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Psychiatric Treatment Effects on After Traumatic Brain Injury

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Perspective

TBI-related psychiatric sequelae can cause severe and frequently long-term impairment in functioning and quality of life, yet their phenomenological and mechanistic intricacies continue to provide significant therapeutic hurdles. The clinical presentation is frequently a jumble of syndromes and co-occurring symptoms, necessitating a highly nuanced and methodical therapy strategy. Despite the fact that few randomised controlled trials have tested treatments for psychiatric problems after TBI and the synthesis of results remains hampered by the heterogeneity of study populations, small samples and varying inclusion criteria and outcome measures, an increasing body of literature supports evidence-based treatment strategies.

We present a narrative overview of pharmaceutical, psychoeducational/behavioral and neuromodulation therapies for mental problems in adults with TBI, as well as known and speculated mechanisms of action. We focus on randomised controlled trials and large case series where a mental disease serves as both a selection criterion and a primary or secondary outcome, when data is available. We conclude by recommending future research directions, including the need for novel neuropharmacological, behavioural and neurophysiological studies, as well as pragmatic trials of multicomponent and adaptive models, to better understand the mechanisms underlying post-TBI psychiatric disorders and to speed the dissemination and implementation of effective person-centered care. Anhedonia, loss of motivation, diminished self-care, inconsistent sleep and/or appetite pattern, feelings of hopelessness, and/or suicidal thoughts are all indicators of TBI-related depression. These symptoms may endure for a few weeks to months (major depressive episode) or for two or more years in a lesser version (dysthymia).

Because of their low risk of adverse effects, SSRIs are frequently used as first-line treatments. Because of their low drug-drug interaction, sertraline, citalopram and escitalopram are frequently prescribed. Sertraline has been the subject of the majority of clinical research; however the outcomes have been mixed. Sertraline produced a substantial response in 87 percent of 15 individuals with moderate TBI in a study and 67 percent attained remission. In a follow-up analysis of individuals with TBI-related depression, no significant differences in depression severity, response, or remission rates were found between sertraline and placebo. In a cohort of 52 individuals with TBI-related depression, Ashman and colleagues observed no statistically significant difference between sertraline and placebo. The absence of difference between the medicine and placebo groups may have been due to the short sample size (N=11) and high incidence of discontinuations.

The annual incidence varies by country, but it ranges from 108-332 new cases admitted to hospitals per 100,000 people. TBI is becoming more common as a result of growing transportation-related injuries and young males (who are overrepresented in transportation, job and leisure accidents) are particularly vulnerable. The ageing of the population has resulted in the emergence of a new cohort of people—elderly people—who incur TBI through relatively low-impact fall. Blast injuries to the brain are also frequent in civilians and military personnel who are exposed to IEDs and suicide terrorist acts. TBI was shown to be prevalent in 12% of people in a meta-analysis of 15 general population studies involving 25,134 participants. Men were more than twice as likely as women to have had a TBI, suggesting that male gender is a risk factor for TBI.

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