

PSYCHOMOTOR AGITATION AND MOOD DISORDERS IN PATIENTS WITH INTELLECTUAL DISABILITIES: EFFICACY OF TREATMENT WITH MOOD REGULATORS

Giuseppe Tavormina

"Psychiatric Studies Center" (Cen.Stu.Psi.), Provaglio d'Iseo (Brescia), Italy

SUMMARY

The frameworks of impulsivity and temperamental irritability of people with intellectual disabilities, presenting disabilities both for organic cause, e.g. postpartum, and for congenital mental retardation, may often present impulse control disorders, irritability and psychomotor restlessness, busyness and insomnia, from likely non-epileptic neuronal dysfunction. The patients with intellectual disabilities presenting mood disorders need to be treated with a therapy similar to that of other patients with mood disorders in the bipolar spectrum (namely predominantly with mood regulators), even if they are not mood pathologies classifiable as the others of the bipolar spectrum disorders: we can call them "abnormal mood disorders".

Key words: psychomotor agitation - intellectual disabilities - abnormal mood disorders

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INTRODUCTION

In past time I wrote that the mood in a person who is euthymic is stable, and that in mood disorders the mood "swings" between depression and euphoria/irritability and therefore there is the "unstable mood"; in consequence of this we can understand that the depressive phases of the mood are only "moments of an instable mood" (Tavormina 2013). However, this notion of mood instability does not apply to the frameworks of impulsivity and temperamental irritability of people with intellectual disabilities: these patients (presenting disabilities both for organic cause, e.g. postpartum, and for congenital mental retardation) may often present impulse control disorders, irritability and psychomotor restlessness, busyness and insomnia, from likely non-epileptic neuronal dysfunction. We can call them "abnormal mood disorders".

SUBJECTS AND METHODS

In this observational study I wanted to pay attention to five patients with intellectual disabilities who had behavioural disorders and with irritable mood that I treated in my private practice clinical activity; because of their organic pathology, these patients came to my office always with the presence of their parents, who over time followed the administration of the care prescribed by me and have also acted as communicators with me regarding the state of well-being of their children's mood.

Three of them presented the diagnosis of "mood disorders in patients with congenital mental retardation", the other two persons instead presented the diagnosis of "mood disorders in patients with a history of neonatal hypoxia". The full family history of these patients did not demonstrate any family history for mood

disorders in the bipolar spectrum; moreover, their EEG has never presented pictures related to epileptic disease.

The two patients with neonatal hypoxia, although of different severity, initially had similar symptoms; the other three patients with congenital mental retardation, on the other hand, presented in the initial stages symptoms often different from each other. The symptoms all of them were presenting when I started to assess them were: irritability, impulsivity, aggression, insomnia, interpretative symptoms, ideo-motor restlessness, isolation. The table 1 shows these symptoms in the five patients.

RESULTS

The five patients, after a period of about three months, during which the therapy was repeatedly settled, taking the therapy described in the table presented good clinical recovery, leading to the disappearance of the initial symptomatology. I have been taking care of them for several years until the period of writing this paper (November 2021): throughout this period of treatment, the cyclic checks carried out have served to settle-modify the therapy with small periodic adjustments if exacerbations of old symptoms or transient appearances of new ones had appeared (for example: in one of the patients with congenital mental retardation, a phase of protracted apathy had occurred that made it necessary to use a low-dose antidepressant for a few months); or some change of drug due to the presence of side effects.

The two patients with neonatal hypoxia presented similar symptoms: impulsivity, aggression, insomnia, ideo-motor restlessness, well controlled by a polytherapy with Valproate, Carbamazepine and Gabapentin; one of them, as I wrote, presented a phase of protracted apathy that made it necessary to use a low-dose antidepressant for some months.

Table 1. Summarise of all data described in the study

Pt	Diagnosis	Mood regulators	STOPPED for s.e.	Symptoms	In treatment until November 2021:
1	Mental retardation	Gabapentin, Oxcarbazepine, Loxapine	Valproate, Olanzapine	irritability, impulsivity, insomnia, ideo-motor restlessness	For 5 years and a half
2	Mental retardation	Valproate		insomnia, interpretative symptoms, isolation	For 4 years
3	Mental retardation	Oxcarbazepina	Valproate	impulsivity, insomnia, ideo-motor restlessness	For 2 years and a half
4	Neonatal hypoxia	Gabapentin, Valproate, Carbamazepine		impulsivity, insomnia, ideo-motor restlessness	For 14 years
5	Neonatal hypoxia	Gabapentin, Valproate, Carbamazepine		impulsivity, aggression, insomnia, ideo-motor restlessness	For 13 years and a half

Instead, the other three patients with congenital mental retardation presented different symptoms from each other, that have made it necessary to use different types of mood regulators. The table 1 shows the drugs used in the treatments of these patients.

CONCLUSIONS

The patients with intellectual disabilities presenting mood disorders need to be treated with a therapy similar to that of other patients with mood disorders in the bipolar spectrum (namely predominantly with mood regulators), even if they are not mood pathologies classifiable within the bipolar spectrum of disorders. We can call these clinical pictures “abnormal mood disorders”; their likely non-epileptic neuronal dysfunctions allow them to present a good response to the same mood-regulating drugs used to treat the bipolar mood spectrum.

These so-called “abnormal mood disorders” are not part of the bipolar spectrum disorders, and the notion of the mixity, basic starting point when talking on mixed states and approaching on the bipolarity (Tavormina 2019), is not usable.

Despite the limitations of the present study (few cases in the study) and the related very scarce presence of international literature (Jones et al. 2011), the present work has shown how the use of mood regulators becomes essential in the therapy of patients with intellectual disabilities presenting mood disorders.

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References

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Correspondence:

Giuseppe Tavormina, MD
President of "Psychiatric Studies Center" (Cen.Stu.Psi.)
Piazza Portici, 11 – 25 050 Provaglio d'Iseo (BS), Italy
E-mail: dr.tavormina.g@libero.it