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## Counselling Survivors of Traumatic Brain Injury

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### Abstract

Counselling for survivors of traumatic brain injury is gradually gaining recognition and acceptance. The objectives of this article are to identify the reasons for the increasing use of psychotherapeutic intervention for brain dysfunctional adults; to explore the complexities of working with this special population; and to highlight the needs and goals typically encountered in the therapeutic session. Knowledge, flexibility, and creativity are required to develop novel ways of healing the shattered sense of self, eliciting a new and integrated self and finding purpose and meaning after traumatic brain injury. Modifications to traditional counselling approaches are discussed.

### Résumé

Le counseling pour les survivants d'un traumatisme cérébral est graduellement en train de se faire reconnaître et accepter. Les buts de cet article sont d'une part d'identifier les raisons pour lesquelles un nombre croissant de psychothérapeutes offrent une intervention psychothérapeutique auprès des adultes avec atteintes cérébrales, et aussi d'explorer les complexités des interventions auprès de cette clientèle particulière, et enfin de faire ressortir les besoins et les objectifs qui caractérisent ces consultations thérapeutiques. Le savoir faire, la flexibilité et la créativité sont à la fois nécessaires pour développer de nouvelles façons de guérir un sens de soi fragmenté, pour créer un nouveau soi intégré, et enfin pour trouver, à la suite d'un traumatisme cérébral, un nouveau but et un nouveau sens à la vie. Les modifications aux approches traditionnelles du counseling y sont également discutées.

There is a growing recognition that counselling forms an important component of a rehabilitation treatment program for survivors of traumatic brain injury (TBI, Cicerone, 1991; Prigatano, 1991). This was exemplified in a recent issue of the *Journal of Head Trauma Rehabilitation (JHTR)*, (1991, December) devoted to the topic of counselling after TBI. Edited by George Prigatano, a longtime advocate of therapeutic counselling for TBI survivors, the articles in this special issue attempt to dispel myths regarding the inefficacy of counselling with this population and to highlight specific treatment issues (Christensen & Rosenberg, 1991; Cicerone, 1991; Klonoff & Lage, 1991; Prigatano, 1991).

Lezak (1986; 1987; 1988; 1989) has also written extensively on TBI survivors' psychological and psychosocial problems in the context of family and community. She targets the need for education, counselling and emotional support to manage behavioural problems that are both direct and indirect consequences of brain damage and which impede normal social interaction.

Few brain damaged patients experience personality changes that are plainly either direct consequences of a brain injury or secondary reactions to impairment and loss. For the most part, the personality changes,

emotional distress, and behaviour problems of a brain damaged patient are the product of extremely complex interactions involving his/her neurological disabilities, present social demands, previously established behaviour patterns and his/her ongoing reactions to all of these (Lezak, 1983, p. 36).

Hartlage (1988) suggests that psychotherapists in private practice are also treating an increasing number of TBI victims and their families. Practitioners working with this population must become aware of emerging issues to be able to provide relevant services. Textbooks of neuropsychology and neuropsychological rehabilitation (Heilman & Valenstein, 1985; Richardson, 1990; Wedding, Horton & Webster, 1986) make important contributions to understanding physiological dysfunction, neuropsychological assessment, cognitive retraining and behavioural treatment, but tend to overlook the value of psychological counselling for the individuals and their families. Wedding et al. (1986) acknowledge family issues arising from disruptions caused by the cognitive and behavioural problems of the brain injured member but do not elaborate on the counselling needs of that individual. The search for writings of practitioner/researchers who promote the use of psychological counselling for the TBI survivor and the family uncovers limited results (Cicerone, 1989, 1991; Lezak, 1983, 1986; Morris & Bleiberg, 1986; Prigatano, 1986, 1987). However, the contributions of these authors and those of the recent *JHTR* issue represent an encouraging trend toward increasing recognition of the value of psychotherapeutic intervention in collaboration with other aspects of rehabilitation, and as an essential component of a holistic and integrated treatment plan.

This emerging acceptance of psychological counselling puts the responsibility for its effective employment firmly in the hands of the counsellor. The TBI client can no longer be dismissed as inappropriate for, or unable to benefit from counselling, which seeks to heal affective sufferings and shattered sense of self. Prigatano (1991) proposes that the purpose of psychotherapy with brain-injured clients is to attend to their "disordered mind" and their "wounded soul" (p. 3). The current trend compels counsellors to evaluate the ways in which traditional counselling models can be revised and implemented to best serve this special population.

### *Traumatic Brain Injury*

Traumatic brain injury, typically the result of traffic accidents, creates a myriad of neuropsychological dysfunctions. Even brain injuries labelled as mild can lead to permanent cognitive deficits and personality changes. Mild, moderate and severe damage negatively affects sense of self, social competence, ability to secure and keep a job and personal indepen-

dence. Drug and alcohol dependency, family breakdown and confrontations with the law are not uncommon consequences.

Assessment in the early stages following head trauma aims to predict rehabilitation recovery outcome by examining duration of coma, post-traumatic amnesia and attentional deficits. Diller and Ben-Yishay (1987) warn that measurement scales provide guidelines for clinicians but cannot replace functional assessments as they relate to rehabilitation programs and outcome goals. Ultimately, the practitioner, ever-cognisant of the measurement tools' limitations for predicting functioning level (Morris & Bleiberg, 1986), must distinguish between actual functional disability and symptom severity as experienced subjectively by the client (Cicerone, 1991).

For the counsellor working with this population, this means (a) utilizing assessment results as tools to help gauge the appropriateness of a particular treatment plan; (b) gathering reports from the client and significant others regarding cognitive, emotional and social functioning; and (c) staying attuned to the client's subjective experience to gain a sense of realistic recovery potential.

This article will not attempt to deal with the complex pathophysiology of brain injury nor with the type of measurement scales generally used with this population. The reader interested in better understanding these important areas is directed to Hagen 1982; Heilman & Valenstein, 1979; Jennett & Bond, 1975; Levin, O'Donnell & Grossman, 1979; Lezak, 1983, 1989; Prigatano, 1986; Richardson, 1990; Teasdale & Jennett, 1974; Wedding, Horton & Webster, 1986.

#### *Possible barriers to change*

It is not the purpose of this paper to provide an exhaustive coverage of the resultant deficits but rather to cite some examples which serve to highlight the complexities facing the practitioner who works with this population. For purposes of length and clarity, the paper will focus on the treatment of adults in post-acute rehabilitation.

*Lack of awareness.* Denial is a psychological defense mechanism which can be used to avoid acknowledgement of the disability and the resulting emotional reaction (i.e. anxiety or grief). What complicates the picture for head injured persons is the fact that one of the most common deficits following TBI is itself the organically based failure to appreciate the nature and impact of one's deficits. This problem is a result of executive dysfunction (failure to monitor, hence be aware of, the quality of behaviour) and deficiencies in abstraction and integration of information (failure to appreciate the nature of one's situation and to integrate the meaning of failures into an overall picture of oneself) (Kay & Silver, 1989, p. 162).

The fact that either or both organic and psychological barriers may initially preclude awareness of the impairments can lead to confusion and frustration for TBI survivors who have been directed to rehabilitation therapy by family members or on the advice of medical or legal professionals. It can also represent a real challenge for their counsellors. The individual may demonstrate obvious cognitive, affective and behavioural problems but remain unaware of them, and so may return to work shortly after hospital discharge, often with disastrous consequences. Thus clients may enter therapy feeling hostile or defensive since they don't perceive or admit any problems.

By creating a safe atmosphere in which the client can openly express his/her thoughts and feelings, the counsellor takes first steps toward dismantling barriers to self-awareness which impede self-efficacy. The purpose is to help the individuals maximize their ability to perceive the impact of their deficits, compensate appropriately, identify remaining competencies and maintain realistic hope. This means the counsellor must be sensitive to defensiveness and psychological denial and to the constraints of organically impaired awareness. Deaton (1986) recommends a balance between support and confrontation of denial or unawareness of deficits, emphasizing behaviours rather than verbalizations, and concentrating on coping with the present reality rather than looking to the future. Cicerone (1991) suggests there may be instances when it is appropriate not to interfere with denial which is not impacting therapy or daily functioning.

It is possible to increase the individual's capacity for self-observation via concrete feedback using videotapes and repeated observations (Cicerone, 1989). Working with the premise that "overt self-observation may compensate for a loss of internalized self-monitoring" (p. 108), structured checklists and self-monitoring inventories can be constructed. As well as engaging in community-based activities which offer salient feedback, Cicerone believes that psychotherapy permits client and counsellor to explore differing perspectives regarding efficacy expectations. Deaton (1986) also suggests that clients may be less defensive to feedback from computers and the therapist can help them make the connection between the computer task and daily functioning. Structured groups encourage discussion of common neuropsychological difficulties and elicit constructive feedback from peers.

*Communication.* Communication can be affected in a variety of ways. Some TBI clients are unable to comprehend abstract notions. An idea must be associated with a concrete example or its meaning may elude the TBI client. *Anomia* refers to loss of ability to recall names. Clients may have to describe objects they are unable to label. Varying levels of receptive or expressive aphasia may be present. Thus, the client may have trouble

understanding the counsellor or may be unable to find the right words to send a meaningful message.

Even without word finding difficulties, speech may be slow and laboured. This requires patience and concentration on the part of the counsellor to attend to the message, both cognitive and emotional, which the client is working hard to express. Initially, it is important that the counsellor does not attempt to speed up the process or pressure the individual to get to the point. Attending to the individual and offering missing words only when requested can reduce levels of anxiety and frustration and increase feelings of unconditional acceptance. Later, it may become a mutually agreed upon goal to assist the client in becoming more verbally concise and being notified when s/he is digressing from the original topic. The purpose is to enhance his/her communication skills outside the therapeutic arena, where acceptance may not be unconditional.

*Attention/concentration impairment.* Attention/concentration impairment reduces the ability to attend to an activity or information and leaves individuals susceptible to distraction by external or internal stimuli. Prescription medication (i.e. anti-convulsive, anti-depressant) may also affect the client's cognitive, behavioural or affective responses and highlights the need for professional information exchange and a coordinated team approach.

Some TBI clients experience personal, spatial and/or temporal disorientation. Even after several sessions, TBI clients may have trouble locating the counsellor's office. When fatigued or anxious, they may forget names or common-knowledge items.

Counsellors should be sensitive to the client's ability to attend to session content and recognize potential distracters. For instance, interruptions by the counsellor or telephone calls taken during the session may cause the clients to lose their train of thought. In some cases, bright colours or bold patterns may cause cognitive interference and impede the therapeutic progress. Reducing distracters, particularly in the early stages, can assist the client's ability to attend and concentrate in the counselling session.

*Emotional lability.* Emotional lability means the individual may change moods quickly and experience emotions in extreme forms. As well as sadness or anger, survivors of TBI are susceptible to frequent bouts of frustration. Their tolerance level is lowered on an emotional level and their deficits create numerous encounters with problems in daily living skills which did not exist prior to the injury. Depression also plagues many TBI clients. This generally occurs after their self-awareness has improved to the point of confronting their limitations.

Impulsivity can be both organic and reactive. In other words, the physical damage to the brain impairs affective response and the individual will also react to his/her ability to think and act at pre-morbid levels. Counsellors working with this population will encounter the behavioural expression of this emotional lability. Being prepared for sudden mood swings, uninhibited self-expression or the muted responses accompanying a depressive episode can help the counsellor stay centred and attentive to the underlying needs of the client.

*Fatigue.* This symptom typically improves spontaneously, but extremely slowly. Some survivors however, endure chronic fatigue which greatly hampers their activity level and employability. Counsellors encountering this impairment must consider the length of counselling sessions as well as the time of day at which they are conducted.

*Judgement, problem-solving, decision-making and organization skills.* Impairment in these areas leads to a great deal of difficulty, discontent and risk for the TBI client. It can represent a major stumbling block in counselling aimed at reviewing available options and helping the client select those which are most beneficial.

By exploring with the individual and his/her family, the counsellor can determine if decisions are made, how they are made, and whether they tend to be appropriate or effective. Executive functioning is the ability to formulate a goal, plan, and carry out goal-directed behaviours effectively. Impairment in this functioning may lead TBI clients either to avoid decisions or to make impulsive choices. They may be capable of performing a specific task but unable to structure themselves to do it. Difficulty with initiation compounds this problem and is often mistaken by family members and professionals for laziness or lack of motivation. The individual may know what s/he wants to do, is capable of performing the task but is unable to get started. By contrast, perseverance means that when an individual with TBI engages in tasks and becomes stuck, s/he is unable to stop and move on to another, even when repetitively unable to complete the task successfully.

Counsellors must be prepared to deal with practical matters such as a client's desire to continue driving or to cope with financial matters such as investments or credit card use. These areas can be very problematic, particularly when lack of awareness colours judgement. Helping the client to assess decisions, to set goals and carry them out safely and successfully are important components of the treatment plan. It may involve jointly documenting or diagramming possible cause-and-effect outcomes, review of recent decisions, and discussion regarding execution and results. The counsellor can encourage the client to make some small decisions regarding some aspect of the counselling sessions and build up gradually to making some choices during the time between

sessions. It is crucial to contemplate the appropriateness of homework assignments so that they do not leave the client feeling defeated and helpless. Together, counsellor and client can explore problematic areas, such as acting on a plan or assessing the result, and the intervention plan can be revised. Each success should be celebrated but should not minimize the persisting problems as the client may be acutely aware of his/her remaining deficits. Regaining executive functioning is "necessary for appropriate, socially responsible, and effectively self-serving adult contact" (Lezak, 1983, p. 507).

As with all of these barriers, counselling success is restricted by the extent of organic damage. Some survivors with right hemisphere injury will have good plans but their inability to integrate or organize prevents them from executing the plan. With those for whom a particular problem cannot be removed, compensatory strategies must be considered. Identifying which caregiver(s) will assume responsibility for this need and how the individual and his/her caregiver can work together most effectively and harmoniously are appropriate counselling goals. For those who may be unable to return to driving, for example, counselling can facilitate acceptance of this restriction while identifying other transit options and even arranging training to use public transportation.

*Memory.* Memory problems are one of the most common complaints following even mild TBI. Structures must be put in place to help the client use compensatory strategies where memory is impaired. For instance, it can be useful to have the individual use a datebook. Together, counsellor and client can choose the type and size, decide how to carry it (pocket, purse, knapsack, briefcase), and how frequently to refer to it. This strategy will help clients remember to attend sessions and other engagements and will create a record of past events. They should also receive telephone reminders the day before, or the morning of, their appointment.

Equally important is the fact that the client may not recall the session content. The counsellor can restrict session content to a few key topics, repeat important content items, provide a review at the end of each session and begin each session with a review of the last. Allowing the client to take notes, or providing a written summary to take home may permit greater absorption and continuity across sessions. Two or more sessions per week, particularly in the initial stages of counselling, can also aid continuity and reduce the impact of memory impairment. Finally, including members of the client's support network in some sessions promotes the application and generalization of skills from the therapeutic environment to the home environment and involves family members actively and cooperatively. Empirical research is needed to support these and other clinically demonstrated phenomena.

*Personality disturbance and social isolation.* Lezak (1987) indicates that personality and emotional disturbances may be more restricting than the cognitive or physical disabilities which follow traumatic brain injury. Using an adaptability inventory divided into three sections (temperament and emotionality, activities and social behaviour, and physical capabilities), she found that the areas having to do with social adjustment were the most impaired. Even as disturbances such as anger control, impaired initiative, poor social judgement and depression improved, social isolation persisted.

Pre-morbid character will impact the treatment program. Gathering information from family members, friends and co-workers can assist the counsellor in forming a more complete impression of the client, pre- and post-trauma. This is important in terms of understanding the way they were and the way they interacted with others. This information affords a better insight into the client's changes in self and recognition of now being treated differently.

Group counselling is one way to reduce the individual's sense of isolation. Successful group counselling should (a) give individuals a chance to enjoy group membership, thereby reducing self-inflicted isolation; (b) offer contact with other brain-injured people which serves to normalize their experiences and build group affiliation; (c) give them practice and discussion on successfully following multi-person conversations; (d) allow them to view others' behaviours, examine their own behaviours and receive constructive feedback in an atmosphere of trust (developing interpersonal skills, re-learning to associate with a non-disabled, non-professional population outside the group, and increasing self-confidence); and (e) begin setting and actively pursuing realistic personal goals.

Group goals may include developing a sense of group affiliation and inclusion, adapting to life with a hidden disability, identifying cognitive and behavioural problems and strategies to manage them, sharing problems associated with TBI such as low self-esteem, interpersonal difficulties and unemployment issues, learning to grieve their losses, setting attainable personal, social and vocational goals, identifying personal strengths, and finding ways to pursue personally rewarding, productive and/or enjoyable activities. Prigatano (1986) suggests that selected group members may vary considerably in cognitive sophistication but those with extremely limited verbal skills (i.e. verbal IQ below 75-80), and those who are psychotic, physically dangerous or with little impulse control should be screened, as they will interfere with group cohesiveness.

*Masking.* In spite of all these disabling conditions, many TBI clients become expert at masking their deficits and presenting a public persona. Some family and friends seeing them ambulatory and without obvious



physical impairment may treat them as fully recovered. The survivor may be feeling confused and guilty. S/he would like to meet their expectations but the impairments, though invisible to others, remain very real and restricting. Other family members, all too aware of their loved one's deficits, may have to contend with the individual's "chameleon-like character" (Lezak, 1988) in which s/he acts appropriately for a short time in the company of others. As a result, those who do not live with the brain injured person may fail to understand the complaints of caregivers.

Counsellors must be alert to clients who look physically normal, who communicate well and who claim to be problem-free. Further investigation and normalization of this phenomenon to TBI clients will often uncover persisting problems and a great deal of emotional distress and isolation. Assisting them to remove the masks in the therapeutic setting is an important first step. The purpose is to gradually recognize and adjust to permanent changes with a trusted therapist before working towards removal of masks with significant others and the public in general.

Obviously, these are not all the deficits the counsellor will encounter but they serve to illustrate the need for knowledge, empathy, and flexibility which are required to build a working relationship which can create an atmosphere of realistic hope and change. The extent of the impairments will dictate the most practical way to conduct a counselling program.

Survivors of TBI are seen by a myriad of medical, legal and insurance professionals. They lose considerable control over their own lives. The counsellor may be the first person to truly hear them, and with whom they are able to express their feelings, confusion and fears and begin the process of rebuilding their lives.

### *Goals of Counselling for Clients with TBI*

*Education.* Education plays an important role in the initial phases of counselling. Although counselling may not begin until many months post-injury, survivors and family members often have little knowledge of traumatic brain injury, the changes associated with it, the short-term and long-term recovery expectations, the local support groups available or how they can be active in the recovery process. By covering this type of information and answering questions in the early stages, one can normalize the experiences of the survivors and their loved ones and enable them to be involved and informed in the process of rehabilitation.

*Developing insight.* As previously mentioned, increasing self-awareness and self-evaluation is a primary goal in counselling TBI clients. To achieve this, the counsellor must gauge the resources and strengths of the client and facilitate reality-testing. Some clients will need to be confronted, others learn best in group situations, and videotaped sessions can be used individually to promote insight.

Some clients simply need a good working relationship in which they can independently dismantle the barriers which protect them from their reality-based fears. Others will require some or all of the strategies suggested to learn self-understanding and self-monitoring.

*Adjustment to deficits.* Awareness of deficit must be recognized as a crucial part of the recovery process (Prigatano & Schacter, 1991). Enhancing self-awareness—to the extent that it is organically possible—is a gradual process and can lead to emotional reactions consistent with the discovery that as a result of the accident, one has been permanently damaged. Depression or extreme anger, directed at self or the party responsible for the accident, often ensues. While maintaining this emerging self-awareness, the counsellor at this point may turn to the emotional needs of the client. Both support for, and normalization of this process can reduce the trauma associated with this adjustment and begin the initial stages of helping the individual find ways to control emotional liability and learn socially appropriate ways of coping to reduce self- or other-imposed alienation.

*Identifying personal strengths.* As well as adjusting to their deficits, these individuals should also be directed toward identifying their strengths and competencies. These will be important keys to finding self-satisfaction in meaningful activities and in social milieus. The extent of their difficulties only heightens the need for the counsellor to spend time addressing positives and helping the client re-discover his/her sense of humour.

*Coping.* The counsellor's ability to assist his/her client to develop coping skills and implement stress management strategies will have wide-ranging benefit. In addition to the adjustment to physical, intellectual and personality changes, the TBI client may be struggling with other factors such as certain aspects of their rehabilitation program, litigation procedures which create anxiety and uncertainty, and adjustment to a lifestyle that has been drastically altered. In some cases, they may need to grieve for friends or relatives hurt or killed in the same accident. There may also remain unresolved issues which evolved prior to the injury.

Stress management exercises such as structured guided imagery can help clients learn to relax and slow their racing thoughts. Audio-tapes can be recommended which allow them to practice daily or assist them in falling asleep. Practical review of stressors can serve to identify ways in which clients exacerbate stress levels with unrealistic expectations of self or others. Alternate attitudes and behaviours, such as learning to appropriately express their needs, can be explored.

Problems with impulsivity often lead to social distancing. To help clients overcome this difficult problem, it is essential that they feel unconditionally accepted. In a genuine, non-judgemental atmosphere,

they can begin to dissect the events which lead up to an outburst. Although at first they may believe that their reaction happens instantly, further investigation undertaken cooperatively can help detect negative self-messages, feelings of being attacked, and the use of triggers to release pent-up frustration. The strength of the therapeutic relationship can determine how far the counsellor can go to challenge and support the client.

*Family.* Motor vehicle accidents are the leading cause of brain injury (Durity, 1990). Survivors may also have suffered other physical injuries. The cognitive, emotional and behavioural changes can have a devastating impact on families. Some members are unable to cope with the strain and become estranged from the injured relative. Friends fall by the wayside. Family members, who may not have worked previously or recently, may suddenly find themselves responsible for providing for the financial needs of the family. In addition, they may find their daily schedule includes escorting their loved one from one appointment to the next, providing support in the face of emotional outbursts, and coping with the personality changes that can render TBI victims virtual strangers.

The importance of providing education and supportive counselling for these significant others cannot be overemphasized. Clinically, there are indications that achievement of recovery potential is enhanced in cases where family members are actively involved in the rehabilitation process. This has yet to be proven empirically.

Lezak (1988) explores the stresses experienced in specific family relationships such as those of the brain-injured person's parent, child, sibling or spouse. The differing roles carry with them a myriad of personal and psycho-social burdens. Parents of an injured child may experience marital strain leading to marriage breakdown. This may be the result of differing opinions on how to care for the child, the time and energy requirements needed to care for the child which may leave one parent feeling neglected, and grief suppressed due to the physical presence of the child. Aging parents of adult survivors may find themselves permanent caregivers, attempting to meet physical, emotional and financial needs of a dependent adult. Their hopes of increased personal and financial freedom may be dashed. Having a parent or sibling whose behaviour has changed significantly affects children in a variety of ways. Responsibilities at home may increase, parental attention may decrease, normal family activities may be curbed and children may be reluctant to bring friends home. Confusion, guilt, and shame may be some of the emotions of child experiences at a time when the parent(s) are not able to attend fully to them and their needs.

The spouse of a brain injured individual often loses his/her closest emotional support, primary companion, and sexual partner. Upon medi-

cal release, those spouses may find themselves living with someone who physically resembles their mate but who is, in effect, a stranger. Their partner is gone and they are left with the responsibility of caring for an individual with emotional, cognitive and behavioural problems. Lezak (1988) points out that these problems are compounded by the "social impermissibility of mourning the loss of their loved one: although the person loved by the spouse has vanished, custom allows us to mourn only when the body is dead" (p. 122).

The role of the counsellor working with family members is to support and normalize the experience for them. Family support groups can be helpful in reducing their sense of isolation and guilt. Grieving needs to take place so that they enable themselves to reintegrate the injured member into the family in a new way or in some cases, so that they can separate from that person without forever carrying a burden of guilt and remorse. Even with the restrictions brought about by caring for a brain injured person, it is essential that caregivers make time to engage in outside activities, maintain some level of social contact and recognize their own limitations and needs.

### *Seeking individuality and meaningfulness*

The TBI survivor's sense of self has been both changed and impaired. Physiological damage has caused disruptions of cognitive, emotional and behavioural functioning. The resulting dysfunction makes self-evaluation difficult both neurologically and psychologically.

Personality changes leave such survivors feeling like strangers to themselves. They are treated differently by friends and family. Body image may be affected by impaired coordination or paralysis, and/or scarring or amputation from secondary injuries. Childhood memories, the base from which they have evolved, may be sketchy or irretrievable. Self-worth associated with employment may be gone and the future uncertain. Family roles are significantly disrupted.

Cognitive abilities, which previously permitted TBI survivors to solve new problems, recall and incorporate past experiences, and make sense of confusion, are now faulty. Remaining areas of ability are hampered by self-doubts. Questioning the reasons for the accident and joining the search for purpose in a life restricted by neurological disability are steps on the journey to recovery.

Prigatano (1991) refers to Jung's ideas of integration of self through expression of symbols and this approach seems a valuable one to consider when working with this complex population. Communication impairments, as reported earlier, often hinder the typically verbal counselling session. By introducing new modalities of expression, we may find tools more beneficial to our clients than just the spoken word. In his

clinical work, Prigatano (1991) uses music to create a therapeutic relationship and finds that the lyrics can express and define the creation of purpose in one's life, post-TBI. He also suggests that the symbols of American [sic] culture—intelligence, beauty, winning and health—must be replaced, for the TBI survivor, with the more basic symbols of work, love and play. By expanding our repertoire to include projective techniques and creative expression such as drawing, painting, writing, sculpting, acting, listening to songs or stories, we can provide our clients with a wider range of tools for self-reparation, the healing of the soul and acceptance of the new self.

*Accountability.* Whatever the goals for a specific individual, Rosenthal (1989) cautions that psychotherapy is likely to be closely scrutinized and criticized by consumers, professionals and reimbursement agencies. He advises that clinicians “document the goals and accomplishments of psychotherapy carefully” and that researchers “identify those aspects of successful outcome that may be attributable to the effectiveness of psychotherapy with the brain injured” (p. 116).

Eames, Turnbull & Goodman-Smith (1989) suggest ways to evaluate the methods and effectiveness of rehabilitation programs. They suggest that the process should consider the outcome of the program both in terms of the changes in the TBI client and also with regard to changes in quality of life. Although difficult to assess and monitor, they believe that cost effectiveness of the program must be assessed and justified, and that decisions may be collaboratively made, on the basis of regular and comprehensive assessment procedures, to consider termination when rehabilitative progress has ceased.

### *Conclusions*

As counselling for survivors of traumatic brain injury and their families finds its place in private practitioner's offices as well as rehabilitation programs, researchers and clinicians need to find common ground and provide empirical support on which to base treatment designs. For rehabilitation specialists and counsellors in private practice the importance of attending to basic needs, re-training for employment, and social re-involvement must be aligned with the needs of the self, working through the losses, integrating a new sense of self and finding activities which are meaningful and provide a sense of purpose and accomplishment. The knowledge, flexibility and creativity of the counsellor can facilitate optimum adjustment to the changes, striving for wholeness and finding new meaning and pleasure in life as a survivor of traumatic brain injury.

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