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Article 60

Group Counseling Interventions for Military Personnel With Brain Injury

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Veterans and TBI: An Overview

“For the first couple of months, I couldn’t really think that straight. I would forget things and had problems picking stuff up and remembering things. I was in the hospital for a bit. So that’s my injury that I sustained, they call it traumatic brain injury, TBI” (Sage Byrd, as quoted in St John, 2010, para. 6). As the ‘signature injury’ of the Iraq and Afghanistan wars, traumatic brain injury (TBI) is becoming a noteworthy issue facing service members and veterans (Defense and Veterans Brain Injury Center, 2009a, para. 1). An increasing number of people are surviving traumatic brain injuries (TBI) thanks to increased awareness through medical and technological advancements. The increased use of rocket-propelled grenades, along with the use of improvised explosive devices (IEDs) and land mines exposes military personnel to “increased risk of blast-related trauma, particularly blast-related traumatic brain injury” (Defense and Veterans Brain Injury Center, 2009b, para. 1).

The Department of Defense has identified approximately 134,000 service members with TBI since January 2003 (Daniel, 2010, para. 12). Hawaii Senator Daniel K. Akaka III has further speculated a number closer to 360,000 suffer brain injuries during service in Iraq and Afghanistan (Daniel, 2010). In spite of the increased numbers of TBI diagnosed, the Veteran’s Administration (VA) only treated 1,736 patients with

severe brain injuries between March 2003 and December 2009 (Daniel, 2010). Of those, 879 were active duty service members, and 736 were injured in Iraq or Afghanistan (Daniel, 2010, para. 12). As a result of the increased survival rate, more individuals are living with permanent disabilities that affect them physically and psychologically. Because of the complexities of TBI and its treatment, the transition and recovery process for returning service members and veterans can be challenging. This paper will discuss the incidence of TBI, complications to therapeutic interventions, and utilization of cognitive behavioral and psychotherapy groups in treatment of military service members and veterans.

TBI Incidence

According to the Center for Disease Control (2010), roughly 1.7 million individuals experience a traumatic brain injury annually (CDC estimates of TBI do not include injuries documented at the U.S. Department of Defense or U.S. Veterans Health Administration Hospitals). Falls and motor vehicle/traffic related incidents are the leading causes of TBI in the U.S., respectively, with males ages 14-24 being most frequently diagnosed (Faul, Xu, Wald, & Coronado, 2010; Schwartz, 2009). For active duty military personnel in war zones, blasts have been found to be the main cause of TBI (Champion, Holcomb, & Young, 2009). The Defense and Veterans Brain Injury Center identifies four ways that TBI can occur as a result of a blast injury; including primary, secondary, tertiary, and quaternary. Primary blast injuries are the “result of exposure to the over pressurization wave or the complex pressure wave that is generated by the blast itself” (Defense and Veterans Brain Injury Center, 2009b, para. 4) with severity of the TBI consistent with proximity to the blast. A secondary blast injury results from fragments that are energized that may cause a penetrating brain injury. The tertiary blast injury, which is similar to blunt force trauma associated with a high-speed motor vehicle accident, occurs when the individual is thrown from the blast into some solid object. Finally, quaternary blast injuries include the most comprehensive injuries. Quaternary blast injuries occur in “the presence of severe blast related trauma resulting from significant blood loss associated with traumatic amputations or even from the inhalation of toxic gases resulting from the explosion” (Defense and Veterans Brain Injury Center, 2009b, para. 4).

In addition to the severity of circumstances in which TBI can occur, TBI has three classifications; mild, moderate, and severe (Dixon, Layton, & Shaw, 2005). Factors for diagnosing mild traumatic brain injury (mTBI) include: loss of consciousness, if any, of less than 30 minutes; memory loss after the traumatic event (lasts less than 24 hours); and a Glasgow Coma Score of 13-15 (Dixon et al., 2005). To diagnose a moderate TBI there needs to be a loss of consciousness for longer than 30 minutes but less than 24 hours, memory loss after the traumatic event lasting for 24 hours to 7 days, and a Glasgow Coma Score of 9-12 (Dixon et al., 2005). A diagnosis of severe TBI is based on a loss of consciousness that lasts for more than 24 hours, memory loss for 7 days or more, and a Glasgow Coma Score of 8 or less (Dixon et al., 2005). Early ratings of TBI severity are not always determinative of later functional outcomes (Schwartz, 2009).

The psychological consequences of TBI vary in severity depending on the location and level of assault to the brain (Krupan, Levine, Stuss, & Dawson, 2007). The

prefrontal regions of the brain, according to Krpan et al. (2007), are vulnerable to TBI and are the primary region responsible for executive function (initiation, planning, cognitive flexibility, decision-making, judgment, regulation). As a result of the problems with executive function, it is not uncommon for individuals with TBI to either seek out or be referred for counseling services. Typical problems a counselor will see in clients with TBI are deficits with memory, anosognosia, depression, anxiety, emotional lability, flat affect, personality changes, substance abuse, decreased frustration tolerance, impulsivity/disinhibition, lack of initiative, sexual difficulties, isolation, agitation, dependence, aggression management, and an overall lack of ability to cope (Alderman, 2003; Anson & Ponsford, 2006; Schwartz, 2009).

TBI results in cognitive and behavioral changes in the person who experienced the injury. More specifically these cognitive and behavioral changes result in emotional and adjustment issues, such as reduced ability to deal with anger, increased incidence of depression and anxiety, lowered self-esteem, and an overall inability to cope (Alderman, 2003; Hiott & Labbate, 2002; Kreutzer, Sell, & Gourley, 2001). The ability to cope is determined by different emotional, social, and cognitive processes, all of which may have been impaired by the brain injury (Krpan et al., 2007). Therapeutic interventions have been used to successfully help individuals with brain injury adjust to their new disability.

Complications to Therapeutic Interventions

Several factors have been identified as potentially inhibiting the progress of any type of therapy used with an individual with TBI. Predicting which persons with TBI who engage in therapy and will receive benefit is a complex and highly individualized endeavor. Those with TBI are a non-homogenous population. These differences result from variability in severity, location, and extent of lesions/damage on the brain, along with varying levels of cognitive, emotional, behavioral and physical impairments (Swan & Alderman, 2004). Anson and Ponsford (2006) advocate for over inclusion in therapy, as receiving no treatment is thought to be worse than treatment that may not be effective. Based on a review of the literature, several factors have been attributed to therapy outcomes with this special population. Such complicating factors are: level of self-awareness; severity of injury which results in cognitive difficulties, including current states of mood disorder (e.g., depression, anxiety), and style of therapy used with TBI clients.

The first complicating factor is a low level of anosognosia, or self-awareness, and how it can negatively impact psychological intervention. Individuals with TBI gain an awareness of their deficits through a three stage process: intellectual awareness, emergent awareness, and anticipatory awareness (Crosson et al., 1989). Intellectual awareness is the ability to comprehend that certain functions are impaired and the complications of having such impairment. Recognizing a problem is happening when it is occurring is emergent awareness. When an individual can anticipate that a problem will happen as a result of having a deficit or impairment they have anticipatory awareness. Successful rehabilitation depends upon awareness of deficits and a positive perception of quality of life (Brown, Gordon, & Haddad, 2000; Trudel, Tryon, & Purdum, 1998).

Fleming, Strong, and Ashton (1998) discovered that a lack of self-awareness contributed to participants not realizing the need to continue treatment. Flashman and

McAllister (2002) found, for example, that those with TBI were cooperative in therapy but discontinued compensation techniques and therapeutic strategies learned in therapy once therapy discontinued. These clients then had significant declines in their functional ability once therapy terminated. Individuals with TBI in the Anson and Ponsford (2006) study who were assessed to have a greater awareness of their problems prior to taking part in a Coping Skills Group (CSG) intervention responded more favorably to psychological intervention. Conversely, those in the study who had a poorer sense of self-awareness prior to taking part in the CSG were more depressed after being in the CSG. The authors speculated that the increase in depression could be related to gaining a better self-awareness of current limitations and resulting obstacles over the course of treatment. Participants received peer feedback and were involved in self-reflection all to increase self-awareness. It is not uncommon for increased awareness of deficits along with the impact of physical, cognitive, and psychosocial restrictions on the individual's self-concept to lead to emotional distress (Vickery, Gontkovsky, Wallace, & Caroselli, 2006; Wallace & Bogner, 2000).

A second complicating factor to therapy effectiveness is severity of injury. Aeschleman and Imes (1999), utilizing a cognitive behavioral therapy (CBT) based stress inoculation program with participants, found those who were categorized to have a more severe brain injury received less benefit from therapy than those with milder injuries. These authors stressed that more behaviorally based interventions such as time out, shaping, and positive reinforcement would be more beneficial with clients with severe brain injury. Anson and Ponsford (2006) also speculated from the results of their study that coping strategies taught in their counseling skills group were most effective with participants with less severe brain injury. When working with individuals with severe brain injury and a history of aggression, Alderman (2003) emphasized caution when using cognitive and CBT psychotherapy based interventions. The cognitive component may be beyond what the client is capable of participating in during the group experience. Behavioral therapies have been shown to be successful with clients with severe brain injury and who also have issues with aggression (Alderman, Davies, Jones, & McDonnell, 1999; Hegel & Ferguson, 2000). One significant advantage of behavior therapy with individuals with cognitive deficits is it provides regular and systematic feedback about performance (Alderman, 1996).

Lastly, a contributing factor to successful outcomes with individuals with TBI is the style of therapy used. The style of therapy used with a client with TBI often relates to documented deficits the individual is experiencing. Anxiety and depression are common disorders among survivors of a TBI (Hibbard, Uysal, Keple, Bogdany, & Silver, 1998). These disorders are often associated with a complex set of biopsychosocial factors, including organic, illness-related and/or environmental factors (Williams et al., 2003). Proper diagnosis and treatment must be approached from a multi-factorial and dynamic approach (Williams, Evans, & Fleminger, 2003). Since TBI typically results in cognitive deficits, it stands to reason that insight oriented therapies may not be as effective as more behaviorally based interventions.

Cognitive Behavioral and Psychotherapy Groups

Cognitive behavior therapy (CBT) helps clients to understand the link between their beliefs, thinking, and behavior. Cognitive distortions are often identified and replaced with more adaptive cognitive beliefs. As is the case with a life changing injury, such as a TBI, CBT can be used to teach the client how to manage psychological distress and reduce BI related cognitive problems (Anson & Ponsford, 2006; Williams et al., 2003). CBT, for instance, has different applications that could compensate for cognitive deficits by focusing on structure, specific behaviors and thoughts, and concrete goals (Khan-Bourne & Brown, 2003). CBT applications such as written aids, prompts, and the use of repetition can all be effective for people with memory problems. Rath, Simon, Langenbahn, Sherr, and Diller (2003) used a CBT-based group with the focus on treatment of problem-solving deficits in participants with mild-to-severe TBI. After immediate completion of the study and at a 6 month follow-up, increases in self-esteem and problem-solving skills were observed and maintained. Variations of CBT individual and group therapy applications continue to be researched for effectiveness with the TBI population.

Vickery et al. (2006) also developed a group intervention to address self-concept changes in clients with acquired brain injury (ABI). This psychotherapy group focused on expanding knowledge of the self in-group members along with strategies to recognize and value positive self-attributes. To achieve the group focus, group members were first administered the Head Injury Semantic Differential Scale (HISDS; Tyerman & Humphrey, 1984) and then participated in a semistructured group with a specified format. At the completion of the groups, the HISDS was once again administered. Group sessions were semistructured, followed a specified format, and participants were instructed to write out the main points of each session. Results indicated that ABI survivors in the postacute stage recovery who went through this group intervention showed increases on ratings of self-concept, self-confidence, attractiveness, hopefulness, and cooperativeness, along with perceived decreased boredom as measured by the HISDS.

Group Interventions With Veterans

With so many of our veterans coming home with transitional issues including medical conditions such as TBI, it is important that those in the counseling profession create treatments designed around the individual needs of this population. Group interventions with veterans with TBI and other traumas has been discussed in the literature as effective, and perhaps more beneficial to some as compared to individual therapy (Glynn et al., 1999; Rozytko & Dondershine, 1991; Ruzek et al., 2001; Shea, McDevitt-Murphy, Ready, & Schnurr, 2009). Rozytko and Dondershine (1991) wrote “the group process more readily protects patients from being overwhelmed by the power of therapy-released emotions and also provides a guilt-reducing distortion-correcting, ‘fool proof’ peer group” (p. 158). The group context is designed to counteract and confront the social avoidance and isolating tendencies many individuals with trauma often experience (Greene et al., 2004). As Yalom (1995) suggests, group provides a forum from which participants, who may feel isolated from others, gain a sense of belonging and a sense of universality with their similar shared experiences.

In developing group interventions for veterans who have TBI, the group leader should consider each member's level of self-awareness and their rating of issues related to the quality of their life after their injury (Chandrashekar & Benshoff, 2007; Malec, Testa, Rush, Brown, & Moessner, 2007; Vickery et al., 2006). With the creation of groups that address life skills and the emotional and psychological issues, group members are allowed a chance to improve their social skills as well as their self-assessments, quality of life issues, and self-efficacy. Westwood, McLean, Cave, Borgen, and Slakov (2010) successfully implemented The Veterans Transition Program (VTP) with veterans with varying degree of combat-related trauma. This program emphasized the following areas: (a) development of an environment in which veterans felt supported and safe; (b) normalization of military experiences and the issues of transitioning back to civilian life; (c) providing group participants with information on trauma and how to deal with it; (d) strategies on how to reduce stress related issues; (e) education on how to improve interpersonal communications with significant others; (f) developing life and career goals; and (g) involvement of family.

Chandrashekar and Benshoff (2007) found that group members were able to make significant gains as displayed in their assessment of their quality of life issues. The authors suggest that by being part of a group of other people who had experienced a TBI, the group members were able to learn from the experience of others. This finding lends credibility to the homogeneity concept of group formation. Westwood et al. (2010) applied group therapy to veterans transitioning home. The authors discussed the need for the groups to be homogenous in order to allow group members to bond and establish trust in the group and the group process. According to Westwood et al. (2010), traumatized combat veterans are more willing to open up to those whom they perceive to have knowledge and understanding of their struggle returning home from the combat zone. Groups that are designed specifically to address the issues unique to veterans with TBI and/or other trauma have the potential to promote increased self-awareness, emotional release, and symptom reduction.

Conclusion

Successful psychological intervention with veterans with TBI, according to the literature, is quite complex. Several factors, as highlighted, in the TBI literature have been researched to determine the best way to meet their needs. Such factors as group homogeneity, level of self-awareness, style of therapy used, and severity of injury with resulting cognitive difficulties, have all been discussed. Three areas are suggested as future research on TBI and veterans. First, more research is necessary to fully understand the complex issues of this population and to determine the best group counseling strategies and interventions that are most likely to lead to successful outcomes. Secondly, research should also focus on the unique complications that co-morbid conditions and trauma related reactions (e.g., PTSD, depression, anxiety) have on the implementation of group interventions. Lastly, research should identify specific interventions that include the family unit in the veteran's recovery and readjustment process. With the increases in awareness of TBI and advances in screening techniques associated with TBI, counselors are called to develop more effective strategies of group interventions with service members and veterans.

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