

# Mild TBI and What To Do About It : Handling Patients and Families

By

Harriet Katz Zeiner, PhD

**Some of the Clinical Presentation  
comes from CME course:**

**VHI Traumatic Brain Injury**

**Available in booklet form and on the  
Web at:**

**<http://vaww.ees.aac.va.gov>**

**or**

**<http://www.va.gov/vhi>**

# The Changing VA Population:

## Polytrauma

- While serving in Operation Iraqi Freedom and Enduring Freedom, military service members are sustaining multiple severe injuries as a result of explosions and blasts.

- Improvised explosive devices, blasts, landmines and fragments account for 65 percent of combat injuries
- (Peake JB, N Engl J Med 2005 jan 20, 352 (3):219-222)

- 7200 people with undiagnosed mild TBI have been sent home.
- Mild TBI refers to the time period of unconsciousness, not to the effects on the person's life.
- Mild TBI can have MAJOR impact on marriages, jobs, relationships, children and roles
- This is not a political issue— It is a major health care problem in America, which the VA is charged to deal with.

**Of these injured military personnel, 60 percent have some degree of traumatic brain injury**

**<http://www.dvbic.org>**

**The four current Traumatic Brain Injury Centers within the VA had already treated a majority of the severely combat injured requiring inpatient rehabilitation**

The VA renamed the TBI lead centers  
Polytrauma Rehabilitation Centers,  
dividing the USA into 4 geographical  
zones

- Palo Alto VAHCS
- Maguire VAMC, Richmond Va
- James Haley VAMC, Tampa Fla
- Minneapolis VAMC, Minneapolis MN

# Occult (Hidden) Brain Injury

- Half the head injured will be blast exposed- half will be motor vehicle accidents.

# The Mission of the Polytrauma Center

- Provide comprehensive inpatient rehabilitation services for individuals with complex physical and mental health sequelae of severe and disabling trauma and provide support to their families.

Did the Veteran serve in Operation Iraqi Freedom (OIF) or in Operation Enduring Freedom (OEF), either on the ground, in nearby coastal waters, or in the air above, after September 11, 2001?  
(Select one answer. Consider only the patient's most recent deployment.)

- No - No service in OEF or OIF
- Yes - Service in Operation Iraqi Freedom (OIF)  
(Iraq, Kuwait, Saudi Arabia, Turkey, Other)

complete all open items

The location of the patient's most recent OIF service was

choose one

- Iraq
- Kuwait
- Saudi Arabia
- Turkey
- Other OIF Service

1. SCREEN FOR PTSD

- Complete PTSD Screen (answer all 4 questions)  
Have you ever had any experience that was so frightening, horrible, or upsetting that, IN THE PAST MONTH, you:

Have had any nightmares about it or thought about it when you did not want to?

- No
- Yes

Tried hard not to think about it or went out of your way to avoid situations that remind you of it?

- No
- Yes

Were constantly on guard, watchful, or easily startled?

- No
- Yes

Felt numb or detached from others, activities, or your surroundings?

- No
- Yes

- Refused PTSD Screening

## 5. POST-DEPLOYMENT SCREEN FOR BRAIN INJURY

1. Did you have any injury(ies) during your deployment from any of the following?

- Fragment
- Bullet
- Vehicular crash (any type of vehicle, including airplane)
- Fall
- Blast (Improvised Explosive Device, RPG, Land mine, Grenade, etc.)
- Other injury
- No injury reported

2. Did any injury received while you were deployed result in any of the following?

- Being dazed, confused or "seeing stars"
- Not remembering the injury
- Losing consciousness (knocked out) for less than a minute
- Losing consciousness for 1-20 minutes
- Having any symptoms of concussion afterward (such as a headache, dizziness, irritability, etc)
- Losing consciousness for longer than 20 minutes
- Head injury
- None of the above

3. Are you currently experiencing any of the following problems that you think might be related to a possible head injury or concussion? (check all that apply):

- Headaches
- Dizziness
- Memory problems
- Balance problems
- Ringing in ears
- Irritability
- Sleep problems
- Other:

**One of the major difficulties in  
assessing BI patients is that  
symptoms of BI are not  
pathognomonic,  
and are often  
confused with psychiatric  
symptoms.**

## **This can have several negative effects:**

- The patient may be placed on inappropriate medications that do not treat the symptomatology**
- The patient can be inappropriately labeled with a psychiatric diagnosis**
- The case manager/therapist will not serve as the patient's and family's primary source of understanding about the nature and course of the cognitive and emotional changes that have occurred**

- **The purpose of this next section is:**
- **To present explanations and treatment suggestions that you can give to BI patients and their families for the most common complaints regarding changes in behavior, function, and personality.**

**Family members of patients with Mild TBI, often complain of “personality” changes in the patient. When questioned specifically, they mention:**

- 1. fatigue**
- 2. anger**
- 3. emotional outbursts**
- 4. problems with concentration/attention**
- 5. slowed information processing**
- 6. memory problems**

- **To reduce the family's stress level**
- **To give therapists and families a framework for tolerating TBI symptomatology**
- **To start the process of treatment of the patient's symptoms by emphasizing structure- even during the initial contact**

**Frequently Asked Questions by**  
**Family**  
**Members, and How to Answer Them**

***1. Why is my family member with TBI so tired all the time?***

## **Fatigue:**

**Many of the cognitive functions, which are automatic and reflexive for people without cognitive impairment,**

**take 2-3 times the mental effort for people with TBI.**

**This is due to the fact that people with TBI often have to think about, and do with conscious effort, what the rest of the world does automatically, without thinking.**

**All thinking requires some expenditure of mental energy:**

**Paying attention,**

**Switching attention to a new person,**

**Keeping up with the topic of conversation,**

**Organizing an answer to a question,**

**Making a decision,**

**Trying to decide what to do next,**

**Organizing your day's activities**

- **Concept of Energy Budget**

***Medical Management Strategy Disturbed  
Sleep/Wake Cycle.***

**1. Medication**

**2. Artificially impose a rigid bedtime  
and rise time on the patient.**

1. What to do with a fatigued TBI patient in your clinic:

- Make important decisions when the patient has the greatest amount of mental energy, usually in the morning.
- Make as many activities as possible into a routine to minimize choice. This saves mental energy.
- Do not fill up the patient's day with scheduled activities.

Do one important thing/day

- The use of an organizer, either taped or electronic is essential.

***2. Why is my family member angry all the time?***

## **Cognitive deficits —**

**slowed rate of information processing, reduced span of attention, loss of the ability to multitask (“Now I’m a one-trick pony.”), memory problems for new information, visuospatial difficulty in perceiving the environment —**

**all serve to make the world seem a more difficult place for the patient to comprehend.**

**The anger expressed by patients is often a symptom of stimulus overload.**

**“Catastrophic reactions”  
are emotional responses of  
neurologically impaired patients when  
the environment is too complex for  
them cognitively.**

**There are four variants:  
silly laughing  
flight  
tears  
anger**

## ***Treatment recommendations:***

- **First, the family can point out the irritability, frustration, or anger when it occurs, and suggest to the patient that too much is coming at them too fast.**

- **Nursing Staff and Family members can be taught to speak with pauses**

**(Speak as if you threw a handful of commas into your speech.)**

**When you pause in parts of the sentence, the patient can “catch up” in information processing.**

**The patient can be asked to talk to  
people one-on-one**

**rather than in groups**

**speaking to two or more people places  
a strain on attentional mechanisms).**

***Why are the family members,  
particularly spouses of patients, so  
complaining and angry?***

**Family members project negative  
emotions onto staff for many different  
reasons:**

**Family members feel they need energy to cope with a crisis, and anger activates people.**

- **The family member is in danger of collapsing in despair, so they get angry to activate themselves.**

- **Anger is often delayed from the acute setting, when coping with disaster, emotional suppression is paramount.**

**These suppressed feelings come out in outpatient settings because “now it’s safe to express how overwhelmed we feel”.**

**TBI often challenges families' assumptions about how the world works. We all hold some false beliefs about the world, such as:**

**◦ Life's fair. This is untrue. In dealing with unfairness, it helps to change the frame of reference of the family member.**

**For example: Everyone who is alive today has beaten the odds. The odds are 100,000,000 to 1 that a particular sperm would fertilize the egg, which resulted in a particular individual. Those are the odds we all win at conception. After we are born, everything else is gratis, icing on the cake. This is offered as an alternative viewpoint to family members who feel cheated that the patient didn't get his/her fair share of good health and long life with any untoward events.**

- **Spiritual beliefs that bad things that happen to us are punishment for sin.**

**Families will state, “But he’s good, why did this happen?”**

**It is helpful to point out that suffering is not a punishment, surely innocent infant/children suffer and are not to blame.**

***How to respond to angry family members:***

- **Never respond in anger, not even in clipped tones.**
- **Give lots of information to the family member about TBI, it binds anxiety.**

**Have them record the information, to review at a later time.**

- **Determine what is fair for the patient —  
and stick to it.**

**Being a broken record is often helpful, this  
means**

**repeating your position, not in anger.**

**Playing dumb can be a useful stance,**

**“ I’m confused, at first I understood you to say**

**that he’s impulsive and can’t be controlled, then**

**you said he’s unable to self-start,**

**can you give me some examples of what you mean?”**

**Always ask for specific examples.**

**Family members don't speak in medical terminology and they may mean something quite different than you do when they say, "he's depressed".**

**If a family member is constantly attacking  
you verbally,**

**demanding predictions and prognoses to  
questions that cannot be answered,**

**recognize that they have difficulty with  
ambiguity.**

**Acknowledge that not having clear answers  
is hard, but you have  
given them all that you can.**

**When pressured by a family's anger,  
delay by taking time to answer.**

**"I can understand why you might think  
that.**

**I'll have to think about that,**

**I'll get back with  
you later." This allows you not to  
answer in anger.**

- **If they continue to question you,**
- **answer questions with a question.**
  
- **This stops the placing of blame on the nursing staff, and places the tolerance of ambiguity where it belongs, back with the family.**

**Consider suggesting that the spouse seek counseling.**

**Acknowledging that care giving is an incredible load for anyone to bear,**

**that anyone would need some stress reduction and support.**

**Have the names of some professionals that are familiar with head injury.**

**The BIA maintains such a list, as does the National Caregivers Alliance.**

**Definitely have literature available on local support groups for family members.**

## ***Point to Remember***

**Dealing with angry and frustrated family members is stressful; listen and provide educational information in a direct, matter-of-fact, consistent manner**

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# Characteristics of Mild Cognitive Impairment that Your Departments Will Have To Deal With

## **Inefficient memory- especially for appointments, episodic events**

1. 3 missed appointments, clinics drop them,
2. Need for memory prostheses and training (PDA)
3. Can't come back later- they will disappear, solve the issue now
4. Allow tape recording of information

## Characteristics of Mild Cognitive Impairment that Your Departments Will Have To Deal With.

### **Slowed information processing-**

1. They need written back-up,
2. Repetition,
3. Allow tape recording of information-
4. Someone guiding them through the process.
5. More dependence on case managers, PCP
6. Strongly consider a Point of Contact Person in your department to handle Pts with TBI/OIF/OEF/Polytrauma

**How does this effect interviews?**

**Underwhelm , Don't overwhelm**

**Don't cram lots of information into small time**

# Characteristics of Mild Cognitive Impairment that Your Departments Will Have To Deal With.

## **Attentional problems-**

1. Can track one thing at a time,
2. Forms are overwhelming
3. Being sent multiple places is  
overwhelming

# Characteristics of Mild Cognitive Impairment that Your Departments Will Have To Deal With.

## **Organizing Difficulty**

1. Don't understand hospital rules
2. Don't understand VA rules.
3. Can follow a plan, but not come up with one
4. If one part of solution is blocked, they drop out

## **Bridge the Gap- Loan Them Your Organizing Ability**

# Communication Tips In Dealing With Patients With Cognitive Difficulty

1. Use every day language, not medical-ese or VA language:  
"Anyone in your shoes would need the stress load reduced"  
instead of "You have PTSD"

or,

"Do you receive monthly money from the VA?"  
instead of "What percent service connected are you?"

2. Respond best to closed ended questions, choices.

"Are you feeling good or bad today?"

Is better than "How are you?"

3. Slow your speech down with commas.