Lessons Learned from Working with Individuals with Dual-Diagnoses: Brain Injury & Psychiatric Disorders

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Introduction

- Patients with dual-diagnoses such as those that are psychiatric and neurogenic in etiology present with unique therapeutic needs. Teasing out speech and cognitive symptoms versus those that are behavioral and social-emotional is problematic.
- In the clinical setting, patients can typically be classified into two groups:

  Group 1. Individuals with pre-morbid psychiatric disorders (e.g., bi-polar disorder, obsessive compulsive disorders, borderline disorders, chronic anxiety) along with communication impairment and,

  Group 2. Individuals with acquired speech and cognitive disorders due to traumatic brain injury resulting in a seemingly similar social-emotional profile.
- In the first group, pre-existing psychiatric disorders may be exacerbated by acquired brain injury, while the second group typically learns to cope with newly acquired communication deficits as well as be confronted with an array of psychological manifestations.

Patient Population: Demographics

Total number of adult patients: 40

Total number of patients with mental health disorders: 28

Mean Age: 57.6 years of age

Age Range: 34 to 79 years of age

Gender: Female 53%

Marital Status:

Married: 25% Single: 47% Divorced/Widowed: 28%

Location: New York Metropolitan Area

Mean Educational Level: College Degree (16 years of education)

Primary Medical Disorders (in order of frequency): Multiple Sclerosis, Stroke, Traumatic Brain Injury, Primary Progressive Aphasia, Tartive Dyskinesia

Group 1. Premorbid Mental Health Disorder with Neurogenic Communication Disorder (n=14)

- **Bi-polar disorders- 28%**
- **Anxiety disorder- 28%**
- **Depressive disorders-22%**
- **Schizophrenic- 7%**
- **Obsessive compulsive disorders- 7%**
- **Personality disorders- 7%**

Group 2. Mental Health Disorder Associated with Neurogenic Communication Disorder (n=14)

- **Depressive disorders- 72%**
- **Anxiety disorders- 28%**

Figure 1. Patient Population

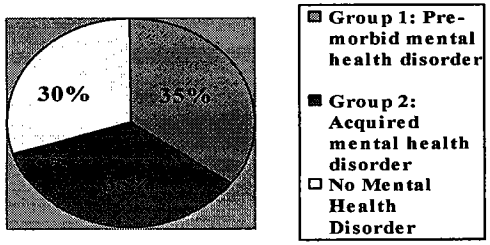
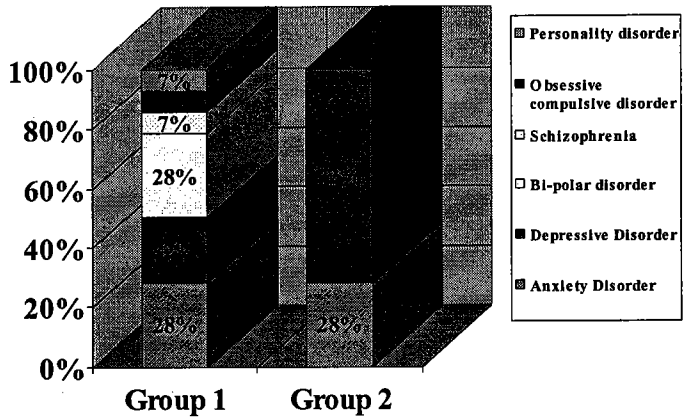


Figure 2. Distribution of Mental Health Disorders



Assessment Tools

Patients with cognitive and communicative disorders paired with social-emotional and behavioral symptoms resulting from brain injury can present with a variety of dysfunctional interpersonal and pragmatic skills. These maladaptive behaviors can interfere with the administration of standardized assessments, therapy, as well as reduce clinical outcomes.

Formal Assessment Tools:

The Scales of Cognitive Ability for Traumatic Brain Injury (SCATBI)
Examining for Aphasia-4 (EFA-4)
Cognitive Assessment of Minnesota (CAM)
Kaplan Baycrest Neurocognitive Assessment (KBNA)
Aphasia Diagnostic Profile (ADP)
Ross Information Processing Assessment-Geriatric (RIPA-G)
Scales of Cognitive and Communicative Ability for Neurorehabilitation-Norming Edition (SCCAN)
The Clinical Evaluation of Language Fundamentals-Fourth Edition (CELF-4)
Gray Oral Reading Tests-4 (GORT-4)
Test of Adolescent and Adult Language-4 (TOAL-4)

Informal Assessment Tools:

Psycho-social assessment
In-depth case history
Family and caregiver interviews
Recalling Digits
Recalling sentences
Temporal orientation
Immediate, Short-term and delayed recall
Problem solving
Deductive and inferential reasoning
Confrontational naming
Written organization
Recalling details from an orally presented paragraph
Language sample

Contact Information

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Interventions

Speech-language pathologists working with this population require specialized training to assess, intervene and treat individuals with multiple co-morbidities. Execution of a multi-disciplinary team to address the holistic needs of these patients is optimal for the development and implementation of treatment.

A. Counseling Coursework
B. Psychological/Social Work Coursework- focusing on the symptomology for major classes of psychiatric disorders
C. Knowledge of pharmacological intervention
D. Implementation of counseling skills
   - Reflective Language
     - *"I sense you are worried today. Let's see if we can help you with these feelings."*
   - Supportive Language
     - *"I understand you are sad"*
   - Rephrasing thoughts and ideas
     - *"Are you trying to tell me that you are frustrated?"*
   - Redirecting Behaviors
     - *"I know today is difficult for you. Lets try to redirect our energy and focus on helping you with your communication skills."*

Patient Profile: Group #1

History: FT is a 64 year old monolingual, college educated, female. She lives alone with full-time home care services. Reports from family indicate that a psychiatric diagnosis has been present since early adolescence. FT Suffered a stroke in her late 20's and a traumatic brain injury resulting from a fall in her last 50's. The history associated with the management of her psychiatric condition is unknown.
Present: Currently, FT has been hospitalized in an inpatient psychiatric unit due to maladaptive behaviors in the community. The psychiatric staff diagnosed FT with bi-polar disorder and is medicating her accordingly. FT's hospitalization's was precipitated by her inability to effectively communicate with her home care staff, indicating the importance of understanding patients with dual diagnoses.
Intervention: Intervention by the speech-language pathologists facilitated FT's ability to effectively communicate her feelings and assisted the psychiatric staff in developing a realistic and feasible discharge plan.

Patient Profile: Group #2

History: FG is a 38 year old monolingual, college educated, male. He suffered a traumatic brain injury after falling off a treadmill while at the gym approximately five years ago. At that time, FG was married, worked in a prestigious NYC museum and maintained an active social life.
Present: Currently, FG presents with dysarthria, a pragmatic disorder and expressive language difficulties including word-finding deficits. Following his accident, FG underwent significant life style changes including his inability to continue working and a subsequent divorce. FG has significant difficulty expressing his feelings. Social and behavioral deficits interfere with satisfying his interpersonal relationships and functional skills required for activities of daily living.
Intervention: Implementation of speech language and cognitive therapy three times a week in addition to three hours of group therapy have resulted in improved pragmatics skills, suppression of maladaptive behaviors, and improved socialization. The speech-language pathologists' awareness and ability to help FG address his feelings and provide support for his depression have planned a critical role in his treatment plan.

Discussion

1. Patients with dual-diagnoses present with neurogenic and psychiatric symptoms which are closely interwoven. In effect, it may be unrealistic to tease apart speech/cognitive symptoms from social/emotional symptoms.
2. In order to best manage this unique therapeutic population, a multi-modal evaluation and carefully developed treatment plan in fact, improves the quality of life for these patients.
3. It is essential to implement a holistic approach incorporating both individual and group therapy to achieve clinical gains.