

The Loyola Clinical Centers: Giving Hope to Those with Acquired Brain Injury

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According to the CDC, there are 795,000 Americans who suffer from strokes each year. While 185,000 of these are recurring events, that leaves 610,000 first-time victims. The process of recovery and rehabilitation can be long, involving both physical and occupational therapies. A patient will achieve what is referred to as “spontaneous recovery” within the first six-12 months after the event, when the patient regains skills lost after a period of time. The continuing skilled care received after that period can be a determining factor in their quality of life.

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 office 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.

A woman’s voice announces they have made stickers with the word, “Neuroplasticity,” written on them—a term referring to the process of rewiring the brain. This process is essential to the continued recovery and rehabilitation of a stroke survivor. Think of driving on a small road after a storm. This is a road you’ve driven every day to a familiar destination—say work or home. This is the only road you ever drive, but today there is a sign that reads, “Road Closed Ahead.” For our example, we navigate around the blockage and find another way hoping that our regular route will re-open tomorrow or the next day. For people with ABI, that road will never re-open. They must use the process of neuroplasticity to find other pathways in the brain to navigate around the blocks. The brain must be reconditioned to provide alternate routes for message transmission.

Improving Communication Skills

Today’s group is the Conversation Group and is primarily focused on the resulting aphasia that can occur after a stroke. Aphasia is a condition that affects the brain’s ability to express and understand written and spoken language. It is not a reflection of intelligence, but rather a processing issue that can occur after a brain injury or tumor is diagnosed. The clients in this group work with each other and four clinicians to establish new neural pathways aimed at improving communication.

Theresa Alexander, M.S., CCC/SLP, is one of two clinical instructors of the Speech and Language Pathology graduate program at the Loyola Clinical Centers. She explains the purpose of the group is more than just improving communication skills. “One of the major concerns for people with aphasia is social isolation,” she says. The group setting provides a supportive opportunity for clients to engage on a myriad of topics ranging from weekend plans, to current events, and other varied interests. It is a place free from judgement where the participants have a unique understanding of communicative difficulties.

Back on my monitor that process plays out in real-time. The graduate clinicians run through a series of topics—Earth Day, the woman’s NCAA Basketball Caitlin vs. Angel controversy, and even extends back to swimmer Ryan Lochte’s lie and subsequent suspension at the 2016 Rio Olympics. Each client is given the opportunity to opine on the subject matter presented. For some, their engagement is more verbally expressive. For others, the clinicians provide numbered multiple-choice responses to each topic. The numbered choices allow participation where verbal expression is more limited by blocked neural pathways.

Drawing People In

Christian is one of the more verbally engaged participants in the group. At the onset of the session, he asks another group member about her chicken coop and a fox. Following the announcement that next Tuesday’s gathering will be the final one of the semester, he expresses his gratitude to the graduate clinicians who will rotate into another group next semester. “Thank you, from the bottom of my heart,” and continues by adding well wishes. “I wish you all luck in (pause), the medical field.”

Christian’s participation on all topics during the conversation group is a catalyst drawing others in—a testament to aphasia being far less related to cognitive function and more a matter of lingual processing. “People with aphasia still have all the complex and nuanced thoughts and opinions about current events that every adult does. It’s just access to the words to represent those ideas,” explains Alexander.

One week later, I sit down with Christian to discuss his time at the Loyola Clinical Centers. In a small drop-ceilinged room used for one-to-one sessions with three chairs, a blonde-wood veneered table, a white board, and spherical mounted camera above it all, Christian is brought the green tea he politely requested sans sugar or milk.

A Different Kind of Birthday

Pleasantries exchanged, I inquire about his comfort level discussing his ABI. Steeping his tea bag, Christian begins by saying tomorrow,

May 3, is his second birthday. It was that day, 13 years ago when Christian suffered 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 off to work. May 3, 2010, 10 a.m., a day off, 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 difficult.

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 suffering 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 *this* 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 some social isolation from the onset of the pandemic.”

“I had lost the ability to communicate,” Christian tells me explaining that his only opportunities to speak during COVID were brief interactions at the grocery store or when buying a bottle of wine. He would talk out loud to his cohabitant, a rescued tabby cat named Large Lion who Christian insists, “found him.” And though Large Lion does speak perfectly in his dreams, she could not arrest the pandemic-based setbacks incurred. I cannot speak to those setbacks now.

Opportunity to Reflect

Back in the same second-floor office, I am observing the Executive Skills Group, which meets the day after the Conversation Group. The screen comes to life again, and I transport back to the same room complete with the U-shaped table and large wall monitor. The session starts with a meditative exercise. From my perspective, I am unsure who is speaking, but a woman’s voice directs the participants to close their eyes. “Inhale rejuvenating oxygen and exhale all that is toxic,” the voice continues.

Power-pointed images of beaches, sunsets, mountains—images that speak to tranquility perform a slideshow for anyone who disobeys the closed eyes direction. The clinicians and clients alike meditate together. They are asked to picture and reflect upon the most precious human connection they possess.

“The one who makes you feel safe, who supports you, who you cry with,” the woman tells them. She continues by evoking a sense of gratitude for their love and care. A graduate clinician shares that she is teary-eyed.

“Who were you thinking of?” asks a woman.

“My Mother,” responds the clinician. “She’s in New Jersey, and I miss her every day.”

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 stuff.” He tells the room that it was much more difficult 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 effects are different 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 affect 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 effective 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 American Psychological Association falling under the umbrella of clinical psychology, the neuropsychology assessment will also address emotional issues that may accompany brain injury.

Thompson’s efforts 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 difficult 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 offers 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 suffered 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 in June 2019 and enrolled in the program for continuing care under the assumption that he would return to work as a CEO. As he began treatment, it became evident that his pre-stroke life had been a casualty of the brain injury. While his path forward would not be defined by the stroke, it must be partnered with this new normal.

Putting in the Work

In his years at the LCC, Ron recounts that he has worked with over 90 clinicians. “These people have changed my life,” he tells me. He remembers the 50-year-old graduate clinician named Trish. She told the group they should be working on brain exercises for least eight hours outside the clinic.

In an affirmation to his intrinsic work ethic, Ron explains, “You tell me eight hours, I’m gonna do 20.” The manifestation of that ethic is two hours of brain work in the morning and another one or two before bed. A religious man, Ron insists that the Lord had something else in mind for him, and he remains an inspirational Christian, member of the Optimist Club, devoted husband, and grandfather of three.

The idea that Ron has worked with over 90 clinicians is astounding to me and speaks to the dual purpose of the LCC. While the clients are there to address their personal continuing care, their presence is essential to the continuing education of the future Tom Thompsons, Theresa Alexanders, and Chris Higginsons. In no other world would a client cycle through clinicians every 12 weeks, but here, there is a beautiful and accepted rhythm to this flux with all parties “buying in.” I speak with two graduate clinicians about their experiences after completing another semester.

Justin Duffy and Anna Tignor both expect to finish their graduate degrees in speech language pathology by the spring of 2024. They speak to the uniqueness of the clinic as both a therapeutic and learning institution.

Treatment and Care

The students are given case files of their clients at the beginning of each semester, and every graduate student will work with two patients on a one-to-one basis, and multiple more subjects in group therapy. That process starts immediately in the very first year. The students will use a patient’s file to pinpoint a successful treatment plan. The plan is submitted to supervising clinicians Thompson and Alexander for approval, and the scripting begins. I ask them both what it is like that very first session when they essentially begin practicing as clinicians.

“Anyone who tells you they weren’t nervous that first time is lying,” says Duffy. Tignor agrees. “It’s very intimidating. You are leading the session, and their care and treatment is in *your* hands.”

They both talk about the scripting and planning that goes into successful care while acknowledging the alacrity required, especially in the one-to-one sessions. But even more important is the data. After every session the graduate students take contemporaneous notes called, “soap notes,” which are then placed in the client’s file for

future clinicians. At the end of the semester with a particular patient, the graduate students will place a report in the client’s files, which aid the next clinician in creating a path for successful continuing care—what strategies were effective, new goals or benchmarks, identifying plateaus—anything that may help progression. But it is the ethic of care that I am struck by.

“We’re in It Together”

With each of these students, I detect a very genuine sense of concern and respect for their patients. Both Anna and Justin are only a year out of the undergraduate program at Loyola, but there is a maturity to their vocation. “When I’m in sessions, I feel like I’m working for my clients, and we’re in it together,” says Justin. He goes on to explain that, yes, they are being graded on their work, but any academic goals become secondary to the sole purpose of wanting to improve the lives and function of their clients. “Being able to go right in and help people right away has only enhanced my learning in the classroom,” he explains.

Anna can only second that notion acknowledging the clients’ participation in her progress as a clinician and therapist. “They know that Loyola is a learning institution, so them coming, knowing they’ll have a new clinician every semester is essential for our growth.” She has just completed her first year and marvels at the insight she’s gained in just one year’s time. “The ABI program has helped me grow immensely as a clinician.”

I ask her to expound.

“My clinical flexibility skills,” she responds without hesitation. “Just being able to be thrown in it and develop appropriate treatment plans based off of previous reports and soap notes that I’ve read from clients.”

I am reminded of what Alexander told me at the outset of this project, “The best care is a partnership.” It requires investment and buy-in from all parties. The clients must have the desire to be there. The supervising clinicians have to shepherd results-based care. The graduate students must be very intentional with their efforts. And all of this must be efficiently implemented in a system that is in a constant state of flux—a balanced rhythm relay where files replace batons, and a reset occurs in 16-week intervals.

Change in Identity

Debra Meyerson was a professor at Stanford University when she suffered a stroke. Her subsequent recovery and continued therapy led her to write a book to and about victims of stroke titled, *Identity Theft*. It deals with the acceptance by survivors of not regaining all pre-stroke functions and capabilities. More importantly, Meyerson writes about the fundamental change in identity occurring after a stroke. She acknowledges the difficulty but professes the importance of embracing one’s new self during recovery. It is as if the stroke has stolen an identity—*Identity Theft*.

In speaking with the graduate clinicians, clinical instructors, and the clients for this story, there is an awareness and reverence to her thesis. Maybe that is because all the work done through 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 difficult 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 *Awakenings*. There is no neat and tidy bow to tie upon a completed arc. The LCC is where *work*—difficult 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 affirming a life choice.

Writing the Next Chapter

Leaving my final interview with Ron, I see Christian in the lobby of the LCC. He is still waiting for a mass transit ride back to his home in Bolton Hill, a midtown neighborhood not far from mine. I ask if I can take him home, and he accepts. We talk on the ride home, not about strokes or life's burdens. We talk about animals—his cat, my cat, my dogs.

Christian tells me he volunteers at the SPCA and is now a "Cat Cuddler 2." He has just started working with puppies. We talk about Ocean City, his grandmother, high school, unmentionable trouble we'd both been in as younger men. I miss the exit to his street, forcing him to navigate.

We arrive at his place, a corner red brick row home subdivided into apartments as most of them have in the neighborhood. The sun shadows dancing trees onto the pavement as Christian notices his new royal blue recycling can before pulling it into the alley beside his house. I tell him how much I enjoyed our time together as he ascends his white marble steps worn with divots from all their prior ascensions. I get in my car and wave as I drive away.

In an effort to bring a thematic agenda to this piece, my thought was to make this all about the various perspectives of ABI at the LCC—those of the supervisors, graduate clinicians, and clients. It was early on in my interview with Alexander when that idea was put aside. She simply said, "I have no idea what's it's like to have a stroke." Those words stayed with me. Now, it seems arrogant to think I could understand the perspective of a stroke victim. That said, I was able to gain insight on one poignant thesis—gratitude. The students are grateful for the clients, and the inverse of that equation is beyond apparent.

As for perspective, the only one I can speak to is mine. That one may be worth a mention. The patients in this story almost lost everything. *They* are survivors. More than that, they are a reminder of life's fragility. And that reminder is a service to any perspective. The continuing care offered at the LCC manifests in the physical. Its spiritual byproduct of hope exists on an entirely different plane.

by Eric Michael Vincent, '93

Eric is a graduate of Loyola University with a degree in Creative Writing. He has spent his post-Loyola years as a song writer, performer, and sound engineer who has toured the world as an artist and in service to Armed Forces Entertainment. Though no longer performing, Eric is still deeply involved in music as a sound engineer, producer, and event coordinator. He has lived in Baltimore City since departing Loyola and currently resides in the Govans neighborhood with his wife, daughter, two dogs, and one cat.