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Therapy for Survivors

On a sunny day in late April, I sit in the waiting room of the Loyola Clinical Centers (LCC) in Baltimore's Belvedere Square. The LCC is the flagship property of a city block lined with a promenade of storefronts, and a subdivided market where vendors and restaurants co-mingle in an interior bazaar. I am here to observe a group therapy session for people with Acquired Brain Injury (ABI)—namely stroke survivors. A clinician escorts me to a second-floor o□ce where I sit in front of dual-linked computer monitors waiting for the feed from one floor below to begin. The right screen suddenly changes, allowing me digital access to a room with a U-shaped table, and a large wall-mounted monitor north of the U's opening.

May 3, is his second birthday. It was that day, 13 years ago when Christian su□ered his stroke. The reference to that date being a "birthday" becomes more apparent as we talk.

The more I speak with survivors and read about post-stroke recovery, the more I realize the importance of the backstory. It involves the onset of symptoms, the location, the duration of time before accessing care, and the hospital stay—always the hospital stay. In much the same way a comic book superhero has an origin story, so too does the survivor of a stroke. Christian's is extraordinary.

He was alone in his apartment after seeing his wife o□ to work. May 3, 2010, 10 a.m., a day o□, Christian literally rolled out of bed paralyzed from the neck down. "I kept rolling and couldn't move," he recounts. The only other real memory of the symptoms is what he describes as an unquantifiable ringing in his ears.

"Like after you go to a real loud concert and park next to a speaker?" I inquire in an attempt to find an equivalent for descriptive purposes. "Louder," he snaps back.

A Medical Crisis

Unable to move his arms or legs, Christian laid on the floor in that post-sleep dismount for seven and a half hours, alone. He was shuttled from Mercy Medical Center to University of Maryland Medical Center, back to Mercy, and finally to Johns Hopkins Hospital. The first two facilities declared his condition too unstable to operate, but a cardiac surgeon at Hopkins would perform Christian's first of two open heart surgeries. His prospect of surviving the surgery was grim, and recovery even more so. Heart valve repaired, Christian began vomiting every 20 minutes. He had an abscess in his brain the size of a silver dollar that was leaking cerebrospinal fluid causing pressure to build between the brain and skull. It required a shunt running from his brain to his stomach to discharge the fluid. The exact placement proved di□cult.

Christian has had 10 brain surgeries. The last one, only five years ago when a cyst was discovered on the original shunt requiring the placement of a second one.

Christian recovered at Mercy Medical Center in downtown Baltimore for five months and speaks lovingly of all those who cared for him. "The Sisters paid the whole bill," he recounts and tells me his grandmother worked at the facility for over 30 years. The aphasia is noticeable at times with some pauses that would be awkward in another setting, but I am captivated by his dry, "matter of fact" delivery of the harrowing event. This man in front of me telling this story was expected to be immobile, in a nursing home for the duration of his life. He would be unable to talk or walk. Christian was expected to spend his years in perpetual convalescence. It took two years of physical and occupational therapy for him to speak and regain mobility again.

"All I could say was 'Happy birthday,'" he tells me. In a moment of levity, he giggles explaining, "Happy birthday," was his go-to for everything—thank you, hello, goodbye, I love you. It was the only phrase he could access.

Spirit and Will

Christian relearned the alphabet and learned to lift paralyzed limbs. "I was a newborn baby," he says which explains his May 3, second birthday. Returning to that matter-of-fact delivery, Christian lists his current condition—blind in the right eye, right side paralyzed, left side numb, the aforementioned 10 brain surgeries, two open heart surgeries complete with a broken sternum, and his most recent surgery, the amputation of his right arm below the elbow. "I couldn't use it," he says as if to make me feel better. "It was just folded up against my chest."

I catch myself from talking about this man as a miracle. That would diminish the work. It would belittle the spirit and will with Christian which may well be Divine. But the work, each and every frustrating minute it took to be the man he is today; the work was tragically human complete with its su□ering and setbacks. "It's like water," he explains. "I just go with the flow."

It is that work ethic and nonchalant courage that brought Christian to place. Alexander recounts his journey. Christian sought treatment in February 2020, but then came a once-in-a-century pandemic, and he could not safely access treatment until the spring of 2022. I ask Theresa about his condition at that point. "He was experiencing someg ses, tdcessk The3

With the meditation complete the session begins by going over the homework from the last meeting. A word search appears on the screen with its randomly lettered square grid and word list. The group is given a moment before the answers appear. The most dominant presence in the room is a man I will come to know as Ron. He is very prepared and is eager to share both his answers and process. There is talk of the "lighthouse strategy," where one anchors on the first letter before guiding and turning to find the exact word.

Solving Puzzles

Ron talks of his intricate work at home on bigger, more challenging puzzles complete with their backwards diagonals, before admitting he is talking too much. And in a gesture of acknowledgement that speaks to others' vulnerability, Ron admits, "But I've been really working this stu." He tells the room that it was much more di cult back when he was, "really messed up."

The group moves through a few more word searches before reviewing the four Sudoku puzzles they were given at the last meeting. In my room one floor above, I am unable to find the solutions before the answers appear reminding me that these are pretty advanced problems. The Executive Skills Group ends with a discussion of weekend plans. A clinician announces that next week's session will be the last of the 12-week group while making a "wah-wah" game show losing noise. She hedges any disappointment by telling everyone that Ron would like to take the entire group to lunch a day after their last meeting. With that, my screen goes black.

Back to the Beginning

The next day I speak with Tom Thompson, M.S., CCC/SLP, another clinical instructor and the founder of the Brain Injury Assessment Program at the LCC. Having spent time doing private practice and contract work for hospitals before his tenure at the LCC, Thompson was asked to start an evaluation protocol for clients with brain injuries. His approach was holistic involving three aspects for patients seeking referrals and resources from the clinic.

Thompson worked with LCC's Neuropsychologist Chris Higginson, Ph.D., professor of psychology, to create an assessment utilizing audiology, speech therapy, and neuropsychology to precisely target each client's needs. The purpose of the evaluation is to present a results-based strategy for continuing care past the point of spontaneous recovery.

"Every brain injury's e ects are di erent and highly dependent on whether it is left- or right-sided, or frontal from trauma," he explains. And just as every injury is unique, the therapeutic regimen must be individualized as well.

Looking for Insight

Each of the three disciplines is crucial to the assessment of new clients. The audiology testing seeks to diagnose any hearing loss or disfunction that may a ect the intake of information. The speech language pathology evaluation will pinpoint the barriers to communicating verbally. But it is the neuropsychological evaluation that provides the insight needed to strategically implement e ective continuing care to a patient.

While the audiology and speech components seem self-evident for a client with brain trauma, neuropsychology grants access to clinicians into any cognitive and behavioral nuances that may be present in each client. Thompson stresses the importance of this aspect saying that it gives the clinicians a "best practice" approach to treatment. Listed as a specialty field by the America Psychological Association falling under the umbrella of clinical psychology, the neuropsychology assessment will also address emotional issues that may accompany brain injury.

Thompson's e orts to start a brain injury evaluation program in 2012 at the LCC were initially oriented toward diagnostic results through which a client would be provided with resources and strategies for continuing therapy. At the outset, a patient would be tested and then referred to practices that could help further recovery. He acknowledges that the post-testing "feedback conference" with the clients can be di cult but insists this is where the silver lining lay. The first part of the feedback conference simply presents the results of the testing. The second part deals with the continuing treatment. "Those meetings, we try to make them more positive," he tells me and says for the client, "this is the recipe for moving forward."

In the 10 subsequent years, the assessment program Thompson and Higginson started has now evolved into a program where the actual treatment is provided in house to the clients.

Another Client's Story

Ron Conley from the Executive Skills Group is certainly the beneficiary of this evolution at the LCC. He has just taken a group of clients and clinicians for lunch to mark the end of another semester. Introductions exchanged, Ron o ers a firm handshake. He is a fast talker, with glasses and greying hair, wearing an all-weather golf pullover, shorts, and sneakers. There are no outward signs of the stroke he su ered back in March 2019. Ron was on his way to church at the onset of symptoms he simply describes as, "just not feeling right."

After going back to his house, his wife took him to University of Maryland St. Joseph Medical Center in Towson where they immediately transferred Ron to University of Maryland Hospital—a facility more equipped for his condition. The quick access to a medical facility experienced in brain injury arrested a worse outcome.

Ron's life pre-stroke was that of a Type-A, highly driven executive. "I had about 800 employees and probably knew over 2,000 people," he recalls while also recanting his prowess as a successful Amateur Athletic Union (AAU) basketball coach. He can recall past players' ascension into the college, and even pro-ranks. At the time of his stroke, Ron was the CEO of Next Day Floors.

Although his spontaneous recovery was quicker than normal, Ron emerged from the hospital with minor aphasia, reduced peripheral vision, and unable to put names with faces. He was evaluated at the

LCC is about identity. Graduate students are there to discover their identities as clinicians. But it is the clients, victims of Meyerson's identity theft, who come to discover and embrace their new selves through hard work.

Success can be a di□cult metric to measure. Client files at the LCC fill with data, soap notes, assessments, session notes, and progress reports. But even those dense files speak in hushed tones compared to the words of the actual clients and clinicians. There is Ron who wrote in a testimonial, "I long for each day that I am allowed to attend LCC. LCC has truly saved my life and made me a much better person."

Reflecting on the Journey

Another client, Peg Drew, wrote me about her time at the clinic. Peg is the survivor of a stroke and I have since learned was the woman's voice leading the mindful meditation at the outset of the Executive Skills Group session.

"Being asked to be included as one of the team through the mindfulness meditation exercise has increased my confidence after my stroke and allows me to be creative," she wrote. "When I engage in group sessions with other stroke survivors, I feel positive and fortunate to have a sense of camaraderie."

She explained her feelings after starting her journey at the LCC this way, "After I left the clinic for the first time, with tears in my eyes, I commented to my husband, 'What's so great is there are people at the clinic who understand what I've experienced.'"

Then there is Christian from the Conversation Group who says simply that he feels, "pride and honor whenever he goes to the LCC." He expressed his gratitude by writing, "I am extremely thankful for the clinicians at the LCC for letting me re-learn my speech/language skills again."

There is an unsolicited gratitude in all of these examples—gratitude not just for the time and space, but for the opportunity to be among "their people,"—clinicians and clients who see them not as they were, but as they are.

It would be easy to sum up this experience with a simple, "The Loyola Clinical Centers is where miracles happen." That would be disingenuous. This is not Robert DeNiro in *A a e* . There is no neat and tidy bow to tie upon a completed arc. The LCC is where —di□cult work, at times accompanied by frustration—happens and will continue to happen indefinitely. All of that work done daily, in dedicated partnerships between clients and clinicians, is what defines the ABI program at the LCC. Its fuel is the hope of recoveries, the embrace of new identities, and the passions of future professionals a□rming a life choice.

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