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Mild Traumatic Brain Injury and Mental Health-Reply

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In Reply We appreciate the interest of Smith and Vipler in our study.[1] The 2 internal medicine physicians raise 3 concerns regarding our findings about the prevalence of comorbid mental health conditions among service members following a concussive blast injury.

First, "increased awareness allows individuals to seek out mental health care regardless of … cause." The report that they cite encourages, not discourages, this point. This was recommended because it was believed to reduce severity and poor outcome, not increase it. That said, we inquired about treatments with all of service members in our study (controls and patients with a concussion). We found that "80% of concussive blast patients endorsed seeking assistance from a mental health care professional. Only….18% reported that mental health programs helped."[1] (p825) Most did not repeatedly seek treatment as suggested because they felt that it did not help.

Second, "repeated assessment …may uncover an otherwise undiagnosed psychiatric condition." While this may be true (and is a goal of a mental health screening), our study carefully screened for a history of a previous diagnosis and undiagnosed psychiatric condition by patient and a collateral source where possible, which was most. Our focus was understanding the contributions of blast concussion on long-term outcomes. We explicitly excluded those with any prior psychiatric condition, as stated in the Methods. Of course, we cannot rule out the possibility of unidentified conditions, but with the extensive history collected, the likelihood is low (a point that was addressed in the Discussion).

Third, "repeated assessments may influence future mental health screening via recall bias if the patient believes they should have a psychiatric diagnosis," which implies that screening increases the endorsement of mental health symptoms or makes them worse. While this is an intriguing theory, the letter provides no reference to any literature that substantiates this claim. Weinick et al[2] specifically advocate for continued screenings to allow for the earliest possible intervention and best possible outcome. If this bias were real, it would affect all clinical care, treatment programs, and research studies that are focused on comorbid mental health conditions. It would also support reducing screenings, so significant caution should be given as this could have detrimental effect on service members who may be experiencing this in silence. A cornerstone in medicine is to screen for treatable diseases.

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The notion that asking about a symptom will increase the likelihood of it emerging (and conversely, that not asking will decrease incidence rates) has long been debunked and is known to contribute to the stigma, under detection, and under treatment of psychiatric conditions. Conversely, there is considerable literature that supports the reduction in symptoms following early screenings and prevention. Even in the scenario of repeated evaluations, a careful review of the literature by the US Department of Health and Human Services in their report[3] identified "no relevant literature" that supported the "harm of screening."[3]

Should recall bias that causes enhanced symptom endorsement from repeated screenings exist, the likelihood that it is driving our results is low given the very large effect sizes in our findings.

References

1. Mac Donald CL, Barber J, Jordan M, et al. Early clinical predictors of 5-year outcome after concussive blast traumatic brain injury. JAMA Neurol. 2017; 74(7):821–829. [PubMed: 28459953]
2. Weinick RM, Beckjord EB, Farmer CM, et al. Programs addressing psychological health and traumatic brain injury among US military service members and their families. Rand Health Q. 2012; 1(4):8. [PubMed: 28083215]
3. Gaynes, BN., West, SL., Ford, C., Frame, P., Klein, J., Lohr, KN. Screening for Suicide Risk: A Systematic Evidence Review for the U.S. Preventive Services Task Force. Rockville, MD: US Department of Health and Human Services; 2004.