Brain Injury Psychiatry Workshop

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Case Presentation

Case- background

- 56 year old single male, DSP, daily carers, living with his mother in their own home, working in telecommunications until made redundant 15 years ago

- 1st TBI- 2.5 years ago bike v car. PTA 27 days, R.sided subdural and frontal/parietal contusions, likely DAI. Acute admission 3 weeks, rehab admission 6 weeks. D/C physically independent, slowed speech and social communication deficits, main goal to return to exercising most of the day

- 2nd TBI- 6 months later ?secondary to seizure. PTA <1 wk, R.parieto-occipital subdural, multiple R. frontal contusions. Acute admission 1 week, rehab admission 6 weeks. Independent with self-care and mobility. Performed reasonably well on neuropsych

Case- referral

- Recovery from TBIs complicated by comorbid psychiatric issues, which culminated in a major depressive episode and prolonged admission to the mental health inpatient unit last year after presenting with suicidal intent and ?psychotic symptoms. Antidepressant, changed antiepileptic and antipsychotic medications
- Community MH case management, referred to BI Psychiatry to identify strategies that could further assist in his rehabilitation given lack of motivation to attend to his hygiene, morbidity associated with his malnutrition, low mood and focus on losing weight to the exclusion of other goals
- Main issues client identified- inability to engage in usual activities: riding a push bike, driving, going to shooting classes, walking his dogs and difficulty reaching a previously attained specific weight
- Anticipated accommodation issue d/t mother's ill health

Case- symptoms

- Low energy and motivation levels- unless there is something with a strict deadline, does not act on it
- Does go for walks most days but disappointed only 1 hr, prior to accident walking 5hrs/day and riding 80km to maintain weight. 200kg prior to being made redundant, down to 75kg, gained 30kg during MH admission
- Reasonable mood- sad about 2 dogs
- Listed things he would like to do- looking for a job at a help desk, obtaining amateur radio licence and attending the dentist, but finds it very difficult to follow through with these plans v before TBIs
- Early morning wakening, back to sleep- until 3pm on weekend when no carers
- Denied suicidal thoughts- mother and sister protective

Case- developmental and family

- Quiet, reserved child overweight through schooling years, never any intimate relationships. Felt like he always tried to make his father proud but no matter what, ended up being a disappointment
- Worked excessively- would access system at home, prided himself on being able to solve difficult technical dilemmas
- Father had gambling problems, passed away with renal cancer. Client thought father might have taken excess sleeping tablets to trigger his death in the palliative stages

Case- mental state examination

- Caucasian male looking older than stated age. Woken when we attended his house at 10 am and took about 10 minutes to emerge. Casually dressed, smelt of aftershave and his hair was curly and fashioned away from his face. He had long nails which had not been tended to and mild central obesity. He did not make any eye contact and was observed to clench his jaw throughout.

- Walked slowly with a kyphosis and did not seem to pay close attention to cars as we were crossing the road. There was a reasonable rapport formed. There was a latency in his speech which had a slow rate and was relatively monotonous. His mood was described as occasionally dysphoric and his affect was congruent and restricted. There was no formal thought disorder.

- Preoccupation with losing weight. There seemed to be some magical, childlike thinking around connections between his behaviours and weight loss, but they did not appear to be fixed false beliefs that were delusional in nature. Experienced auditory hallucinations on two occasions which were in the form of a public service announcement, prior to his seizures. He reported that throughout his life he has had infrequent episodes of increased sensitivity to smell. These are short lived, self resolve and do not impair his functioning. He has not experienced other perceptual abnormalities. Occ suicidal thoughts but denied current intent.

- Partial insight into his situation with an understanding of the need to see psychiatrists and take psychotropic medication, however found it difficult to make links between his behaviours and his physical issues as well as practical ways to address his amotivation.