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Psychiatric Illness is a Consistently Reported Risk Factor for Developing Mood Disorders after Traumatic Brain Injury

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INTRODUCTION

Today there is a high risk of confusing the psychiatric symptom with the characteristic manifestations of the diagnosis of intellectual disability, such that making the diagnosis of psychiatric illness in patients with intellectual disability continues to be a real challenge for clinicians. That is because cognitive impairment can somewhat mask some psychiatric signs and exacerbate others, making it difficult to discriminate the psychiatric symptom from that characteristic of intellectual disability. Despite new knowledge and advances in the neurobiological underpinnings and treatment approaches of bipolar disorder and relapsing depression, increasing relapse rates, persistent sub-syndromal symptoms, and treatment resistance remain challenging problems. It needs to be dealt urgently.

DESCRIPTION

Given the atypical symptomatology and the difficulty in making a diagnosis (for example, due to the inapplicability of scales for the assessment of the normally impaired) there is an increasing need for other clinical supports for the semeiological assessment, such as the interpretation of sudden changes from previous levels of functioning. Mood disorders are a common complication of traumatic brain injury and negatively impact the recovery process and psychosocial outcomes of brain-injured patients. A history of psychiatric illness and limited social support are consistently reported risk factors for developing mood disorders after traumatic brain injury (TBI). In addition, biological factors such as the involvement of the prefrontal cortex and other limbic and paralimbic structures may play important roles in the complex pathophysiology of these disorders.

We know that Cognitive Behaviour Therapy (CBT) is an effective treatment for depression and anxiety, but its application in adults with intellectual disability may be hampered by the pre-existing cognitive limitations. However, recent studies showed that people with intellectual disability can link situations to emotions, identify emotions correctly and have the capacity to differentiate between thoughts, feelings and behaviour. Several authors have suggested that use of role play and visual aids, thought feeling diaries, and identification of automatic negative thoughts may facilitate understanding and-processing relevant information during therapy sessions.

After sessions of cognitive behavioural therapy on people with intellectual disabilities and mood disorders reported that lucid awareness of the participants where they could recall various aspects, such as naming the therapist and the support worker, reasons for having the therapy and elements of what they had discussed in the sessions, positive changes in improving confidence and increasing calmness, the role of the support worker was viewed in a positive way and welcomed by the participants as a friendly presence in their lives, the materials used in sessions and in homework tasks were deemed to be easy and participants would recommend the therapy to others with similar problems and that they would have liked further contact after the end of the allocated sessions. Finally, cognitive-behavioural therapy is increasingly being advocated for relapses of remission disorders such as depression, with or without anxiety, and services provide effective psychotherapy for people with intellectual disabilities.

CONCLUSION

MD has a high prevalence during childhood and adolescence and has a significant long-term impact on the lives of those affected. There is a need to improve diagnostic criteria and adapt them to the pediatric population, with the goal of making it easier for clinicians, especially pediatricians, to make diagnoses and initiate early intervention. Advances in the field of epigenetics can contribute to the development of new preventive, diagnostic, and therapeutic approaches.

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