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CHAPTER 2

Guidelines for Early Psychotherapy Sessions and General Treatment Considerations

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This chapter offers detailed guidelines for the initial consultation and the early psychotherapy sessions. It then describes some important general treatment parameters and techniques for effecting meaningful change with brain-injured patients. A few comments on care coordination and the reimbursement process, together with a brief case study, conclude the chapter.

THE INITIAL CONSULTATION

The initial consultation emanates from Phase 3 of the PEM (see Chapter 1, Figure 1.2). A key determinant for referral of a brain-injured patient to psychotherapy is that the patient has struggled and often failed to achieve independence in the home and community, and/or has been unable to reintegrate successfully to work or school. Alternatively, patients may be referred by their physicians immediately after discharge from an inpatient rehabilitation setting, so as to avoid potential posthospitalization adjustment problems. Of note, patients themselves are often not the ones seeking psychotherapy; distressed and overwhelmed family members or astute health care professionals are usually the ones who recognize that the patients need psychotherapy, with an emphasis on psychoeducation, coping, and adjustment to their deficits. Therefore, a psychotherapist should not assume that a patient is motivated (at least initially) for psychotherapy.

Typically, a patient being considered for psychotherapy will need a physician's referral. This facilitates the acquisition of relevant medical records, which are necessary for determining the patient's appropriateness for therapy and anticipating possible psychotherapeutic needs and challenges. Records should be obtained and reviewed in advance of the initial consultation. Helpful medical records should include the background neurological findings and associated medical history; radiographic reports; neurosurgical reports; consultations by neurologists and neuro-ophthalmologists; and summary reports from other rehabilitation settings (both inpatient and outpatient). If available, prior neuropsychological reports are very informative—especially when they contain pertinent preinjury social history, including drug and alcohol use, employment history, and the psychosocial adjustment of the patient and family members. For a student, prior grades and standardized test scores are very beneficial in establishing the individual's academic and behavioral history.

This volume does not address how to do a neuropsychological evaluation (see Lezak, Howieson, Loring, Hannay, & Fischer, 2004; Strauss, Sherman, & Spreen, 2006; Snyder, Nussbaum, & Robins, 2006; Uomoto, 2004). However, an up-to-date neuropsychological evaluation will provide essential quantitative and qualitative data about the patient's neuropsychological and emotional status, and will delineate specific cognitive strengths and difficulties; therefore, it will guide the consultation (and treatment) process (Erickson, 1995; Prigatano & Klonoff, 1988). For example, the intake interview approach will need to be modified to fit the patient's memory capacity, abstract reasoning skills, language abilities, and speed of information processing. In some situations, the psychotherapist may also be the neuropsychologist who performs the neuropsychological examination. This can be useful, as clinical observations and other data obtained by the neuropsychologist/psychotherapist during the evaluation process typically provide an excellent starting point for the psychotherapeutic and alliance-building process. Table 2.1 lists assessment domains and sample neuropsychological tests for each domain. This list is not exhaustive and can be modified according to the preferences of the examiner, the requirements of the treatment setting, and the nature and extent of the patient's neurological injury. Note that symptom validity testing should be included, in order to be sure that the patient has the necessary motivation to embrace the psychotherapeutic process, with a goal of improving independence and functionality.

The purpose of an initial 1-hour consultation is to make a formal determination of the patient's "fit" for a psychotherapeutic relationship, as well as the potential for meaningful change. It is recommended that family members be included for at least a portion of the consultation. This gives the clinician the opportunity to preview not only the family members' unique emotional resources and psychodynamics, but also the dynamics, interaction styles, and behavior patterns between family members and the patient. All parties are asked in advance for permission (and the patient is asked to sign a release form) to discuss the patient's and family members' perceptions about the patient's deficits. Also, when the first appointment is set, the patient and attending support system members are told that the consultation precedes formal initiation of psychotherapy services, and that as part of the appointment, all parties will be asked about their willingness to proceed with treatment sessions.

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TABLE 2.1. Sample Neuropsychological Domains and Tests

Neuropsychological domain	Sample tests
Effort/motivation	• Number Memory Test (Hiscock & Hiscock, 1989) • Letter Memory Test (Inman et al., 1998) • Victoria Symptom Validity Test (Slick, Hopp, Strauss, & Thompson, 2005) • Test of Memory Malingering (Tombaugh, 1996) • California Verbal Learning Test—Second Edition, Adult Version (CVLT-II) Long-Delay Forced-Choice Recognition (Delis, Kramer, Kaplan, & Ober, 2000)
Attention/ concentration	• Wechsler Adult Intelligence Test—Fourth Edition (WAIS-IV) Digit Span (Wechsler, 2008) • WAIS-IV Arithmetic (Wechsler, 2008) • WAIS-IV Letter–Number Sequencing (Wechsler, 2008) • WAIS-IV Cancellation (Wechsler, 2008) • Trail Making Test, Part A (Heaton, Grant, & Matthews, 2004) • Wechsler Memory Test—Fourth Edition (WMS-IV) Spatial Addition (Wechsler, 2009)
Speed of information processing	• WAIS-IV Symbol Search (Wechsler, 2008) • WAIS-IV Coding (Wechsler, 2008) • WAIS-IV Cancellation (Wechsler, 2008) • WAIS-IV Processing Speed Index (Wechsler, 2008) • Symbol Digits Modalities Test (Lezak, Howieson, Loring, Hannay, & Fischer, 2004)
Motor functioning	• Rey Complex Figure Test—Copy (Meyers & Meyers, 1995) • Bicycle Drawing Test (Lezak et al., 2004) • Porteus Mazes (Porteus, 1965) • WAIS-IV Block Design (Wechsler, 2008) • Finger Tapping Test (Heaton, Grant, et al., 2004) • Grooved Pegboard Test (Heaton, Grant, et al., 2004)

Verbal functioning	• Expression
	  • WAIS-IV Vocabulary (Wechsler, 2008)
	  • Controlled Oral Word Association (COWA) (Heaton, Miller, Taylor, & Grant, 2004)
	  • Boston Naming Test (Goodglass & Kaplan, 2000)
	• Comprehension
	  • WAIS-IV Verbal Comprehension Index (Wechsler, 2008)

Visuospatial functioning	• WAIS-IV Block Design (Wechsler, 2008) • WAIS-IV Perceptual Reasoning Index (Wechsler, 2008) • Rey Complex Figure Test—Copy (Meyers & Meyers, 1995) • Bicycle Drawing Test (Lezak et al., 2004)

Memory	• Working memory
	  • WAIS-IV Arithmetic (Wechsler, 2008)
	  • WAIS-IV Letter–Number Sequencing (Wechsler, 2008)
	  • WAIS-IV Digit Span (Wechsler, 2008)
	  • WAIS-IV Coding (Wechsler, 2008)
	  • WAIS-IV Working Memory Index (Wechsler, 2008)
	  • WMS-IV Spatial Addition (Wechsler, 2009)
	  • WMS-IV Visual Working Memory Index (Wechsler, 2009)

(cont.)

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TABLE 2.1. *(cont.)*

Neuropsychological domain	Sample tests

	• Verbal memory
	  • WAIS-IV Information (Wechsler, 2008)
	  • CVLT-II (Delis et al., 2000)
	  • WMS-IV Auditory Memory Index (Wechsler, 2009)
	• Visual memory
	  • Rey Complex Figure Test—Delayed Recognition and Recall (Meyers & Meyers, 1995)
	  • Subtest 7 of the Category Test (Heaton, Grant, et al., 2004)
	  • WMS-IV Visual Memory Index (Wechsler, 2009)

Concept formation	• Verbal
	  • WAIS-IV Similarities (Wechsler, 2008)
	  • CVLT-II Semantic Clustering (Delis et al., 2000)
	• Visual
	  • Wisconsin Card Sorting Test (WCST) (Heaton, 2003)
	  • Category Test (Heaton, Grant, et al., 2004)

Reasoning	• Verbal
	  • WAIS-IV Comprehension (Wechsler, 2008)
	• Visuoperceptual
	  • WAIS-IV Picture Completion (Wechsler, 2008)
	  • WAIS-IV Block Design (Wechsler, 2008)
	  • WAIS-IV Figure Weights (Wechsler, 2008)
	  • WAIS-IV Visual Puzzles (Wechsler, 2008)
	  • WAIS-IV Matrix Reasoning (Wechsler, 2008)
	• Mathematical
	  • WAIS-IV Arithmetic (Wechsler, 2008)

Executive functioning	• Organization/planning
	  • Porteus mazes (Porteus, 1965)
	  • Rey Complex Figure Test (Meyers & Meyers, 1995)
	• Flexible problem solving
	  • Trail Making Test, Part B (Heaton, Grant, et al., 2004)
	  • COWA (Heaton, Miller, et al., 2004)
	  • Ruff Figural Fluency Test (RFFT) (Ruff, 1996)
	  • Tower of London (Culbertson & Zillmer, 2005)
	• Effective performance
	  • WCST (Heaton, 2003)
	  • CVLT-II (Delis et al., 2000)
	  • RFFT (Ruff, 1996)
	  • Category test (Heaton, Grant, et al., 2004)

Awareness	• Patient Competency Rating Scale (Patient and Relatives' Forms) (Prigatano et al., 1986)
Personality composition and psychological distress	• Minnesota Multiphasic Personality Inventory–2 (MMPI-2; Butcher, 2005) • Millon Clinical Multiaxial Inventory–III (MCMI-III; Millon, 2005)
Estimate of premorbid intelligence	• American National Adult Reading Test (Gladsjo, Heaton, Palmer, Taylor, & Jeste, 1999)

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The initial consultation provides a critical opportunity to assess the patient's neuropsychological and emotional status in order to make cogent recommendations, including possible goals of the psychotherapy process. If psychotherapy is to occur in the context of other treatment modalities, this consultation often provides valuable input regarding the patient's potential to benefit from other therapies.

Table 2.2 lists the relevant domains for inquiry during the initial consultation. These include demographics, social and medical history, injury-related data, subjective report of present status, and current medical treatment. Other key areas to assess are the patient's overall psychological/psychiatric status and the family's involvement.

TABLE 2.2. Topics for the Initial Consultation

Demographics

- Age
- Gender
- Date and place of birth
- Educational history (grade/degree completed and academic status)
- Marital status (current and past) and current family composition
- Occupational history (overview of current and past jobs)
- Living situation and activities of daily living with level of independence

Social history

- Preinjury and current alcohol and drug use
- Preinjury legal problems (e.g., arrests)

Medical history

- Previous brain injury or disease (e.g., loss of consciousness, seizures, high fever)
- General medical history (systemic illness, comorbid disease)
- Prior medical and psychological treatments
- Prior medications

Injury-related data

- Circumstances of injury (date, location, and surrounding events; mechanism of injury; presence–absence of paramedics and/or hospitalization/surgery)
- Absence–presence of loss of consciousness and length of time
- Estimated period of posttraumatic amnesia
- Glasgow Coma Scale score
- Radiographic findings (computed tomography [CT] and/or magnetic resonance imaging [MRI])

Subjective report of post-injury status

- Current cognitive, language, and physical status
- Emotional status (e.g., anxiety, depression, self-harm)
- Sleep, appetite, and libido
- Driving status
- Use of strategies or compensations (e.g., datebook, pillbox)
- Presence–absence of litigation or financial disincentives

Current medical treatment

- Rehabilitation (overview and perception of proposed needs)
- Medical management (other medical services/practitioners involved)
- Medications, including psychotropics
- Medical complications (e.g., pain, seizures)

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Preliminary Inquiry into Awareness, Acceptance, and Realism

A primary goal of the initial consultation is to begin to ascertain the patient's current level of awareness, acceptance, and realism in regard to the injury sequelae. "Level of *awareness*" refers to the patient's understanding of deficit areas (see Chapter 3). Awareness affects the degree of motivation for psychotherapy and other treatment interventions. A preliminary overview of the patient's level of awareness of his or her difficulties is accomplished by asking open-ended questions about current problems in the physical/perceptual, cognitive/language, and emotional domains. During the discussion, the patient is asked to rate items in these three domains on a 10-point Deficit Rating Scale, with 0 representing no problem and 10 indicating a severe problem (see Figure 2.1). For patients who experience an absence of self-reported changes, specific questions can be asked (e.g., "Do you notice changes in your speed of thinking? How about your memory?"), followed by cautious inquiry into self-ratings. In order to encourage a sense of autonomy, the patient is asked first for his or her perceptions. Family members are then included in the exploration process, with an eye to evaluating the concordance versus dissimilarity of perceptions, as well as the patient's responsiveness (or lack thereof) to his or her family's input. Family members' ratings may differ significantly from the patient's, often ascribing greater degrees of impairment. In order for the patient not to feel "ambushed," the purpose of asking family members for their input is explained beforehand, including a proviso that their ratings may be different.

A rough index of *acceptance* is obtained by asking the patient about his or her willingness to employ new compensatory strategies, such as a detailed datebook system or procedural checklists (see Chapter 5). This also yields prognostic information about his or her "coachability" in acquiring new skills. A preliminary and general overview of the patient's level of *realism* is obtained by inquiring about career aspirations, driving status, and the capability to be unsupervised in the home and community (see Chapter 9). Family input on these topics is also beneficial.

The clinician must be astute to the particular distinctions between patients with more acute versus more chronic injuries. An acutely injured patient often struggles primarily with organic unawareness, convinced that he or she does not need intensive treatment and can simply return to his or her preinjury existence. A benchmark of readiness for change is a patient's voluntary identification of at least one area of nonphysical deficit that he or she will even tentatively consent to address (e.g., memory, depression). The combination of dawning awareness with the patient's voiced trust and motivation for the ensuing treatment process bodes well for a positive outcome.

Patients with more chronic injuries have generally encountered multiple "hard knocks" in attempts to successfully regain their former independence and quality of life. They are more aware, at least on a basic level, of some of their deficits and the potential advantages of treatment. However, these individuals tend to struggle more in the domain of acceptance and realism. Their life aspirations tend to be a poor match with their neurological status. They have also often developed entrenched inefficient or otherwise unhelpful ways of compensating for their deficits, which need to be supplanted with more efficient compensations. In this

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Ask the patient, followed by a significant other, to provide *oral* ratings of the domains below. Use the following scale: 0 = no problem; 1 = small (mild) problem; 5 = medium (moderate) problem; 10 = large (severe) problem.

Domain	Patient	Significant Other
Physical/perceptual		
Weakness		
Coordination		
Visual neglect		
Double vision		
Headaches		
Cognitive/language		
Memory		
Attention and concentration		
Speed of thinking		
Reasoning and problem solving		
Organization		
Multitasking		
Impulsivity		
Language comprehension		
Language expression		
Reading		
Writing		
Spelling		
Arithmetic		
Emotional		
Frustration		
Depression		
Feeling overwhelmed		
Irritability		
Distrust		

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FIGURE 2.1. Deficit Rating Scale.

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case, the psychotherapist will explore the patient's openness to trying new compensations (e.g., a datebook). It is a positive sign for effective collaboration when these patients express even cautious receptivity to new interventions. Therefore, the clinician must gain an overall appreciation of the patient's capacity for change, regardless of the multitude of areas to be addressed.

Overall Psychological and Psychiatric Status

During the initial consultation, the clinician is on a discovery course to gain an initial sense of the patient's general pre- and postinjury psychological and psychosocial status. This is accomplished by empathic inquiry, with "clinical eyes" on how the individual tolerates preliminary questioning, including the extent to which he or she can disclose pertinent and personal information. For example, does the individual become annoyed or defensive early in the interview when asked about preinjury individual and family psychiatric history, work performance, or problems with the law? Guardedness, evasiveness, suspiciousness, or irritability in regard to this type of inquiry constitutes a potential warning sign that the patient may be too easily overwhelmed or emotionally brittle to tolerate or benefit from an insight-oriented, psychoeducational approach. However, even when encountering preliminary trepidations or resistance (i.e., PEM "yellow" [warning zone] behavior; see Figure 1.2), the psychotherapist should try to develop rapport with the patient and not make too quick a presumption that the patient cannot benefit from psychotherapy. Over time, the commitment to the psychotherapy process can evolve (i.e., PEM "green" [coping zone] behavior).

Often patients arrive at the initial consultation interview in considerable emotional distress, or even, in crisis. Possible symptoms of depression should be explored, such as feelings of helplessness, hopelessness, and joylessness. It is essential to inquire into such a patient's current (and past) intentions of self-harm. Access to firearms should be determined. The psychotherapist must have a protocol for immediate intervention, should the patient present with either overt or covert signs of suicidal risk. Preferably, the therapist should have a professional relationship with a psychiatrist who can intervene or provide appropriate consultation, as well as a list of appropriate emergency treatment options or settings.

Patients should also be asked directly about preexisting substance use patterns. Total abstinence from alcohol and street drugs is a requirement for psychotherapy in my practice. These substances directly interfere with active rehabilitation and neurological recovery; they also increase the likelihood of medical complications, such as seizure disorders (see Lezak et al., 2004, for a review; see also Sparadeo, 1993). Alcohol and street drugs also cloud judgment and affect other capacities (e.g., impulse control, problem solving, and balance) that are important to the patient's safety. Furthermore, postinjury problems with depression, anxiety, suicidality, and psychosocial adjustment are increased in patients with substance abuse histories (Felde, Westermeyer, & Thuras, 2006; Klonoff & Lage, 1995; MacMillan, Hart, Martelli, & Zasler, 2002; Mainio et al., 2007; Wagner, Hammond, Sasser, & Wiercisiewski, 2002). Because the psychotherapist has reviewed the medical records in advance, he or she will generally be aware of preexisting problems. The patient's and family's candid disclosure of this information dem-

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onstrates the willingness for honest dialogue and personal ownership. Patients with a preexisting substance abuse history must agree to random urinalyses as part of their psychotherapy, be open to psychiatric treatment and/or concurrent substance abuse counseling, and commit to disclosing possible relapses.

The psychotherapist should also be alert to a patient's possible attempts to consciously exaggerate symptomatology for purposes of secondary gain (Millis, 2008; Rogers, 2005). Motivational problems will undermine progress within a psychotherapeutic relationship founded on improving the patient's adjustment, especially when a goal of therapy is working toward gainful employment (Klonoff & Lamb, 1998).

In general, the initial consultation is aimed at helping the psychotherapist begin to differentiate the patient's underlying neurobehavioral difficulties, preinjury psychiatric status, and postinjury motivations and emotional reactions. This differentiation provides a basis for developing meaningful psychotherapeutic interventions (Prigatano et al., 1986).

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Family Involvement

Family members (or the members of a patient's support network) often experience overwhelming bewilderment and anguish about their loved one's condition and prognosis. In this context, part of the initial consultation is to evaluate the psychological status of the family members and their capacity to collaborate with the psychotherapist and patient. Considerations include their commitment to physically attend regular family sessions and/or a family group (see Chapter 7). Active involvement is the foundation for necessary psychoeducation and emotional support, without which their loved one will flounder. The family members' demeanor, verbalizations, and style of interaction with the patient during the consultation will also provide a preliminary indication of their general psychological health and aptitude for developing a positive working alliance, including comfort and frankness in sharing. This sets the stage for later progress in setting and achieving psychotherapeutic goals, and for improving family adjustment and harmony.

At the end of the initial consultation with the patient and family, all parties decide on the advisability of continuing the dialogue process. Typically, the next step is to agree to a finite number of sessions (e.g., two to six) to further explore the patient's (and family's) psychological status and needs, and to gain a better appreciation for the patient's and family's capacity to develop a working alliance. For a variety of reasons, the parties may decide not to continue with treatment, and the psychotherapist should then provide information about other appropriate treatment resources in the community. If psychotherapy seems feasible, the psychotherapist arranges one or more follow-up appointments to conduct a more in-depth interview.

THE IN-DEPTH INTERVIEW PROCESS

When a patient is a likely candidate for psychotherapy, the therapist conducts a more in-depth interview, with an emphasis on gaining a more holistic perspective

of the patient. This process may take a few sessions, which constitute the beginning of the psychotherapy. These sessions should further the collaboration. There are three components to this process: a preinjury psychosocial history; a comprehensive exploration of the patient's impressions of his or her current neurological/neurobehavioral status; and early goal setting.

The Preinjury Psychosocial History

The psychosocial history is integral to further exploring the patient's preinjury behaviors, interests, psychological constructs, and interpersonal relationships. It is often striking how much suffering patients have experienced prior to their neurological event. Discovering their prior life events allows interpretation of present feelings and behaviors in the context of these events and gives insight into the preinjury coping style. The latter is a predictor of psychological readiness for the psychoeducation process and eventual postinjury adjustment (Lewis & Rosenberg, 1990). Taking a psychosocial history also facilitates clinical observations of a patient's capacity for trust—a fundamental precursor to any substantive progress in the psychotherapeutic process.

There are various approaches to taking a psychosocial history. Some psychotherapists prefer structured interviews for increased reliability and validity (Groth-Marnat, 2003; Karg & Wiens, 2005). The disadvantages are that these may constrain the flow and spontaneity of the interview process, and may make patients feel that they are being interrogated, or that the psychotherapist is merely on a fact-finding mission. Likewise, some psychotherapists have patients complete a lengthy questionnaire prior to the first appointment. This can seem impersonal or even intrusive, especially when patients are asked to recount in writing troubling personal history, outside of an empathic treatment ambience.

I prefer to take a semistructured approach—that is, to cover a list of topic areas by asking open-ended questions (see Table 2.3). This approach offers flexibility, encourages patients to tell their stories, and heightens rapport (Groth-Marnat, 2003; Roter, Cole, Kern, Barker, & Grayson, 1990). The open-ended questions also allow a psychotherapist to walk in a patient's shoes. Yalom (2002) describes the process of taking a history as intuitive and automatic—as *part of* therapy, not *preceding* therapy. Helpful adjunct approaches include comments to encourage the flow of conversation and asking for more specifics (Groth-Marnat, 2003).

It is worth noting that exploration of the patient's past often happens over time, and that the past may well be revisited intermittently as part of the psychotherapy process. Often only later in therapy do patients reveal personal details of their lives that heretofore they were ashamed or frightened to share. This only serves to empower the working alliance. For example, a male patient who suffered a traumatic brain injury felt depressed and emotionally detached from his teenage sons. Once the working alliance solidified, he shared a long-kept secret: He had been the victim of severe beatings and horrifying sexual abuse by his father, which had always interfered with his ability to become emotionally involved with and attuned to his own sons. This history was a powerful declaration, which enhanced the course of treatment by bridging the neurological, historical, and interpersonal realms.

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TABLE 2.3. Topics for a Detailed Psychosocial History

Social history

Topics

1. Family history (including parents' and siblings' occupational, medical, and psychiatric health)
2. Childhood experiences and traumas
3. Preinjury psychiatric diagnoses and treatment
4. Preinjury financial status
5. Preinjury hobbies and interests

Sample inquiries

1. Which parent are/were you closer to and why?
2. How would you describe your home life while you were growing up?
3. How did your childhood experiences/traumas affect you while you were growing up? How do they affect you currently?
4. How was your experience of any prior psychiatric/psychological counseling? Did it help (and if so, how)?
5. How did any prior financial burdens affect you?
6. Why did you choose to get involved in certain hobbies?
7. What was your favorite pasttime and why?

Developmental and educational history

Topics

1. Developmental history (prenatal or postnatal complications; developmental delays in walking, talking, etc.)
2. Academic strengths and difficulties; learning and/or behavioral problems in school

Sample inquiries

1. How did any early health problems affect you and your family?
2. Did you like school? Why or why not?
3. What was your favorite/least favorite class and why?
4. How did you behave in school?

Occupational history

Topics

1. Occupational history (including major job fields, job transiency, and occupational problems)

Sample inquiries

1. Why did you choose this (these) occupation(s)?
2. What was your favorite job and why?
3. What was the most difficult aspect of your job?
4. How did you get along with your supervisors and coworkers?
5. How were your performance evaluations and why?
6. Were you ever terminated from a job? If so, why?

Subjective report of postinjury status

Topics

1. More detailed exploration of cognitive, physical, language, emotional, and interpersonal problems
2. Perception of course of recovery—improvement versus deterioration
3. Family relationships
4. Hobbies, interests, and socialization
5. Perception of work capacity
6. Goals and aspirations for the future

(cont.)

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TABLE 2.3. *(cont.)*

Sample inquiries

1. How do your (cognitive, physical, etc.) problems manifest themselves from day to day?
2. Do you ever feel hopeless about the future, as if there is no reason to go on?
3. How do you feel about your recovery—its pace and timing?
4. How is your family reacting to/handling your circumstances?
5. Are you happy with your current involvement in hobbies?
6. How is your social life going and why?
7. What do you miss most currently?
8. What is your current impression of your work abilities?
9. What occupation do you want to pursue and when?
10. How do you see yourself in the next 6 to 12 months?

Table 2.3 lists the areas to be explored in taking a detailed psychosocial history. These include social history, developmental and educational history, and past occupational history. Some sample questions are included; however, the clinician is cautioned to follow the flow of the unfolding process, rather than adhere to a predetermined script. Overall, these early sessions signal the patient's capacity to share information.

Patients' Impressions of Their Current Neurological/Neurobehavioral Status

Exploration of patients' current frustrations, desires, and ambitions is central to the early sessions. The therapist should query patients in more depth about their impressions of cognitive, physical, language, emotional, and interpersonal problems, including their perceived course and pace of recovery. Other topics include assets and challenges within a patient's family and support network; the presence or absence of meaningful postinjury hobbies and outlets; and the patient's ideas about work. Table 2.3 also contains some sample questions for these domains. This inquiry is in part a precursor to a more in-depth evaluation of the patient's degree of awareness, which is discussed further in Chapter 3.

Early Goal Setting

In collaboration, the psychotherapist and patient identify initial treatment goals; again, this is a gradual process. The therapist should note that patients' (and families') current levels of awareness, acceptance, and realism are further revealed by inquiry into their expected time frames for goal completion. In general, the benefits of psychotherapy often take many months to manifest themselves, and patients (as well as families) often underestimate the amount of time and energy that they will need.

Preliminary goal setting can generate the necessary commitment and momentum for change. It is recommended that the agreed-upon goals be explicit and concrete (e.g., 12 sessions to address catastrophic reactions and improve awareness). The patient needs to have an unambiguous understanding of the purpose of the psychotherapy. This is particularly crucial with this population, given the influ-

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ence of memory, language, and executive function deficits, and the prevalence of organic unawareness. The family members should be included in the dialogue about initial goal setting, to maximize their "buy-in."

The initial goals of therapy should be made realistically attainable, to avoid creating undue frustration and disenchantment in the patient. This requires the psychotherapist to have a sufficient working knowledge of the nature and extent of the patient's organically based deficits. Specific subgoals with anticipated time frames should also be developed. For example, if a patient is adjusting to a new work environment, it is helpful to propose a 6- to 8-week period to monitor mood and adjustment. Specific markers should be identified, including positive work reviews and self-ratings of psychological well-being. These mutually chosen benchmarks of progress will help the therapist and patient determine whether psychotherapy is succeeding. Later chapters explore the distinctive approaches and techniques for goal setting in the context of awareness, acceptance, self-identity, realism, and social reintegration.

Overall, the above-described interview techniques and clinical observations provide a mechanism for contemplating and embarking upon the psychotherapy process.

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GENERAL TREATMENT CONSIDERATIONS

The following treatment considerations are recommended for accommodating the common cognitive, psychological, and interpersonal sequelae after acquired brain injury. These recommendations should be tailored to the needs of each patient, of course.

Structure, Regimen, and Accountability

The broader goals of psychotherapy with brain-injured patients are improved relationships and a return to productive status. Therefore, the context of therapy should emulate the context of healthy real-world relationships. It is most effectual to impose a level of structure (Judd & Wilson, 2005), regimen, and accountability within the psychotherapeutic relationship. Given patients' memory, auditory processing, and comprehension problems, therapy expectations and their rationale should be introduced in a written contract format along with in-session explanations (see Figure 2.2). The contract should be reviewed with the patient prior to the formal initiation of treatment. For example, the patient should be informed in writing about the purposes, risks, and benefits of psychotherapy; the frequency, length, and location of appointments; expectations regarding homework; fees, insurance reimbursement, and payment requirements; limits of confidentiality; record-keeping protocols; cancellation policies; and ways to contact the psychotherapist after hours in case of an emotional crisis or other emergency. It is advisable to have the patient sign this document, indicating that he or she has read and understands this information. The family members involved in the treatment process should also be aware of this information, to avoid confusion about the nature and purpose of the psychotherapy process.

[Insert your professional name,
address,
phone,
fax,
and e-mail address]

Outpatient Services Contract

Welcome to my practice. This document contains very important information about how I conduct my professional practice and business policies. Please read it carefully and make notes on any questions you might have, so that we can discuss them. Once you sign this document, it will reflect that you have read and fully understood the contents, and that it will constitute a binding agreement between us.

Psychological Services

The process of psychotherapy is not easily defined or described. The nature of the process varies, depending on a number of factors—including the training and experience of the therapist, the personalities of all parties involved, and the particular problems that a patient brings forth to work on. It is not like visiting a medical doctor, because it requires you to take a very active, participating role. To gain the most benefit from psychotherapy, you will need to work both during the sessions and at home.

Psychotherapy involves both risks and benefits. The risks include possibly experiencing uncomfortably strong feelings, such as sadness, frustration, guilt, anger, anxiety, loneliness, and helplessness. To be successful, psychotherapy also often requires recalling and talking about unpleasant events in the past. However, psychotherapy has also been shown to benefit those who undertake it: There is often a reduction in feelings of distress, resolution of specific problems, or an improvement in significant relationships. However, these are not guarantees about what will happen.

Entering into a psychotherapeutic relationship is a decision that requires serious thought and commitment. Therapy involves a great amount of time, money, and energy, so you should be very careful about the therapist you decide to work with. I would ask that you commit to coming in for two sessions, during which we will have the opportunity to evaluate one another and make an informed decision about continuing further with psychotherapy. At the end of that evaluation period, I will be able to provide you with some initial impressions of what our therapy should include and a beginning treatment plan, if you should decide to continue and enter into a professional relationship. If you have questions about my approach or procedures, we should discuss them whenever they arise. At the end of the evaluation or at any time thereafter, if you should have significant doubts or wish to discontinue treatment, I will be happy to help you obtain an appropriate consultation with another mental health professional.

Meetings

If we both agree to begin psychotherapy, I typically schedule one 45-minute session each week at a mutually agreed-upon time. Sometimes sessions will be longer or more frequent, as your needs dictate and as we agree upon. Once this appointment hour is scheduled, you will be expected to pay for it unless you provide 24 hours' notice of cancellation, or unless we agree that you were unable to attend because of circumstances beyond your control.

(cont.)

FIGURE 2.2. Outpatient services contract.

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Professional Fees

My fee is _____ per 45-minute treatment session. In addition to weekly appointments, it is my practice to charge this amount on a prorated basis for other required professional services (such as report writing or telephone conversations) that last longer than 10 minutes; attendance at meetings or consultations with other professionals that you have authorized; preparation of records or treatment summaries; or time required to perform any other service that you may request of me. At times, patients become involved in legal proceedings that may require my participation. If this should occur, you will be expected to pay for the professional time required to prepare for such an event, even if I am compelled to testify by another party. Because of the complexity and difficulty of litigation, I charge _____ per hour in preparation for and attendance at any legal proceedings.

Billing and Payments

You will be expected to pay for each session at the time it is held, unless we agree otherwise or you have insurance coverage that requires another arrangement. Payment schedules for other professional services will be agreed upon at the time the services are requested. In circumstances of financial hardship, you have the option to fill out our Sliding Scale Fee Reduction Application, in which my billing company will review and set a fee based upon the U.S. Department of Health and Human Services poverty guidelines.

If you are using insurance to reimburse me for my professional services, once we have all the information concerning your insurance coverage, we will discuss what we can expect to accomplish with the available benefits and what will happen if those benefits run out before you feel ready to end our sessions. You should also remember that you always have the right to pay for the services yourself and avoid the complexities involved with many insurance claims. If your account is more than 60 days past due and suitable payment arrangements have not been agreed upon, I have the option of using legal means to secure payment, including collection agencies or small-claims court. In such cases, usually the only information I release about a client's treatment would be the client's name, the nature of services provided, and the amount due. Even if this circumstance should come about, I will provide you with referral sources to deal with your treatment needs.

Insurance Reimbursement

In order to set realistic treatment goals and priorities, it is important to evaluate what resources are available to pay for your treatment. If you have a health benefits policy, it will usually provide some coverage for psychotherapy through mental health benefits. You should carefully read the section in your insurance coverage booklet that describes mental health services. If you have any questions, please call your plan and inquire. Of course, I will provide you with whatever information I can, based on my experience, and will be happy to try to help you understand the information you receive from your carrier. I am willing to call the carrier on your behalf, if this is necessary to resolve any confusion. I will also provide assistance in filling out any necessary forms, as appropriate. However, you, and not your insurance company, are responsible for full payment of the fee to which we have agreed. Therefore, it is very important that you find out exactly what mental health services your insurance policy covers.

The increasing concern and debate over the cost of health care have resulted in increasing levels of complexity in insurance benefit programs, to the point that it is sometimes difficult to determine exactly how much mental health coverage is available. Managed health care plans, such as health maintenance organizations (HMOs) and preferred provider organizations (PPOs), often require advance authorization before providing reimbursement for mental health services. Such plans are often oriented toward a short-term treatment approach that is designed to resolve specific problems interfering with a person's overall level of functioning. In my experience, while much can

(cont.)

FIGURE 2.2. *(page 2 of 4)*

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be accomplished in such short-term therapy, many clients feel that more services are necessary after insurance benefits expire. It may therefore be necessary to seek additional approval for a certain number of sessions. Be aware that some HMOs and PPOs do not allow for additional services once your benefits are no longer available.

You must also realize that most insurance agreements require you to authorize me to provide them with a clinical diagnosis and, at times, additional clinical information (such as a treatment plan or summary). In rare cases, such agreements require them to obtain a copy of the entire treatment record. This information will become part of the insurance company's files, and in all probability some of it will be computerized. All insurance companies claim to keep such information confidential, but once it is in their hands, I have no control over what they do with it. In some cases, they may share the information with a national medical information databank. If you request it, I will provide you with a copy of any report that I submit to them.

Contacting Me

I am often not immediately available by phone. Although I am usually at work between 8 A.M. and 5 P.M., the bulk of this time is spent in treatment with patients, and I usually will not answer the phone when in a treatment session. However, during those hours someone is almost always available to take a message at (000) 000-0000. Outside of the above-mentioned hours, there is an answering machine available at this number, and the messages are checked every workday morning. If you are difficult to reach, please leave times when you will be available, so that I can return your call as promptly as possible. In case of an emergency, call the hospital operator at (000) 000-0000 and inform them that it is an emergency. The operator will then page me. If you cannot reach me, and you feel you cannot wait for me to return your call, you should call your family physician or go to the nearest emergency room and ask for the psychiatrist who is on call. If I am unavailable for an extended time, I will provide you with a name of a trusted colleague whom you may contact if necessary.

Professional Records

Both the law and the ethical code of my profession require that I maintain appropriate treatment records. You are entitled to receive a copy of these records. However, because they are professional records and may be misinterpreted and/or can be upsetting, if you wish I can prepare an appropriate summary that will provide the level of detail necessary for your purposes. If you wish to see your records, I recommend that we view them together, so that we will have the opportunity to discuss what they contain. There will be an appropriate fee charged for any preparation time required to comply with any information requests.

Minors

If you are under 18 years of age, please be aware that the law provides your parents with the right to examine your treatment records. It is my policy to request an agreement from parents for their consent to give up access to your records. If they agree, I only provide general information on how your treatment is proceeding, unless I feel there is a legitimate reason to do otherwise. For example, if there is a high risk that you will seriously harm yourself or another person, or I learn of child abuse, pregnancy, or serious drug use, I will notify them of these concerns. I will also provide them with a summary of your treatment when it is complete. Before giving them any information, I will discuss the matter with you and do my best to resolve any objections you may have about what I am prepared to discuss with them.

(cont.)

FIGURE 2.2. *(page 3 of 4)*

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Confidentiality

In general, the confidentiality of all communications between a client and a psychologist is protected by law, and I can only release information about our work to others with your written permission. However, there are some exceptions.

In most judicial proceedings, you have the right to prevent me from providing any information about your treatment. However, in some circumstances—such as a child custody proceeding, or proceedings where your emotional condition has been determined to be an important element—a judge may require my testimony if he or she determines that the resolution of such issues demands it.

There are some situations in which I am legally required to take action to protect others from harm, even though this action may reveal some information about a client's treatment.

1. If I believe that a child, an elderly person, or a disabled person is being abused, I must file a report with the appropriate state agency.
2. If I believe a client is threatening serious bodily harm to another, I am required to take protective actions, which may include notifying the potential victim, notifying the police, or seeking appropriate hospitalization.
3. If a client threatens to harm him- or herself, I may be required to seek hospitalization for the client or to contact family members or significant others who can help provide protection.

These first three situations have rarely arisen in my practice. However, should such a situation occur, I will make every effort to fully discuss it with you before taking any action.

4. I occasionally find it helpful to consult about a case with other professionals. In these consultations, although I make every effort to avoid revealing the identity of my patient, this cannot be guaranteed. Also, the consultant is legally bound to keep all information confidential. Unless you object, I will not tell you about these consultations unless I feel it is important in our work together.

Although this written summary of exceptions to confidentiality should prove helpful in informing you about potential problems, it is important that we discuss any questions or concerns you may have at our next meeting. As you might suspect, the laws governing these issues are quite complex, and I am not an attorney. While I am happy to discuss these issues, a formal consultation with an attorney may be desirable if you feel you need specific legal advice.

Your signature below indicates that you have read the information in this document and agree to abide by its terms during our professional relationship.

Signature	Date
Psychotherapist's Name	Date

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FIGURE 2.2. *(page 4 of 4)*

Once the treatment process begins, the relationship progresses most smoothly when both parties are conscientious about punctuality and follow through on agreed-upon assignments. This serves to provide a reassuring and secure foundation for the intensive work of psychotherapy, and at the same time conveys that all parties have made a mutual and earnest commitment. The frequency of appointments is agreed upon, based on the psychological and practical needs of the patients. As goals are met, increased spacing of appointments (e.g., from weekly to twice monthly to once monthly) assists in preparing for the termination process and eases patients into new routines.

Timing and Pacing of Feedback

Patients often feel a sense of emotional vulnerability and fragility after acquired brain injury. Many if not most of their suppositions and aspirations in life are shattered. Therefore, introducing feedback to improve a patient's awareness, acceptance, and realism requires careful timing and pacing. It is imperative that the psychotherapist be judicious about how much, when, how, and in what context the psychoeducation process unfolds. This often necessitates picking one's battles, chunking the feedback into digestible subcomponents, and engaging the patient in dialogue about his or her emotional state. In general, new information can be perceived as troubling or even shocking, particularly in the context of organic unawareness. It should first be shared within a private session with the patient, rather than in a more public forum, such as a group setting. The psychotherapist should also try to avoid introducing emotionally laden and potentially disturbing topics on Fridays; otherwise, patients' rigidity, perseveration, and depression will tend to erupt over weekends. It is best to introduce unsettling material when a patient is emotionally calm and most logical—in other words, "striking when the iron is cold" (Yalom, 2002, p. 121).

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Collateral Data and the "Advisory Board"

Giving patients collateral data in the form of feedback from family members, patient peers, successful "graduates" from the psychotherapy process, employers, coworkers, and friends provides powerful elucidation and reinforcement of treatment principles (Klonoff et al., 2008; Klonoff, Lamb, Henderson, Reichert, et al., 2000). Telling stories about other patients with similar challenges or treatment impasses is also highly effective (Prigatano & Klonoff, 1988).

Often a psychotherapist can encourage a patient to develop a personal "advisory board," made up of trustworthy confidants who will share honest and constructive feedback. This becomes especially necessary during life episodes (both within and outside of treatment) in regard to which the patient questions or discounts therapeutic input. Ideally, as the working alliance builds, the patient begins to consider the psychotherapist as a valued member of his or her advisory board.

Psychoeducation and Directiveness

Because of patients' deficits in executive functions, attention, concentration, and memory, psychotherapists generally must take a more directive and information-

dispensing approach in their interventions (Klonoff, 1997; Prigatano & Klonoff, 1988; Whitehouse, 1994). This provides the structure, forethought, and guidance necessary for patients to plan and execute goals, including plotting their psychological course of action. However, a psychotherapist's role is to assist patients, not to dictate to them or usurp their right to personal choice and self-determination. Generally, a therapist supplies useful exercises and facilitates dialogue to assist a patient with conceptualization, problem solving, goal setting, and execution. The psychotherapist must then closely monitor the patient's progress toward achieving goals and adapt the therapeutic approach to meet the patient's evolving needs or tribulations.

Note Taking and Journal Keeping

Note taking is integral to the psychotherapeutic process after brain injury (Klonoff, 1997; Kortte, Hill-Briggs, & Wegener, 2005; Whitehouse, 1994). A patient arriving for a session without a notebook is like a marathon runner arriving for a race without running shoes; it is possible to run long distances in bare feet, but not desirable or effectual. Some psychotherapists may argue that note taking detracts from the dialogue process; however, in my clinical experience, note taking is vital for these patients. It helps them acquire the ability to summarize, synthesize, and eventually integrate the content of discussions.

Note taking should occur at intervals during a session when it appears appropriate to stop and summarize a discussion, or alternatively at the end of the session. Deciding how and when a patient should take notes requires clinical acumen, flexibility, and practicality. In general, the more severe the patient's cognitive deficits are, the more frequent the breaks to take notes should be, and the more assistance the patient will require to formulate and record the salient points. Often patients need help determining where and how to take notes, and what notes to take. For example, patients with aphasia or higher-level abstract reasoning difficulties often have difficulty deducing main ideas and/or formulating them into coherent, concise, and cohesive bullet points. Therefore, the psychotherapist may need to dictate some notes to serve as examples. Patients with executive function deficits may need cueing as to where in their notebooks to place the notes, as well as how to keep notes in chronological order. In cases where a patient is unable to write because of motor or vision deficits, the psychotherapist needs to take the notes him- or herself (often on a computer, to facilitate their readability).

At the beginning of sessions, time should often be taken to revisit previous discussions by reviewing notes, even if the therapist has to read them to the patient (Klonoff, 1997; Langenbahn et al., 1999; Whitehouse, 1994). This is especially important for patients with severe memory problems, who have discontinuous, fragmented, confabulated, or no recollection of prior events. The written record also allows a patient to review previous discussions outside of formal sessions, providing a permanent source for reconstruction of previous dialogue. Asking the patient to look over notes at the outset of sessions and summarize the main points also provides a useful cognitive exercise and practice with abstraction and deductive thinking. A patient who is comfortable with doing so can be

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encouraged to share psychotherapy notes with relevant family members, to help them gain insight into their loved one's postinjury psychological constructs and challenges. This enhances the support system's capacity to empathically relate to the patient. Often patients share that they have later gone back and reviewed their notes during troubling periods, and have found solace and guidance in doing so.

Yalom (2002) describes the process of "cyclotherapy," wherein themes in psychotherapy are continually revisited in order to deepen the process of exploration and revelation. Therefore, patients who are experiencing intense emotional distress or resistance also benefit greatly from note taking, as it allows a healthy "breather" in the discussion and provides the opportunity to write down major concepts and insights that can later be further digested and explored. For patients who have a tendency to distort or misinterpret feedback, structured note taking also serves as a useful therapeutic tool to keep the discussion on track, neutral, and clarified.

A patient who is capable of keeping a journal can be encouraged to use this tool between appointments. It provides a wealth of information to the psychotherapist regarding the patient's experiences, thoughts, and feelings, especially in the context of forgetfulness. Stream-of-consciousness journal entries also enhance self-reflection and an unhindered flow of ideas, which might be censored within the therapy room (Kerner & Fitzpatrick, 2007).

"Rehab Lingo"

"Rehab lingo," or user-friendly language, can greatly enhance the acceptability of feedback to patients. For example, when describing problems with irritability or agitation, I might use the expression "snarky"; this is less jarring and confrontative, and preserves the working alliance. Similarly, instead of using a sterile neuropsychological term such as "mental flexibility," it is better to say "going with the flow" or "shifting gears." Patients and families are more inclined to appreciate the positive intent of feedback when it is more colloquial and "softer" in its presentation. Using terminology that is germane to the patient's personal lifestyle and lexicon helps make the process more tolerable and "speaks" to the patient. For example, a piano player with impulse control problems was encouraged to "set a slower speed" on his "internal metronome" to better gauge his reactions.

Slogans and Mantras

Slogans or catchy phrases assist patients in priming their psychological energies (Sherer, Oden, Bergloff, Levin, & High, 1998). These tag phrases handily cue patients in a more engaging manner. For example, "Just do it" reminds patients of the need for initiative, ingenuity, and task execution.

Mantras are useful tools to maintain patients' focus on their treatment priorities and goals. A mantra usually consists of a word or phrase symbolizing pertinent challenges and aspirations. Mantras also encapsulate main guiding principles for patients' day-to-day happiness and stability. Daily mantras are particularly helpful for patients with severe memory problems, who benefit from brief

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and frequent therapeutic reminders. Examples include "I think I can, I think I can" (Piper, 1986) in instances where patients display self-doubt, and "Silence is golden" for difficulties with hyperverbality. The mantra should be written and placed in an accessible location for patients to refer to as often as possible (e.g., in the front of the datebook, or posted at home on a mirror or refrigerator door). The wording and concepts contained in mantras should be tailored to the particular patient and based on his or her interests, culture, and lifestyle. They are most often discovered through psychotherapeutic dialogue, and implemented conjointly and enthusiastically by the psychotherapist and the patient. They can also serve as comfortable and empowering cueing devices for family members.

Metaphors

Metaphors are other potent mechanisms for illustrating principles on a symbolic and figurative level. They also provide practice for patients in less concrete, more abstract thinking (Sherer et al., 1998). Like mantras, metaphors should be meaningful to each individual patient and based on his or her unique background, preferences, and circumstances. For example, when a patient who was a wood craftsman terminated treatment and moved to a different state to attend a university, he was presented with a "new tool kit" of principles and coping mechanisms from the psychotherapy sessions that he could access and apply to his new life.

Diagrams and Drawings

Diagrams and drawings are personal favorites of mine for illustrating and elucidating principles and issues that arise during the psychotherapy process. Like many other techniques described above, they are instrumental for patients with deficits in executive functions (e.g., abstraction and seeing the "big picture") and memory. Diagrams and drawings provide concrete and accessible ways to conceptualize and synthesize issues (Kortte et al., 2005; Langenbahn et al., 1999; Prigatano & Klonoff, 1988). For example, Figure 2.3 is a beautiful visual depiction of the power of the working alliance and collaborative process; it can remind patients in times of turmoil and disillusionment that their therapists and support networks are partners in their journey of recovery. Or a staircase diagram can help remind patients that the recovery process is gradual and stepwise. Like mantras and metaphors, diagrams and drawings need to be customized to each patient.

Additional Psychotherapy Exercises and Complementary Media

Additional psychotherapy exercises can include constructing lists of pros and cons or pie charts to help with decision making, and writing essays to expand, reinforce, and integrate psychotherapeutic constructs. Such exercises are powerful vehicles for dialogue and help guide a patient's self-reflection and adaptation. They can be conducted in either individual or group psychotherapy. Complementary media, including books, journal articles, movies, art, and music, are all core tools. Further examples are given in later chapters.

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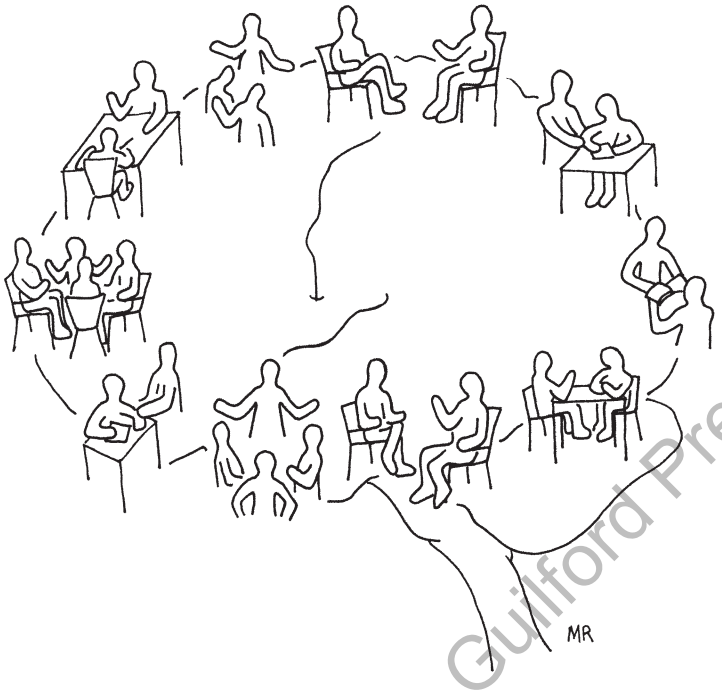

FIGURE 2.3. A drawing depicting the power of the working alliance and collaborative process for patients with brain injury.

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COORDINATION OF CARE

Given the variety of injury sequelae, patients with brain injury typically benefit from a team approach that coordinates care and treats the patients holistically. This approach can also benefit a psychotherapist, as it introduces the expertise of multiple specialists and thus lessens the therapist's burden of responsibilities. For example, a speech–language pathologist or occupational therapist can provide "nuts-and-bolts" training for a patient in using a datebook system in the home and school or work environments, enabling the psychotherapist to focus some of his or her energies on increasing the patient's psychological acceptance of the tool.

In addition, cotreatment and close coordination of services should result in the reinforcement of primary therapeutic principles by multiple specialists, which will provide validation and support for the psychotherapist's efforts. Naturally, such coordination will require the formation of liaisons with the referring rehabilitation physician, neurologist, psychiatrist, and so forth. It is important to remember that the patients' motivation and willingness to pursue their psychotherapy and broader rehabilitation goals will depend to a great extent upon the purposeful and collegial interaction of all therapists and physicians involved in the treatment process. When the professionals function synergetically, pooling their knowledge and working collaboratively toward the recovery of each patient as a whole individual, the treatment process is generally most efficacious (Klonoff et al., 2003).

Patients' outcomes can only be as good as the energies, harmony, vision, and ideals of the professionals who are guiding the process.

The psychotherapist sometimes functions as a team leader and may carry unique responsibilities and wear multiple "hats": those of an administrator; a personnel manager; a cognitive therapist; the "psychotherapist at near distance" for the patients he or she treats directly; and a "psychotherapist at far distance" for those he or she consults for. Core skills include empathy, open-mindedness, flexibility, hope, vision, and optimism—all expressed not only in work with the patients and families, but also in interactions with team members. These qualities, of course, must be tempered by a realistic and pragmatic "game plan," with an orientation toward the development of achievable goals. At the same time, the team leader should have a "cosmic view," with the internal capacity to envision and be appropriately decisive about the best course of action. He or she must then galvanize and support the team, patients, and families to accomplish goals in a stepwise manner, minimizing unwarranted misdirection. Moreover, the team leader's ability to understand and explain the underlying psychodynamics between the patients and therapists, in conjunction with how these play out within the team dynamics (Hartman, 1971), will help to integrate the team. The team leader can bolster the therapists' commitment and energy reserves through demonstrating a strong sense of loyalty toward and advocacy for the team. His or her guidance and insights are instrumental when the team is considering complex psychological and compliance issues, which can be particularly stressful and unnerving. Finally, when the psychotherapist conducts regular staff meetings, time should be allocated for introspective dialogue and replenishment of the team's emotional resources; doing so will increase the collective momentum and promote effective goal setting for the patients.

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THE REIMBURSEMENT PROCESS

Depending on the country, region, or state where they reside, patients being referred for psychotherapy may need a physician's prescription for such therapy to ensure reimbursement. Reimbursement for psychotherapy after brain injury either can be embedded in overall payment for a program of outpatient therapies, or can be paid directly to a psychotherapist as part of a private practice. In situations where the psychotherapist is functioning as part of a treatment team, it is preferable to include services for psychotherapy as part of the full complement of services within overall contractual arrangements; psychotherapy services are typically billed as part of mental health benefits using the neurological diagnosis. When it is feasible to do so, delegating this time-consuming and sometimes laborious job to a specific individual with expertise in these duties (e.g., an insurance verifier) frees the psychotherapist to devote his or her specialized skills toward the instrumental goal of patient care.

In general, most private third-party insurance companies in the United States will pay for a specified number of yearly psychotherapy sessions. In more favorable situations, there may be unlimited visits; however, reimbursement for these is usually based on medical necessity and/or medical review. Obtaining preautho-

rization and benefit information before the start of psychotherapy is required, so that the patient and therapist are fully aware of reimbursement factors and limitations. From an ethical standpoint, this is also critical, so that all parties are aware of the allocated number of visits; this will enable the setting and accomplishment of realistic goals within feasible parameters, and will prevent problems with premature termination or abandonment of care. In some situations (e.g., workers' compensation), there is more latitude in the time frame for therapy, although all parties should be attentive to attaining subgoals and not exploiting precious resources. Funding agencies also appreciate adherence to these accountability principles, so that valuable resources are not squandered when patients (and/or families) are not making the requisite commitment and effort essential to maximize their recovery and rehabilitation potential.

Sometimes state agencies are viable funding sources. Examples include state department of economic security (DES) independent living rehabilitation services (ILRS), which allocate funds to improve patients' level of independence in the home and community, or DES vocational rehabilitation services (VRS), whose fundamental mission is to return patients with neurological injuries to gainful employment. Usually, however, these agencies require that a patient has no other comparable insurance benefits.

Whenever possible, it is extremely helpful for a patient's family to request assistance from an insurance case manager who can individualize the convoluted maze of insurance benefits. It can also behoove the psychotherapist to develop and maintain strong working relationships with counselors within the state agencies, and with case managers within private third-party companies and workers' compensation. For example, the therapist can hold monthly meetings with a VRS counselor, a patient, a family member, and (when appropriate) other treating therapists to provide an update on the patient's progress and goals. This facilitates a deeper understanding of, and greater professional investment in, the intricacies of the psychotherapy and neurorehabilitation process. Regular and clear documentation is also helpful in procuring further financial support for psychotherapy. When problems arise, direct dialogue with insurance plans' medical directors is sometimes beneficial in the education process. Buttressing the clinical principles with peer-reviewed research demonstrating the efficacy of psychotherapy specifically, and neurorehabilitation in general, is also recommended to legitimize the treatment process (e.g., Klonoff et al., 2006, 2007).

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CASE STUDY

Dr. Smith was a 48-year-old dental surgeon who had suffered a cerebral infarct due to a spontaneous right internal carotid artery dissection. This resulted in left-sided hemiparesis. Dr. Smith was referred from an outside medical setting and initiated psychotherapy approximately 6 months after his stroke. Although Dr. Smith had suffered a serious right-hemisphere stroke, he had made a remarkable recovery within the first 6–8 weeks afterward. His social history indicated that he was extremely bright and a gifted surgeon, suggesting the advantage of cognitive reserve capacity (Satz, 1993). He was also very personable, and his background history indicated that he was happy and well adjusted.

Dr. Smith had partial awareness of his stroke-related deficits, in that he identified primarily physical sequelae, including gait disturbance, hemiparesis of the left arm and hand, and left-sided visual neglect. He also had a rudimentary appreciation of cognitive changes, as he acknowledged that it took him longer to review paperwork. When asked about other possible intellectual changes, Dr. Smith was contemplative but noncommittal. He hypothesized that he was unable to return to work in his present condition. Dr. Smith developed excellent beginning rapport with the psychotherapist during the initial consultation, and expressed a genuine interest in continuing treatment in order to master the full ramifications of his stroke, so as to reattain his prior work status.

After confirmation of his health benefits, Dr. Smith agreed to undergo a neuropsychological assessment. He also enrolled in an outpatient setting where the therapists coordinated their efforts to treat patients holistically. He agreed to undergo multidisciplinary assessments to delineate his overall neurological status.

After the initial assessment is conducted and a working alliance has begun to form, the psychotherapist must begin to increase the patient's awareness of his or her situation. This is the topic of the next chapter.

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