How to help return to work after a mild traumatic brain injury

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The importance of recognition and education in RTW after a mild traumatic brain injury and groups for whom the process is more difficult.

A talk by Dr Jenny Ponsford looks at the importance of recognition and education in returning to work after a mild traumatic brain injury and the groups for whom the process is more difficult.

Recovering from a brain injury, just like any injury, is a different process for different people. This can relate to age, gender, pre-injury factors and the sorts of support and attention a patient is exposed to post-injury. For all, however, support and understanding goes a long way in getting better and back to work.

Dr Jenny Ponsford is director of the Epworth Hospital's Rehabilitation Centre and is a professor of neuropsychology at Monash University. She has decades of experience in clinical work and research involving brain injury.

At the People at Work Conference in Adelaide, South Australia, she outlined the biggest influences on successful RTW following a brain injury as: social support structures, compensation status, psychological trauma, employer support, work environment, work demands or flexibility, and the physical injury and pain. Some of these factors together, she said, will interact to influence the timing and success of the RTW process.

Traumatic brain injury (TBI) should not be confused with intellectual disability or mental illness. It is caused by an assault to the head – this could be the result of an attack, fall or gun shot wound for example. In the article 'Before and after a brain injury' (under 'Matters' section of this site) we talked about a brain injury as fitting any of the following definitions: the brain may be torn, stretched, penetrated, bruised or become swollen; oxygen may not be able to reach brain cells and there may be bleeding.

What defines a 'mild' TBI?

It's normally associated with any loss of consciousness, loss of memory, alteration in mental state at the time of the incident and focal neurological deficit (a problem in nerve function that affects a specific location or function) that may or may not be transient. Under the definition of 'mild' any loss of consciousness would not exceed 30 minutes.

Dr Ponsford explained that in most cases the common symptoms of traumatic brain injury (TBI) – like headaches and fatigue – have usually been resolved within three months after the brain
injury, and in some cases after only a week. 74–78% of those with mild TBI have returned to work from three months to one year after injury, she said.

A significant portion of those with ongoing symptoms have something in common: they had previous neurological and psychological problems, they were a student or they had other life stressors (something that speeds up a reaction rate). These people are also more likely to be female, and are significantly more likely to have been injured in a motor vehicle accidents.

“Typically,” she said, “mild traumatic brain injury patients return to work three to seven days post-injury, as symptoms subside.”

For moderate to severe brain injuries (remembering that severity is measured based on the duration of post-traumatic amnesia and loss of consciousness, as well as the ‘Glasgow Coma Score’ after resuscitation) the story is a little different. Slower recovery and return to work in these cases is associated with demographic factors including older age, male gender, lower education and pre-injury behaviour problems.

A 2006 study (Nolin P and Heroux L) looked at the factors differentiating patients who had and had not returned to work after mild head injuries. It was found that demographic, injury severity or cognitive function didn’t have an impact – but rather the important factors were self-reported affective, cognitive and physical symptoms, such as emotional sensitivity, irritability, feelings of frustration and impatience, mental fatigue, poor concentration, trouble thinking, poor balance, sleep problems, lack of energy, managing household chores, social and leisure activities, problems in relationships with children and difficulty dealing with family demands.

Another study (Ruffolo) showed that social interaction, jobs with greater decision-making latitude and discharge home was associated with better occupational outcomes, but not better cognitive function.

Social support structures in a huge influence. Without the understanding and assistance from employer, medical treatment provider, and family and friends, chances of a successful return to work diminish significantly. A work environment that supports the need for flexibility, and altered work load or duties is part of this understanding.

The patient’s personality and coping style will also have an effect on the return to work process, and patients' influence on their recovery should not be underestimated.

Dr Ponsford emphasised the equal importance of treating other physical and neurological factors involved with TBI, such as sleep disturbances, hearing loss or tinnitus, visual disturbance, balance problems, dizziness and vertigo, headache and other forms of pain.

Psychological factors need to be recognised, she said. Accident-related stress, anxiety and
depression can develop in response to injury symptoms and/or attempts at returning to work. Pre-existing psychological issues, personality factors, cultural factors and litigation factors will all contribute to this.

“Recognition and education about mild TBI,” Dr Ponsford said, “is crucial in managing RTW, as is accessing and addressing potential barriers to RTW (cognitive, physical and psychological), communicating with the employer, modifying the job according to injured workers limitations, taking a graduated approach and following up to deal with any problems that arise.

If we are aware an employee returning to work after a mild TBI might be more likely to be easily frustrated or depressed, to use two examples, then we are more likely to show these workers compassion and understanding as they continue to work through their rehabilitation process.