CASE REPORT

Positive Talk Training in an Adult With Traumatic Brain Injury

Hon Keung Yuen

Key Words: cognitive rehabilitation • interpersonal relations • social adjustment

Persons with severe traumatic brain injury (TBI), especially frontal lobe damage, often exhibit socially disinhibited interaction behaviors. This disinhibition can lead to offensive and provocative interactions with others and, subsequently, to arguments and physical aggression. Inappropriate social interaction skills in persons with severe TBI have been shown to be one of the major barriers to successful reentry into the community and to maintaining employment (Morton & Wehman, 1995).

Social interaction skills training is an essential component in rehabilitation programs for persons with severe TBI (Johnson & Newton, 1987). Complimentary statements embedded in conversation skills training are part of social skills training programs. Complimentary statements toward others during social interactions are important for peer acceptance and for building and maintaining friendships, both of which are essential for persons with TBI to live and work harmoniously in the community.

Literature Review

Among the few social skills training programs for adults with severe TBI described in the literature, two included positive statement or compliment components. The social skills training program implemented by Braunling-McMorrow, Lloyd, and Fralish (1986) for three young adults with severe TBI (ranging 2–4 years after injury) targeted six skill behaviors: social interaction, politeness, criticism, social confrontation, questions and answers, and compliments. All subjects received 30 min to 60 min of training (in the form of playing a board game) two to three times weekly for 12 sessions. Training procedures included feedback, self-monitoring, social reinforcement, and progressive goal setting. Results indicated that all subjects showed improvement in the six target skills. Two subjects demonstrated generalization of the compliments skill and three other target skills to a natural setting.

The social skills training program implemented by Brotherton, Thomas, Wisotzek, and Milan (1988) for four young adults with severe TBI (ranging 3–8 years after injury) was more traditional and also targeted six skills: self-manipulation, posture, speech dysfluencies, personal attention, reinforcing feedback, and positive statements. Individual structured training sessions were held for 30 min twice weekly and included instruction, modeling, behavioral rehearsal, videotaped feedback, social reinforcement, and homework assignments. Results regarding the positive statements skill indicated that the woman for whom data were available did not show improvement, even after 20 training sessions. The discrepancy between Brotherton et al. (1988) and Braunling-
McMorrow et al.'s (1986) studies may be due to difference in length of time after injury between the two subject groups, use of different rating systems for the target behaviors, use of individual versus group (in the form of a board game) intervention, and methods of training (e.g., videotaped feedback and homework assignments vs. self-monitoring and goal setting).

According to a survey of occupational therapists practicing in mental health settings (Taylor & Manguno, 1991), social skills training was ranked the most frequently used treatment medium. However, the effect of specific components of this training for adults with psychosocial deficits has not been well described or evaluated (Hayes, Halford, & Varghese, 1991). Even the social skills training program designed for clients with severe TBI attending an occupational therapy day-treatment program did not explicitly mention the component of positive talk training (Johnson & Newton, 1987). This report illustrates the use of one social skills training technique, that of positive talk toward others, with an adult with severe TBI.

Method

The client was a 43-year-old man with frontal lobe damage sustained 20 years earlier. He was transferred from a nursing home to a rehabilitation center because of his verbal and physical aggression toward others. He wore a protective helmet during awake time because of uncontrollable seizures. The client demonstrated an unsteady gait but was able to use a wheelchair to travel independently both indoors and outdoors on level ground. His upper-extremity sensorimotor skills were within functional limits. His thinking tended to be very concrete and egocentric, and he demonstrated slow information processing and moderate memory impairments. In the area of language capability, the client demonstrated word-finding difficulty and an inability to clearly express abstract ideas; he could ask and answer simple questions. Verbal expressions toward others tended to be negative and included sarcastic or derogatory statements. He seldom took the initiative to socialize with other clients and often sat idly.

The client's physical and cognitive abilities suggested that he was capable of living in a supervised group home. However, this move was hampered by his interpersonal skills deficits, including the number of negative statements he made toward peers.

Evaluation

An evaluation of the client's ability to produce complimentary statements was conducted during a small parallel group activity. Instruction regarding positive statements was provided with examples and modeling. When given the opportunity, the client did not self-initiate positive statements toward others and continued to make negative, brusque, or demeaning statements. Several trials were conducted, but the client was still unsuccessful in making positive statements.

The client was then evaluated during a one-on-one therapy session. Motivation was not a barrier in therapy, and he was cooperative and responded well to positive praise and attention. It was determined that he required consistent praise and a more concrete approach in order to formulate positive statements toward others.

Intervention

A positive talk component was included in the client's occupational therapy treatment program 2 weeks after admission. Positive talk is defined as verbal statements that contain positive remarks, compliments, and praise directed toward another person. For 5 min daily, the client received training aimed at modifying his statements toward peers to be more positive. For the remainder of his 1 hr of occupational therapy, he received other individual cognitive and perceptual training. The client also participated in a group social skills training program with six to eight clients that was conducted by a behavior specialist and that met two to three times a week for 1 hr. The curriculum covered a variety of social skills, including anger control; situation-specific social interaction, such as telephone skills; verbal skills in basic conversation, such as listening and following instructions; and acknowledgment. However, positive talk training was not included in this group program.

During the initial phase of the positive talk program, the therapist used modeling and role-playing techniques. For example, an occupational therapist and a speech-language pathologist praised each other in front of the client and then asked the client to praise one of themselves. He was also given a prompt to think only of positive statements. The client was directed to look at a therapist's appearance and make comments such as, "You are wearing a nice shirt or tie today" or "You've combed your hair nicely."

After achieving success in praising therapists, the client was directed to praise another client with the prompt to comment on physical or tangible aspects, such as appearance or clothing. He was successful when engaging in these types of concrete compliments but less so when attempting to make abstract positive statements when praising others. Instead, the client would make a neutral comment by saying to another client, "You're very quiet." Modeling was used at these times to assist the client in rephrasing his statements.

After 2 weeks of positive talk training, the client was
encouraged to make positive observations of his peers outside the therapy room. He was directed to expand and provide positive statements about something other than a peer’s physical appearance and encouraged to identify positive aspects and good qualities about another’s personality. For all positive statements about others, the client was given positive social reinforcement.

**Results**

After 4 weeks, the client was able to make positive statements whenever he was given prompts (e.g., “Tell me something good about [another client]”) and while in settings other than the structured therapy room (e.g., the gymnasium, the resting area at the rehabilitation center). Furthermore, his praising statements were not confined to tangible characteristics, and negative statements did not increase.

**Discussion**

The client was able to generalize the skills (positive comments toward others) that he learned in the positive talk program to settings other than occupational therapy, such as the gymnasium and resting area. He progressed from making negative statements to making neutral and more positive statements, from statements related to tangible characteristics to statements about personality traits or skills of other clients, and from requiring multiple prompts to needing only one prompt. Incorporating a positive talk program into social skills training resulted in small changes but not social competency. Long-standing social problems cannot be entirely remediated within 4 weeks. On the basis of improvements in positive talk, other social skills (e.g., anger control), and his medical condition (i.e., frequency of seizures), the clinical team recommended that the client move to a supervised apartment. Follow-up observation, at about 1 month after discharge, indicated that the client still demonstrated a decreased level of social interaction, which was then addressed in the supervised apartment setting.

An awareness of inappropriate social interactions and a demonstrated motivation to change are important factors leading to self-initiated expressions of positive statements toward others. However, the client’s severe cognitive impairments and concrete thinking made it difficult for him to fully understand the underlying implications of his inappropriate social interactions, which may explain why he still had difficulty providing spontaneous positive statements. His cognitive deficits in concept formation, memory, and generalization made it difficult for him to interpret social interactions. However, his more intact categorization skills allowed his thought process to be redirected to making positive statements, but he was only able to recognize the need to make socially appropriate statements by responding to external cues to “say something positive.” In view of the client’s long-standing negative behavior, the positive change in his making positive statements after this short intervention period can serve as a starting point to increase his social interaction with other clients. With an increase in positive statements, other components of socially appropriate interaction skills (e.g., initiating and maintaining conversation, taking turns, accepting criticism, being aware of and responsive to needs of others), as suggested by Giles and Clark-Wilson (1988), should be part of future social training.

**Limitations and Recommendations**

Validity of the measurement would have been improved if both positive and negative statements had been recorded. Keeping track of all the client’s comments during nonstructured or nontherapy time would have been difficult because the level of supervision he required was for a half-hour check. Use of a time-sampling technique might not have reflected his improvement in positive statements toward others because of his low initiation of social interaction. Until the client’s initiation of social interaction and frequency of positive statements toward peers increase, a more realistic way of collecting valid and objective data would be to videotape a dyadic or small group activity when he is required to interact with another client.

Evaluating the benefit of this positive talk training using an independent indicator, such as a concurrent improvement in other prosocial behavior or a decrease in maladaptive behaviors other than negative statements, would have been better. However, the client’s maladaptive behavior was so low that it was an invalid indicator.

Concrete, positive statements may not always be appropriate, depending on the nature of statements, tone, and context of the conversation. For example, statements can imply generous or sarcastic comments or may not be appropriate for the gender being addressed. Persons with severe TBI who demonstrate concrete and inflexible thinking patterns may not be able to discriminate the appropriate use of positive statements for different situations.

**Summary**

Social skills often create a barrier to placement in less restrictive environments for persons with TBI. This case study illustrated the use of a positive talk program in the treatment of a person with long-standing social skill deficits. Occupational therapy intervention with speech-language consultation began with an evaluation of the cognitive barriers that influenced the client’s social behavior. Work with the client’s concrete concept formation, decreased memory, and poor generalization skills led to the
development of the positive talk training program described. Through an understanding of the underlying cognitive deficits that influenced the client's behavior, the clinical team was able to develop an individual treatment plan. The intervention resulted in modification of behavior that would have required placing the client in a restricted environment. In the final analysis, the client's social skills improved to a level where he could be discharged to a less restrictive environment.

Acknowledgments
I thank Joyce Hartwick, MS, OTR/L, Patricia Wilson, and Mariana D'Amico, MS, OTR/L, for their editing suggestions.

References


OCCUPATIONAL THERAPIST
Brookfield, MO

Supervise a certified OT and 2 department aides in the delivery of high level of quality therapy services upon physician referral, by performing evaluations and developing individual treatment plans and goals to maximize functional outcomes. Actively participate in discharge planning, implement the treatment program and reassess treatment results. Deliver services within the framework of a team approach, including all disciplines, significant others and the patient, in compliance with Life Care Centers of America's ethical standards, policies and procedures, national professional standards, state practice acts, where applicable and current accepted state-of-the-art practice.

Bachelor's degree in occupational therapy and 2 years experience required. Must be eligible to be certified by the National Board for Certification in Occupational Therapy (NBCOT) 40 hrs/wk, 9am-5pm, $65,000/yr.

The job order number for the job opportunity is 501493.

Send resume to:
Shirley J. Gregory
Missouri Division of Employment Security
1411 Main Street
Kansas City, MO 64105

Must have proof of legal authority to work in the United States.