important to define the philosophical, moral and ethical
foundations, or values, why we choose to train and work as neuropsychologists. This is likely in most circumstances to be grounded, at least to some degree, in the universal ethical principle that guides all health professionals: primum non nocere, or, “in the first instance do no harm, and if possible do some good”. Considered carefully, this principle suggests that when interacting with other humans it is possibly more productive to first address the more submerged process of things we don’t do (harm), which directs our more explicit interventions (good). For example, to be aware of, but not act in any way, when confronted with negative behaviours, to be able to preserve the interpersonal bond (avoiding doing harm) and then later have the opportunity to rather reinforce positive behaviours in a person (doing good).

Accordingly, is it not possible, that at a much deeper psychological level it is from these more fundamental philosophical and personal convictions or values for being a clinician, that some of our counter-transference originates, rather than necessarily only the in-session behaviours of the patient?

The second point is more strategic in nature, and re-visits the suggestion by Veale (2008) that providing psychological therapy entails prioritising doing a few simple things, well, and repeatedly, in preference to the pursuit of complex, high intensity interventions. Why then repeatedly? Long-term psychological adjustment, for some patients, may possibly be better facilitated by adding potentially the most important catalyst of all: Time. I am repeatedly struck by how the process of emotional adjustment and complex journey after acquired brain injury is a long and torturous one for many of our patients. For this reason it can sometimes be wise to prioritise length of time over intensity or frequency of sessions (see also Coetzee, 2008, in this regard), maybe also where resources are limited. Under these circumstances we need to try and identify the core components of how we can provide the most, to more, of our patients. Generally speaking, rehabilitation after brain injury temporally progresses through the phases of helping patients through the processes of increased awareness, acceptance and realism (Klonoff, 2010). From a psychological adjustment perspective, inevitably this will often require two basic catalysts: enough time, and repetition of psychotherapy strategies that facilitate the development of awareness, acceptance and realism. Although perhaps a gross oversimplification, the five suggestions for psychotherapy practice outlined in this paper may have the potential to, over time, mirror and augment the process described by Klonoff (2010):

(a) While helping patients with developing better awareness certainly depends on psycho-education and other interventions, it may be useful to also use CBT strategies to assist patients with knowing “what thoughts are, and what they are not”, to ultimately at a deeper level understand “what is, and is not, brain injury.”

(b) Acceptance for many patients relies heavily on time, introspection and other factors, but could possibly be facilitated by psychotherapy work utilising an understanding of personal change, including loss, through the language of narrative, showing compassion, and listening.

(c) Realism is probably underpinned by many things, including for example self-awareness and a successful trial of using compensatory strategies. It may over the longer term also be facilitated by psychosocial interventions aimed at assisting patients through their narratives with defining values to live onwards by, and helping patients with the committed pursuit of these, by subtle use of reinforcement during psychotherapy sessions.

These are fairly simple, almost “background” psychotherapy strategies, which if applied to augment slower stream long-term community-based psychological rehabilitation after brain injury, may lend themselves particularly well to environments lacking in resources, or where high intensity, sub-acute rehabilitation has been completed.

Conclusions

Relatively large numbers of persons survive acquired brain injury in the 21st century. Expectedly, most state-provided healthcare focuses its resources on providing trauma and acute care. But this does not mean we should ignore or wish away the elephant in the room that for many brain injury survivors there is often no or preciously little help regarding their long-term emotional adjustment. Suggesting and waiting for more post-acute brain injury rehabilitation resources to be funded is not the most creative solution and perhaps does not always in an intellectually more open way examine the possible core aspects of what may work as alternative approaches. In this paper it was suggested that where very limited resources are available, there may be a need to try and explore and define some of the more basic, but possibly highly effective components, of providing long-term psychological support to our patients – in order to facilitate their adjustment, and ultimately decrease their dependence on society and the State.

Potential benefits of pursuing simplicity in psychotherapy work in this clinical population include the following. The important tasks of providing training and skills development for under-resourced health systems, including those of developing countries, or where neuro-rehabilitation services are lacking, may be facilitated by an approach such as described in this paper. Second, prioritising length of time over high intensity, complex, short duration approaches may for some make more clinical sense for long-term adjustment and spread limited resources more evenly and to larger groups of patients. Third, hopefully this approach can go at least some way towards preventing “revolving door” types of services evolving over time, where care is referred to patients with a chronic neurological condition, usually driven by damaging relapses as opposed to long-term patient needs. Finally, research and practice development in this area may be stimulated, as more clearly defined and relatively easily trainable and deliverable psychotherapy strategies are possibly less complex to measure for effectiveness and explain variance.

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REFERENCES


