Current PSYCHIATRY

Ask returning veterans about traumatic brain injury

The article "6 screening questions for military veterans" (Pearls, Current Psychiatry, September 2008, p. 78-9) is a well written and thorough review for clinicians treating active duty personnel and military veterans. A very important and clinically relevant seventh question is to ask about traumatic brain injury (TBI) that may have occurred during training or deployment to Iraq or Afghanistan. One tool clinicians can use to screen these patients is the Brief Traumatic Brain Injury Screen developed by the Defense and Veterans Brain Injury Center.[1] Coupled with a clinical interview, this 3-question survey will assist clinicians in identifying possible TBI patients. Referring TBI patients to a polytrauma rehabilitative center through the Department of Veterans Affairs is part of a comprehensive treatment plan.[2]

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References

1. Schwab KA, Baker G, Ivins B, et al. The Brief Traumatic Brain Injury Screen (BTBIS): investigating the validity of a self-report instrument for detecting traumatic brain injury (TBI) in troops returning from deployment in Afghanistan and Iraq. *Neurology* 2006;66(5)(suppl 2):A235.
2. Friedmann-Sánchez G, Sayer NA, Pickett T. Provider perspectives on rehabilitation of patients with polytrauma. *Arch Phys Med Rehabil* 2008;89(1):171-8.

Dr. Barry responds

Mild traumatic brain injury (mTBI) is one of the signature diagnoses of the conflicts in Iraq and Afghanistan, and we're learning more about the pathogenesis, manifestations, sequelae, and treatment of this syndrome. Most veterans have basic knowledge about this condition because the military educates and screens all personnel for mTBI and employs aggressive, multi-disciplinary treatment plans for those in need. Thus, clinical interview, physical examination, and screening for mTBI—as suggested by Dr. Berigan—might yield useful information for clinicians treating veterans.

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Psychiatry ethics guidelines need to be revised

At a time when 28.4% of psychiatric practices provided no psychotherapy during a typical week,[1] applying psychotherapy principles to ethical judgments involving psychiatrists is inappropriate and should be abandoned ("Psychiatrist/patient boundaries: When it's OK to stretch the line" Current Psychiatry, August 2008, p. 53-62).

The American Psychiatric Association should revamp its ethics annotations by removing psychoanalytic references and terms such as "identification" to make these guidelines relevant to all psychiatric practices, even those without psychotherapy.

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Reference

1. Mojtabai R, Olfson M. National trends in psychotherapy by office-based psychiatrists. *Arch Gen Psychiatry* 2008;65(8):962-70.

Examine the evidence on expert witness testimony

The authors of "Psychiatrist/patient boundaries: When it's OK to stretch the line" (Current Psychiatry, August 2008, p. 53-62) cited the American Academy of Psychiatry and the Law's recommendation that "psychiatrists avoid acting as expert witnesses for their patients or performing patient evaluations for legal purposes... The intrusion of another role into the doctor/patient relationship can alter the treatment process and permanently color future interactions... these situations create the appearance that you have conscripted a vulnerable individual into your practice."

These statements raise several questions:

- Aren't most individuals coming into psychiatric practices vulnerable?
- If psychiatrists avoid patient evaluations for legal purposes, who will do them?
- Which opinion carries more weight, that of a psychiatrist who has worked with a patient for years or that of an independent evaluator who has seen the patient for an hour or 2?
- Is it in the best interest of the patient or the therapeutic alliance if the treating psychiatrist declines the patient's request to testify or write an

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evaluation because of possible mercenary motivations, particularly when the testimony might make a significant difference?

If the patient and psychiatrist are willing to forego confidentiality, the doctor should have the option to represent the patient's psychiatric treatment as a witness, not as an independent medical examiner. Salaried psychiatrists testifying for patients treated in public agencies—from city to federal—do not receive fees for testimony. As far as I know, there is not a standard forensic fee for private practice psychiatrists, who can adjust their fees to reflect work done, perhaps applying their hourly office rate for time spent on preparation, travel, and testimony. These psychiatrists also can discuss the fee with patients to prevent undue financial strain.

Hope is a precious commodity that should not be denied to patients because of possible overinterpretation of boundary concepts.

Perhaps I have overinterpreted the authors' points. Maybe forensic psychiatric testimony should be re-examined in light of its possible harmful effects on psychiatrist/patient relationships. However, I think the material cited by the authors could needlessly deprive patients of assistance. I thought our goal is to use our clinical judgment to serve the best interest of each patient, not merely avoid lawsuits or board complaints as we go.

S. Epstein, MD
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Drs. Marshall, Teston, and Myers respond

Dr. Epstein's questions imply that in some cases, the legal system might serve as an ally to the therapist. Our assumptions about the legal system are less charitable. Though there may be occasions when treatment goals and a legal ruling may align, risks multiply when therapy moves from the office to the courtroom. Although we agree that our decisions should not be driven by a desire to avoid lawsuits or board complaints, once a case goes to court the therapist surrenders control of the therapeutic process, opening a Pandora's box of potentially negative consequences.

Although there are unusual circumstances—such as physicians practicing in rural areas—when a physician may assume dual roles, physicians under oath serve the court, not the patient, and litigation is not always driven by the patient's best interests. Presumably, the treating psychiatrist possesses more information about the patient, but what if the patient has lied? Or what if the psychiatrist reveals sensitive information about the patient, which results in a patient losing a job, losing respect in the community, or getting divorced? In other cases, patients may not be sufficiently competent to "forego confidentiality," or they might not fully appreciate the risks involved in granting the therapist permission to testify.

As noted, patients are not obliged to maintain boundaries. In fact, they are not even obliged to tell us the truth. Only psychiatrists have the obligation to tell the truth, maintain boundaries, and protect our patients, even—at times—from themselves. Advocate courageously for your patients, but be judicious (no pun intended) where you exercise that courage.

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