LANGUAGE & COGNITION DEFICITS

When the brain has been injured, it does not process information as efficiently or as effectively. For example, a person may speak clearly and demonstrate no visual or hearing impairments, but the content of what is said does not make sense and the person behaves differently.

When the damage resulting from a stroke or traumatic brain injury is minimal, perhaps the only noticeable difference is that a person processes information incompletely or more slowly than before. When damage is more extensive, the changes are more obvious. Some or all of the following problems may impair thought processes leading to communication breakdown.

1. Disorientation is seen when the person is not aware of the correct time (hour, day, date), where they are, or who familiar people are.
2. Attention deficit is an inability to focus on a task without being distracted, or being unable to concentrate on a task with sufficient organization an ability to complete it.
3. Memory problems can be classified by type. Long-term memory deficits occur when there is difficulty remembering past events. Immediate or short-term memory deficits occur when there is difficulty remembering new information. There is more likely to be a problem with learning and remembering new information, as opposed to remembering information omitted to memory years ago.
4. Judgment and problem solving deficits are noticeable when the person has difficulty taking all pertinent facts into consideration, then using experience and common sense to arrive at realistic conclusions and solutions.
5. Sequencing difficulties, problems organizing information into steps that logically follow one another, may be present in a simple process (such as eating a meal) or in a complex process (such as preparing a meal).
6. Abstract reasoning problems commonly involved divergent thinking (coming up with multiple solutions to a problem) and convergent thinking (or using all available facts to arrive at a solution). Other problems can include difficulty managing multiple forms of input simultaneously, and organizing all incoming material.
7. Problems with initiation happen when a person cannot organize and start an activity at the proper time.
8. A related problem is preservation, which means not being able to stop an activity and then switch to another “track” appropriately.
9. Auditory perceptual deficits occur when the processing of incoming sounds is disturbed. The sounds are loud enough, but they are not perceived or understood properly. For example a word sounds familiar but the meaning is not recalled; or the sounds of a word are heard “all mixed up” so the word doesn’t make sense. One cannot repeat a word that doesn’t make sense.
10. Visual perceptual deficits may include visual field “cuts”, where blank spots cut down on the normal field of vision. For example, the left half of the vision in each eye may be gone. Another problem is when a person sees clearly but does not pay attention to objects on one side. This person may neglect objects on the left side of their dinner tray, and when drawing a clock may omit the number on the left side. Still a different problem is where the printed word is large and clear

enough to read but it doesn't make sense or look familiar (like trying to read and understand a "foreign language").

Understanding the nature and extent of these problems is the first step in the rehabilitation process. This involves skilled observation and testing where possible. Testing helps professionals know where to start treatment. Starting at too low a level could make the patient feel frustrated or insulted; starting at too high a level could make the patient feel unsuccessful and upset.

Changing the level and complexity of treatment tasks is done with the overall goal of helping the patient be as independent as the brain will allow.

HINTS FOR CAREGIVERS

1. The brain responds best to frequent and consistent exposure to proper stimuli. By attending therapy sessions when appropriate, you can learn treatment routines to practice with the patient during the later afternoon and evening hours when no formal therapy sessions can be scheduled. This can hasten the rehabilitation process. (And sometimes patients respond better to help from known and trusted caregivers such as family and friends.)
2. Help the patient get to scheduled therapy on time so that valuable therapy time is not lost. Often the brain injured person does not value time or have the motivation the help themselves.
3. Learn from therapists the most effective way of "cueing." This means supplying hints or clues (not answers) to help the injured brain process information as independently as possible.
4. Present information to the patient in the right way and at the proper level of difficulty to help avoid frustration. A therapist can help you learn how to do this.
5. Structure the environment to help the brain work efficiently. This might mean reducing clutter or turning off the TV to reduce noise. For an executive, it may mean having a secretary screen phone calls to cut down on distractions.
6. Allow extra time for the person to digest incoming information, and to formulate expression.
7. Understand the fact that with brain injury, processing may ultimately never be the same as before, but different of alternative strategies of processing can be effective.
8. Provide realistic and helpful feedback. Sometimes patients deny they have cognitive problems because they do not recognize then and lack insight regarding the consequences of them.
9. On the other hand, some patients feel overwhelmed when their problems. Their feelings of helplessness and depression can be alleviated when you help them recognize small successes through noticeable changes daily.
10. Inform your health care professionals of characteristics about the patient that you remember and know. Education and experience, learning style, and personality traits must be taken into account in the relearning and reorganization process. Knowing where a person was, guides a therapist to know what to recover.