Persistence of Brain Injury Misconceptions Among Speech-Language Pathology Graduate Students

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Traumatic brain injury (TBI) occurs with alarming frequency in the United States, with 1.5 million people sustaining TBIs annually (Brain Injury Association of America [BIAA], 2001). The frequency with which individuals experience long-term consequences resulting from TBI is shocking as well: An estimated 5.3 million Americans have a lifelong need for assistance to perform activities of daily living after having sustained a TBI (BIAA, 2001).

Despite this prevalence of TBI and its associated consequences, researchers have found that both the lay public and health care professionals endorse misconceptions about

ABSTRACT: Purpose: Despite the prevalence of traumatic brain injury (TBI) in the United States, members of the lay public and health care professionals endorse misconceptions about TBI in general as well as specific information about coma, memory problems, and the recovery process. The purpose of the present study was to determine whether typical collegiate programs for training graduate-level speech-language pathologists (SLPs) are effective in dispelling these common misconceptions.

Method: Speech-language pathology students either entering (n = 197) or graduating from (n = 117) a master’s degree program at institutions accredited by the American Speech-Language-Hearing Association completed an 18-item survey questionnaire regarding common misconceptions about TBI. Results were compared with survey responses from 318 members of the lay public who participated in a previous research study (K. Hux, C. Deuel-Schram, & T. Goeken, 2006).

Results: Descriptive statistics revealed that beginning master’s students, graduating master’s students, and the lay public all endorsed some misconceptions about TBI. A series of chi-square analyses revealed that the 3 groups demonstrated significant differences in response accuracy. Specifically, the lay public endorsed more misconceptions than both student groups, and the graduating master’s students endorsed fewer misconceptions than the beginning master’s students.

Conclusion: Although education is effective in dispelling some common misconceptions about TBI, persistent endorsement of some erroneous beliefs continues. Direct training is needed to address these fallacies.

KEY WORDS: traumatic brain injury, graduate students, misconceptions, education
TBI in general as well as specific information about coma, memory loss, and the TBI recovery process (Gouvier, Prestholdt, & Warner, 1988; Guilmette & Paglia, 2004; Hux, Deuel-Schram, & Goeken, 2006; Willer, Johnson, Rempel, & Linn, 1993). For example, by surveying the lay public about TBI, Hux and colleagues (2006) found that a majority of respondents believed that (a) people in a coma are aware of their environment; (b) survivors can be normal in every way, except they forget who they are and do not recognize others; (c) recovery mainly depends on how hard a person works; (d) having had one TBI does not predispose a person to having a second one; and (e) complete recovery from a severe TBI is possible if the person wants badly enough to recover. In addition, almost half of the respondents believed that (a) most people wake up shortly and have no lasting effects after being knocked unconscious, (b) people with amnesia do not have trouble learning new things, and (c) new learning following TBI is no harder than remembering information that was mastered before the injury.

Social scientists attribute the phenomena in which groups of people perpetuate false beliefs to informational cascades (Anderson & Holt, 1997; Bikchandani & Hirshleifer, 1992; Bikchandani, Hirshleifer, & Welch, 1998; Hirshleifer, 1993). As explained by Kuran and Sunstein (1999), “An informational cascade occurs when people with incomplete personal information on a particular matter base their own beliefs on the apparent beliefs of others” (pp. 685–686). One result of informational cascades is that, when multiple sources repeatedly endorse incorrect information, reinforcement and perpetuation of false beliefs occurs. This phenomenon may be a major contributor to the persistence of misinformation about TBI among the lay public.

Unfortunately, misconceptions about TBI are not limited to the lay public; subgroups within the health care professions may also endorse misconceptions about TBI. Swift and Wilson (2001) found support for this notion by conducting 19 semistructured interviews with people with brain injuries, their caregivers, and rehabilitation professionals about their perceived knowledge of the general public as well as health care professionals without TBI expertise. Analysis of participant responses indicated a belief that members of both groups have inaccurate or inadequate knowledge about TBI. Specifically, interview participants believed that the lay public and nonexpert health care professionals held inaccurate conceptions about recovery time from a TBI, extent of recovery, abilities of people with TBI, the relation among TBI and other disabilities like mental retardation, and problems resulting from TBI.

Misconceptions about brain injuries also persist among health professionals—such as school psychologists and speech-language pathologists (SLPs)—whose scope of practice includes the assessment and treatment of TBI survivors. In a survey of school psychologists to assess their endorsement of myths and misconceptions about TBI, Hooper (2006) found that, although school psychologists performed significantly better than the lay public on 6 of the 11 survey items, misconceptions persisted on items related to injury mechanisms and recovery. Similarly, Hux, Walker, and Sanger (1996) conducted a survey of school-based SLPs concerning their knowledge of TBI and their readiness to provide services to TBI survivors. Respondents indicated that they were uncertain about providing services to TBI survivors, and their responses revealed inaccurate perceptions about TBI in the following areas: federal legislation, characteristics of the survivor population, and diagnostic and intervention needs of students with TBI.

Most (97.1%) of the SLPs participating in Hux et al.’s (1996) study possessed a master’s degree; however, only half reported having received specific TBI training as part of their college course work. This sporadic receipt of training should no longer be the case, because the American Speech-Language-Hearing Association (ASHA) requires accredited graduate programs to ensure that students acquire and demonstrate knowledge of the nature of speech, language, hearing, and communication disorders and differences in the areas of cognitive, social, and pragmatic aspects of communication (Council on Academic Accreditation in Audiology and Speech-Language Pathology, 2007). More specifically, ASHA (2005) stated that SLPs should play a primary role in the identification, assessment, intervention, counseling, collaboration, education, advocacy, prevention, and research of infants, children, adolescents, and adults with cognitive–communication disorders (i.e., the communication disorder most frequently associated with TBI). Hence, typical speech-language pathology collegiate programs address TBI either in a course pertaining to various types of acquired language disorders (e.g., aphasia, language of dementia, cognitive-communication impairments) or, less commonly, in a course dedicated solely to TBI.

Despite the expectation that graduates of speech-language pathology master’s programs will have completed course work about TBI, we do not know whether their training is sufficient to dispel commonly held misconceptions. Hence, the purpose of the present study was to determine whether typical collegiate programs for training graduate-level SLPs are effective in dispelling common misconceptions about general knowledge, coma, memory problems, and the recovery of people with TBI.

**METHOD**

**Respondents**

Survey respondents consisted of three groups. Group 1 included 318 people from the lay public in Nebraska who participated in the Hux et al. (2006) research, Group 2 included 197 graduate students in their first year of attendance in a master’s degree program in speech-language pathology at institutions accredited by ASHA, and Group 3 included 117 recent graduates of a master’s degree program in speech-language pathology at those same institutions plus two universities. Data for the 3 groups were not collected at the same time. Instead, Group 1 data were collected for a previous research project, and data for Groups 2 and 3 were collected for the current study. Respondent characteristics (i.e., gender, age, and years of education) appear in Table 1.

Among the Group 2 respondents (i.e., beginning master’s students), 80.7% (n = 159/197) reported having taken
a class in which brain injury was one of several topics discussed, and 21.3% (n = 42/197) reported having taken a class specifically about brain injury. Approximately half (n = 99/197; 50.3%) of the respondents in Group 2 reported having a relationship with someone who was a brain injury survivor. In addition, a comparable number (n = 101/197; 51.3%) of Group 2 respondents reported work experience in either a setting with large numbers of people with disabilities or a setting with large numbers of people with brain injuries; 8.1% (n = 16/197) reported work experience in both settings. Among the Group 3 respondents (i.e., graduating master’s students), almost all (n = 109/117; 93.2%) reported having taken a class in which brain injury was one of several topics discussed, and two thirds (n = 79/117; 67.5%) reported having taken a class specifically addressing issues related to brain injury. Three respondents (2.6%) reported a personal history of brain injury, and 75 (64.1%) reported a relationship with a survivor of a brain injury. In addition, 44.4% (n = 52/117) of Group 3 respondents reported work experience in either a setting that included large numbers of people with disabilities or one that included large numbers of people with brain injuries; 31.6% (n = 37/117) reported work experience in both settings.

### Questionnaire

The survey instrument included 18 true/false statements (Table 2). Seventeen of the statements were from Hux and colleagues’ (2006) modification of Gouvier and colleagues’ (1988) questionnaire; the additional item queried respondents about their knowledge of special education verification categories for students with TBI. The 17 original survey items included four general knowledge statements about brain injury, three statements about coma or unconsciousness, four statements about memory problems associated with TBI, and six statements about recovery. The questionnaire also included probes to obtain information about respondents’ demographics, academic course work, work experiences, and personal experiences with survivors of TBI.

### Procedure

Responses for Group 2 and 3 participants were collected over a 2-year time period. During this time period, we sent faculty members of speech-language pathology departments at 10 universities in diverse geographic regions of the United States (i.e., California, Florida, Idaho, Maine, Missouri, Nebraska, South Dakota, Washington, and Wisconsin) 276 questionnaires for distribution to newly admitted, first-year graduate students (Group 2). Each time new students entered the program, faculty members at each university informed prospective Group 2 respondents about the voluntary nature of participation in the research and then distributed questionnaires to interested students within the first 2 weeks of class. The faculty members collected and returned 197 (71%) completed questionnaires. Subsequent mailings totaling 314 questionnaires were sent to faculty members at the same universities as well as universities in Illinois and New Hampshire for distribution to graduating, second-year master’s-level students (i.e., Group 3). Again, faculty members informed prospective respondents that their participation was voluntary. Faculty at each of the 12 universities collected and returned 197 (71%) completed questionnaires. Subsequent mailings totaling 314 questionnaires were sent to faculty members at the same universities as well as universities in Illinois and New Hampshire for distribution to graduating, second-year master’s-level students (i.e., Group 3). Again, faculty members informed prospective respondents that their participation was voluntary. Faculty at each of the 12 universities collected and returned a total of 59 questionnaires, and 58 of the Group 3 respondents individually returned their questionnaires by mail. Hence, a total of 117 questionnaires (37.3%) were returned by Group 3 respondents.

### Data Analysis

After being entered into a database, questionnaire responses were used to determine the percentage of respondents with accurate and inaccurate beliefs about TBI consequences and
RESULTS

Descriptive Statistics
Detailed results from the lay public respondents appear in Hux et al. (2006). The percentage of correct responses to each survey statement given by lay public participants appears in Table 2 along with the percentage of correct responses given by beginning and graduating master’s students. Overall, results showed that the lay public tended to endorse more misconceptions about TBI than did the students entering graduate programs in speech-language pathology, and entering graduate students endorsed more misconceptions about TBI than did graduating students. All groups endorsed at least some misconceptions about brain injury.

### Table 2. Percentage of accurate responses and chi-square analyses results for individual items.

<table>
<thead>
<tr>
<th>Questionnaire item (correct answer)</th>
<th>Lay public</th>
<th>Beginning master’s students</th>
<th>Graduating master’s students</th>
<th>p value</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. A head injury can cause brain damage even if the person is not knocked out. (T)</td>
<td>99</td>
<td>99</td>
<td>100</td>
<td>.484</td>
</tr>
<tr>
<td>2. Whiplash injuries to the neck can cause brain damage even if there is no direct blow to the head. (T)</td>
<td>90</td>
<td>85</td>
<td>93</td>
<td>.066</td>
</tr>
<tr>
<td>3. Emotional problems after head injury are usually not related to brain damage. (F)</td>
<td>84</td>
<td>93</td>
<td>98</td>
<td>.000abc</td>
</tr>
<tr>
<td>4. Most people with brain damage look and act disabled. (F)</td>
<td>94</td>
<td>91</td>
<td>99</td>
<td>.012abc</td>
</tr>
<tr>
<td>5. When people are knocked unconscious, most wake up shortly with no lasting effects. (F)</td>
<td>52</td>
<td>45</td>
<td>69</td>
<td>.000abc</td>
</tr>
<tr>
<td>6. Even after several weeks in a coma, when people wake up, most recognize and speak to others right away. (F)</td>
<td>76</td>
<td>80</td>
<td>93</td>
<td>.000abc</td>
</tr>
<tr>
<td>7. People in a coma are usually not aware of what is happening around them. (T)</td>
<td>40</td>
<td>55</td>
<td>51</td>
<td>.002ab</td>
</tr>
<tr>
<td>8. After a head injury, people can forget who they are and not recognize others but be normal in every other way. (F)</td>
<td>7</td>
<td>13</td>
<td>34</td>
<td>.000abc</td>
</tr>
<tr>
<td>9. Sometimes a second blow to the head can help a person remember things that were forgotten after a first blow to the head. (F)</td>
<td>71</td>
<td>89</td>
<td>91</td>
<td>.000ab</td>
</tr>
<tr>
<td>10. People with amnesia for events before the injury usually have trouble learning new things too. (T)</td>
<td>52</td>
<td>38</td>
<td>60</td>
<td>.000abc</td>
</tr>
<tr>
<td>11. After head injury, it is usually harder to learn new things than it is to remember things from before the injury. (T)</td>
<td>52</td>
<td>44</td>
<td>71</td>
<td>.000abc</td>
</tr>
<tr>
<td>12. How quickly a person recovers depends mainly on how hard they work at recovering. (F)</td>
<td>47</td>
<td>76</td>
<td>83</td>
<td>.000abc</td>
</tr>
<tr>
<td>13. People who have had one head injury are more likely to have a second one. (T)</td>
<td>32</td>
<td>31</td>
<td>69</td>
<td>.000abc</td>
</tr>
<tr>
<td>14. A person who has recovered from a head injury is less able to withstand a second blow to the head. (T)</td>
<td>70</td>
<td>67</td>
<td>83</td>
<td>.008abc</td>
</tr>
<tr>
<td>15. Once a recovering person feels “back to normal,” the recovery process is complete. (F)</td>
<td>97</td>
<td>99</td>
<td>99</td>
<td>.162</td>
</tr>
<tr>
<td>16. It is good advice to rest and remain inactive during recovery. (F)</td>
<td>60</td>
<td>77</td>
<td>76</td>
<td>.000ab</td>
</tr>
<tr>
<td>17. Complete recovery from a severe head injury is not possible, no matter how badly the person wants to recover. (T)</td>
<td>28</td>
<td>43</td>
<td>56</td>
<td>.000abc</td>
</tr>
<tr>
<td>18. A special education verification category exists for students with traumatic brain injury. (T)</td>
<td>N/A</td>
<td>65</td>
<td>70</td>
<td>.401</td>
</tr>
</tbody>
</table>

1Lay public and beginning master’s students differ significantly (p ≤ .05). 2Lay public and graduating master’s students differ significantly (p ≤ .05). 3Beginning master’s students and graduating master’s students differ significantly (p ≤ .05).
Accurate perceptions. More than 80% of the respondents in all three groups correctly answered 5 of the 17 survey items. These items included all four general knowledge statements (i.e., Items 1–4) and one item about the recovery process (i.e., Item 15). In addition, more than 80% of the beginning and graduating student respondents provided accurate answers to two other items (i.e., Items 6 and 9). Item 6 addressed the plausibility of people emerging from a coma with fully intact cognitive and language skills. Among entering graduate students, 80% responded accurately; among graduating students, 93% responded accurately. These response rates contrasted with 76% accuracy from the lay public. Item 9 addressed the likelihood of a second blow to the head eliminating memory deficits caused by a previous injury. Within both of the speech-language pathology student groups, approximately 90% of the respondents correctly judged the statement to be false, whereas only 71% of the lay public respondents provided a correct response to this item.

The graduating master’s students also responded with more than 80% accuracy to two other items about the recovery process (i.e., Items 12 and 14). Item 12 addressed how the effort of the patient affects the speed of recovery. Although the graduating master’s students responded with 83% accuracy to this question, only 76% of the beginning master’s students and 47% of the lay public provided an accurate answer. Item 14 addressed second-impact syndrome. The graduating master’s students responded with 83% accuracy to this question in contrast to 67% accuracy by beginning graduate students for one item (Item 10: χ² = 9.330, p < .002)—“People with amnesia for events before the injury usually have trouble learning new things too.”

Inaccurate perceptions. For the remaining items, response accuracy ranged from 7% to 70% correct for lay public respondents, 13% to 77% correct for entering master’s student respondents, and 34% to 76% correct for graduating master’s student respondents. Between 60% and 80% of the respondents across groups provided the correct response to Item 16, which related to the recovery process following brain injury. Also, Item 18—to which only participants from the two speech-language pathology student groups responded—generated a majority of correct responses (i.e., 65% and 70% for entering and graduating master’s students, respectively). All other misconception statements were erroneously endorsed by a majority of survey respondents from at least one of the three response groups.

The statement associated with the greatest percentage of misconceptions was Item 8—“After a head injury, people can forget who they are and not recognize others but be normal in every other way.” This was the only statement to which fewer than 50% of the respondents in all three groups provided the correct answer. Other majority-endorsed misconceptions within specific groups included Items 5, 7, 10, 11, 13, and 17. Specifically, fewer than 50% of the lay public respondents accurately answered Items 7, 12, 13, and 17, and fewer than 50% of the entering master’s student respondents accurately answered Items 5, 10, 11, 13, and 17.

Group Comparisons
A 3 × 17 chi-square analysis was performed to determine whether the three respondent groups demonstrated different patterns of response accuracy to questionnaire items. As shown in Table 2, significant differences in response accuracy were found for all questionnaire items except Items 1, 2, and 15—three of the five items to which a majority of respondents from all three groups provided accurate responses. A series of follow-up chi-square analyses were performed for the remaining questionnaire items to determine significant differences between (a) lay public and beginning master’s students, (b) lay public and graduating master’s students, and (c) beginning master’s students and graduating master’s students.

Lay public versus beginning master’s students. Significant differences emerged between the lay public and beginning master’s students regarding the accuracy of their responses to eight of the 17 survey items. For seven of these eight items, the lay public was more likely to endorse erroneous beliefs about TBI than were students entering a graduate program in speech-language pathology. Specifically, beginning speech-language pathology graduate students were significantly more accurate than members of the lay public in responding to one general knowledge statement (Item 3: χ² = 10.492, p < .001), one coma statement (Item 7: χ² = 11.133, p < .001), two memory statements (Item 8: χ² = 6.378, p < .012; Item 9: χ² = 21.624, p < .000), and three TBI recovery statements (Item 12: χ² = 39.637, p < .000; Item 16: χ² = 15.002, p < .000; Item 17: χ² = 12.496, p < .000). The lay public respondents generated significantly more accurate responses than beginning graduate students for one item (Item 10: χ² = 9.330, p < .002)—“People with amnesia for events before the injury usually have trouble learning new things too.”

Lay public versus graduating master’s students. Graduating master’s students also tended to generate more accurate responses to questionnaire items than did lay public respondents. Pair-wise comparisons revealed significant differences on 13 of the 17 items: two general knowledge statements (Item 3: χ² = 16.867, p < .000; Item 4: χ² = 5.112, p < .024), three coma statements (Item 5: χ² = 10.055, p < .001; Item 6: χ² = 15.537, p < .000; Item 7: χ² = 4.241, p < .039), three memory statements (Item 8: χ² = 53.979, p < .000; Item 9: χ² = 19.324, p < .000; Item 11: χ² = 13.074, p < .000), and five recovery statements (Item 12: χ² = 43.787, p < .000; Item 13: χ² = 48.450, p < .000; Item 14: χ² = 7.183, p < .007; Item 16: χ² = 9.553, p < .002; Item 17: χ² = 30.126, p < .000).

Beginning master’s students versus graduating master’s students. Pair-wise comparisons revealed significant differences in response accuracy between entering and graduating master’s students on 10 questionnaire items, with the beginning students providing less accurate responses than the graduating students in all cases. Specifically, the graduating students were significantly more accurate than the entering students regarding two general TBI knowledge statements (Item 3: χ² = 3.858, p < .050; Item 4: χ² = 8.858, p < .003), two coma statements (Item 5: χ² = 16.631, p < .000; Item 6: χ² = 9.686, p < .002), three memory statements (Item 8: χ² = 19.481, p < .000; Item 10: χ² = 13.982, p < .000; Item 11: χ² = 21.199, p < .000), and three recovery statements (Item 13: χ² = 42.197, p < .000; Item 14: χ² = 9.401, p < .002; Item 17: χ² = 5.173, p < .023).
DISCUSSION

The purpose of this study was to determine whether collegiate programs for training SLPs are effective in dispelling common misconceptions about TBI and the coma, memory impairment, and recovery experiences of survivors. Overall, the results showed that speech-language pathology undergraduate and graduate training programs are effective in eliminating many common misconceptions; however, other misconceptions persist despite existing educational efforts. Although positive in the sense that emerging speech-language pathology professionals appear to endorse fewer misconceptions than the lay public, this finding also provides evidence about the durability of some TBI misconceptions and the strength with which people endorse such beliefs.

The Role of Education in Dispelling Misconceptions

Education is a powerful tool for dispelling inaccuracies regarding medical issues. The fact that lay public respondents—with an average educational level corresponding with 13 to 14 years of schooling—endorsed significantly more misconceptions than beginning master’s students provides support for the notion that education—at least in the form of undergraduate speech-language pathology programs—is valuable and effective in counteracting erroneous TBI information. The further finding that graduating master’s students in speech-language pathology outperformed beginning master’s students lends additional credence to the idea that education is an effective tool. Still, universal dismissal of TBI misconceptions did not occur among the graduating speech-language pathology students, thus confirming that professional training alone and in its current form is not fully adequate in this area.

In particular, existing undergraduate and graduate programs in speech-language pathology fail to educate all students that (a) persistent consequences occur in the majority of cases in which people sustain injuries that are sufficient to cause unconsciousness; (b) people in a coma are typically unaware of activities in their immediate environments; (c) people with memory impairments from TBI almost invariably have other cognitive impairments as well, especially regarding new learning; (d) new learning is harder than relearning previously known information for survivors of TBI; (e) people who have sustained one TBI have an increased likelihood of sustaining a second one; (f) resting and remaining inactive are not effective in promoting rehabilitation following TBI; (g) complete recovery to premorbid levels of functioning across all abilities is an unrealistic expectation following severe injury; and (h) a special education verification category exists for students with TBI. Some of these points (e.g., points e and h) are simple facts that can easily be addressed in classroom lectures; others (e.g., points b and c) may be more effectively taught through clinical practicum experiences. Regardless of teaching method, conveying accurate information about these points is crucial for students’ development into professionals who are effective in assessing and treating the cognitive and communication challenges of TBI survivors.

Challenges Regarding Majority-Endorsed Misconceptions

The phenomenon of informational cascades may be a major contributor to the persistence of misinformation about TBI. Informational cascades contributing to misconceptions about TBI stem largely from movies, television shows, news clips, and personal interest stories in newspapers and magazines. For example, in recent years, movies such as 50 First Dates (Ewing & Segal, 2004), Regarding Henry (Greenhut & Nichols, 1991), Memento (Todd, Todd, & Nolan, 2000), and Finding Nemo (Burton, Stanton, & Unkrich, 2003) have inaccurately portrayed the cognitive, physical, or social ramifications of TBI or memory loss. In addition, media coverage of individuals with brain injuries, such as Terri Schiavo, has led to confusion surrounding the abilities of people in a coma. In coming years, given the recent identification of TBI as the “signature wound of the Iraq war” (Zoroya, 2005), the public is likely to continue hearing about the occurrence and consequences of TBI through these venues. If such reports persist in misrepresenting the consequences and recovery process associated with TBI—as well as in omitting key facts—belief in fallacies and partial truths will continue. Furthermore, without ready access to complete and accurate information, people have no reason to question or change their existing beliefs and opinions.

Study Limitations

Some methodological limitations associated with the current research are worthy of mention because they potentially impact the accuracy, interpretation, and generalization of the findings. These limitations concern the manner in which data collection occurred. First, different data collection procedures were used for the various respondent groups. Data from the lay public were collected at Nebraska shopping stores and malls via interviews, and data for the speech-language pathology students were collected via surveys that were distributed by faculty members in diverse geographic locations across the United States. Although this could potentially have influenced the results, the consistency of previous researchers’ findings across various regions of North America (e.g., Gouvier et al., 1988; Guilmette & Paglia, 2004; Hux et al., 2006; Willer et al., 1993) reduces the likelihood that this difference impacted the findings in any substantive way.

Second, substantial response rate differences existed between the beginning and graduating master’s student groups. Specifically, more than 70% of the beginning master’s students completed and returned a survey, but only 37% of the graduating master’s students did so. Again, the disparity was probably a result of differing data collection procedures. Whereas faculty members collected and returned all of the surveys from the beginning master’s students, this was not always possible for student respondents finishing their graduate programs. Instead, many of
these prospective respondents were responsible for mailing the completed survey to the researchers in the stamped and pre-addressed envelope provided—a procedure that may have decreased the likelihood of respondents completing and returning the survey. If this inconvenience was the sole reason for the lower response rate of graduating student respondents, it probably had a negligible effect on the study findings. Alternately, however, the low response rate may have occurred because prospective respondents who were uncertain of their response accuracy may have opted not to return the survey. In this case, the finding that graduating student respondents endorsed fewer misconceptions concerning TBI than respondents from other groups may have been an artifact of the data collection procedure rather than an actual difference among response groups.

Conclusion
In conclusion, members of the lay public appear to have only a rudimentary understanding of TBI and its consequences. In contrast, students graduating with a master’s degree in speech-language pathology are more likely to have accurate knowledge about TBI. Thus, education in speech-language pathology appears to provide students with sufficient information to dispel at least some commonly held TBI misconceptions, although some other erroneous beliefs persist.

Clearly, dispelling misconceptions about TBI is a formidable challenge. Even with rather extensive education—typically including one or more classes in which TBI is a specified topic of discussion—endorsement of some TBI fallacies persists. This phenomenon hints at the potency of informational cascades and suggests that successful dispelling of misconceptions requires direct challenges to the erroneous information supported by strong research and clinical evidence. Given that public awareness is currently heightened because of increased media attention regarding the frequency with which military personnel sustain blast-related TBIs, the time to address TBI inaccuracies perpetuated by informational cascades is now. Media attention to TBI has the potential to provide the general public, as well as health care professionals, with more accurate information than has previously appeared through popular venues. At least when education rather than entertainment is the end goal, survivors, caregivers, and TBI professionals should insist on honest and complete portrayals of TBI consequences and outcomes rather than allowing fictionalized renditions to appear that make good stories but do not relay the reality and struggles associated with living life with acquired brain injury.

Acknowledgment
The authors appreciate the support of their colleagues—Rebecca Burke, Gary Cumley, Aimee Dietz, Michael Fraas, Liz Hanson, Charlotte Harvey, Nancy Manasse, Byron Ross, Judy Walker, Lisa Wood, and Lina Zeine—in assisting with data collection for this research.

References


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