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Forensic, Child, Adolescent, and Adult Psychiatry

INDIVIDUAL & FAMILY PSYCHOPHARMACOLOGIC TREATMENT OF:
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TRAUMATIC BRAIN INJURY SCREENING: OVERVIEW

This is a brief summary concerning Traumatic Brain Injury, since a reasonable understanding of significant head injury can assist in deciding which of your cases warrant a neuropsychological evaluation. Although significant Traumatic Brain Injury causing a skull fracture indicates a referral, brain damage may be present in cases, sometimes called minor head trauma, where the following is evident:

1. *Minimal or no head contact/injury was sustained during the incident.*
2. *Minimal to no loss of consciousness has occurred.*
3. *No skull fracture has been sustained.*
4. *MRI or CAT scans are negative for major head injury.*
5. *Gross neurologic evaluation are non-remarkable.*

An MRI/CAT scan will indicate MACRO-anatomic injury in more severe head trauma. However, there are cases in which MICRO-anatomic cerebral injury has been sustained which may not show in an MRI/CAT scan. The mechanism for brain injury is presented in an accident where there is sudden acceleration or deceleration, the centrifugal force secondary to the injury causes the peripheral part of the brain (i.e., the cortex) to move more rapidly than the inner structures of the brain (i.e., brain stem). This differential acceleration causes axonal shearing (i.e., the destruction of cortical axons). This can result in a MICRO-anatomic brain injury causing significant neuropsychiatric and neuropsychological deficits, including problems with memory, concentration, thinking.

What is the best technique to screen for significant head injuries?

In attempting to provide a questionnaire for screening for symptoms of Traumatic Brain Injury, I have spoken with a number of neuropsychiatrists who are experts in working with patients who have sustained Traumatic Brain Injury. The general consensus is that if there is any possibility that an individual has sustained a brain injury, the initial evaluation should be conducted by a neuropsychologist. There may be some cases in which the finding will be negative for brain injury, but in other cases findings may be positive. In such cases, It is my opinion that the following procedure would be best in evaluating these patients:

1. Neuropsychiatric evaluation to define the degree of brain injury.
2. Neuropsychological evaluation.
3. The administration of a Positron Emission Tomography (PET) scan. I recommend Dr. Joseph Wu, of the University of California at Irvine, to provide a detailed PET scan analysis. *Note: The SPECT scan is much less sensitive that the PET scan.*

What is the psychological effect upon one who has sustained Traumatic Brain Injury?

When an individual has sustained Traumatic Brain Injury, the symptoms affect that individual's mental health and thus, ability to work. Since a person's identity is based upon intact psychological functioning, even minor brain in jury -- resulting in, for example, a 10% decline in one's cognitive abilities -- can cause significant symptoms of depression and anxiety, especially in those whose job duties cannot be performed unless their cognition is intact. In addition to depression and anxiety, a patient may also develop Post-Traumatic Stress Disorder and psychosis. Even in the case where an individual is not working in the labor force (e.g., a stay-at-home parent watching children and managing a household), that individual's ability to perform his/her duties in a safe and efficient manner depends upon intact cognition and lack of same may cause partial inability to function with resultant onset of depression.

Screening for signs of malingering

In screening for a Traumatic Brain Injury, it is very important to rule-out malingered mental illness. Although my personal philosophy is to give the patient the benefit of the doubt, malingering can cause obvious problems. The two main forms of malingering are: 1) *Pure malingering*, where a patient has no mental illness, and all symptoms are fabricated; and 2) *Partial malingering*, where there may be some genuine neuropsychiatric symptoms, but the individual is embellishing these symptoms.

Note that patients who describe a change in their ability to smell, or complain of inability to taste or smell food, generally tend to have significant brain damage.