The 'Walking Wounded' Faced with Communication Challenges at Work

by Sadia Hussain, BSc (Hons) Speech and Language Therapy

Claimants diagnosed with brain injuries, without physical disability and who retain subtle cognitive communication difficulties are commonly referred to as the 'walking wounded'. They present with understated communication difficulties, which are barely noticeable in general conversation but which become heightened in structured communication tasks. These tend to surface when a claimant is confronted with clerical, administrative and managerial functions at work. Or, in their personal life, where socialising with friends and family becomes a struggle, rendering them to the risk of social isolation. As a SLT expert witness, I readily come across cases where a claimant's inconspicuous communication deficits cause permanent disruptions in their working life. In this article, I will share three cases to highlight the communication challenges facing the 'walking wounded':

Case One: A claimant in her forties, involved in an accident at work, was diagnosed with a mild brain injury and discharged from hospital within days of her injury. She was physically mobile and, although slightly confused at the time of the injury, was able to engage in conversation and unintentionally masked deeper cognitive impairment. After a short recovery period, she began a gradual return to work as a Human Resources Director, only to find that she was no longer able to perform her work duties. She particularly struggled to process complex information, chair boardroom meetings, make executive decisions, conduct interviews, deliver presentations and meet target deadlines. She had difficulty deciphering literal interpretation from sarcasm and missed the nuances of indirect conversation. This, in itself, caused her difficulties maintaining effective interactions with her colleagues and she found herself amidst a work-based conflict.

I was instructed as a SLT expert to determine whether a communication disorder existed, what it was caused by and how it affected her work. By comparing her pre-injury baseline to her current situation, it was evidently clear she had developed cognitive-communication disorder and high level language difficulties, which affected her ability to reason information, problem solve incongruities, interpret multifaceted situations, and deliver narratives. This was a direct result of her brain injury and she was unfit to continue within her current executive position. As part of the recommendations it was recognised that she would only manage to work part time, in a less demanding role, and with the support of a personal assistant to facilitate administration. In addition to this she was recommended technological devices to support her memory, speed of processing and written communication.

Case Two: A gentleman, working as a sales manager, who suffered a stroke as a result of medical negligence. Given that he showed no obvious physical paralysis, it was deemed his symptoms had fully resolved, only for him to later discover he experienced persistent difficulties when reading. When he returned to work his communication struggles magnified and he found it challenging to explain his ideas coherently, use technical language he had been using for most of his working life and to book appointments in his diary. This caused him anxiety and he felt he could no longer work. I was instructed to provide a SLT opinion and my assessment showed he was harbouring an array of difficulties ranging from verbal dyspraxia, mild dysphasia (language disorder) and cognitive-communication disorder. Given that these difficulties were permanent, the claimant and his employer came to a mutual agreement for him to retire early and the cost of earnings was provided through a settlement. He re-considered vocational options, choosing to go down the route of voluntary work with the help of SLT technological support, using a tablet device with communication software to support reading and writing skills.

Case Three: My final case is about a male university graduate, who incurred a brain injury during a diving expedition whilst serving in the navy. He was diagnosed with minor physical impairments and a severe case of PTSD (Post Traumatic Stress Disorder). PTSD symptoms masked significant cognitive-communication difficulties, which only became noticeable months later when his relationship came to an abrupt end and he struggled to maintain his friendships. A once popular and sociable man, he found it difficult to cope in group situations, not being able to digest humour and hold conversations with friends.

Immediately upon my instruction, the scale of his difficulties were apparent, when he showed difficulty recalling telephone conversations to arrange assessment appointments. However, more interestingly, the results of the assessment showed that most of his formal communication skills were within the normal range, apart from some mild anomia (word finding difficulties), memory impairment and some executive dysfunction. Collectively, these impacted his pragmatic ability to engage in conversation and his awareness of social situations. His once proficient musical skills had also been affected and he was no longer able to read music and play the piano. My recommendations included vocational rehabilitation targeting social communication, to aid a change in

career more suitable to his needs. He was also recommended support to increase his communication confidence and awareness in social situations. This was largely done through a support worker, SLT intervention and regular leisure activities.

In all three cases, communication deficits were inadvertently missed, but why did, and indeed does, this happen? To answer this question, we have to look at two aspects including the level of SLT care afforded to individuals in the initial stages of brain injury and the complexity of the communication deficits involved.

Having worked in the acute setting, it is evident that the capacity of specialist SLT intervention to assess and diagnose less obvious cognitive-communication disorders in acute hospitals is limited. My experience is that the clinical priority is very often to assess and treat swallowing problems, which pose a physical risk. When it comes to communication deficits, SLT's have less capacity to do full assessments and rely on screens often done by other health professionals, who are most likely to pick up on more obvious dysphasia or dysarthria features rather than under the radar communication or social features. For example, 'slurred speech', 'muddling up words' or 'not following simple commands' are typical features of impaired communication post brain injury or stroke. The limited resource of SLTs in hospital settings has been publically recognised: 'While the speech and language therapy profession has grown in the last 10 years, most of this has been outside the NHS, with managers reducing by 23% since 2010 (NHS digital).'

Cognitive communication operations involve the brain's 'executive functions', including planning, organisation, flexible thinking and social behaviour. Brain injuries, usually involving frontal lobe damage, raise the potential for communication difficulties affected by cognition, which Headway describe as: 'Attention and concentration difficulties, memory problems, literal interpretation, reduced reasoning and problem-solving skills, cognitive fatigue, slowed speed of information processing, impaired social communication skills and reduced insight.'

It is evident that the components of cognitive-communication disorders and high level language are far ranging and complex, which means they can be easily masked, misunderstood or missed. If an individual is able to converse fluently and can manage functional situations, the communication deficit is difficult to identify. It is also the case that some of the symptoms listed above only amplify when an individual is confronted by multi-layered tasks, which use these in combination. Such tasks are typically found outside personal routine and familiarity and usually arise in the work place. Unfortunately, later identification of such symptoms can cause a person grave anxiety and cause disruption in personal and working lives.

As a SLT professional I can see that it's imperative that identifying subtle communication changes earlier in the course of injury is necessary to avoid further complications. The only way I see this is possible is through increased awareness and education for brain injury sufferers and professionals of all levels (health, legal and social) who engage with such individuals.

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Somek & Associates is one of the largest providers of Expert Witness services in the UK, and has over two hundred experts, which include, occupational therapists (care experts), nurses, midwives, physiotherapists, speech and language therapists, and other allied health professions.

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