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Treatment Approaches and Clinical Concepts of Disinhibition Social Engagement Disorder

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Short Communication

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DESCRIPTION

Disinhibition is a psychological term for a lack of self-control that shows itself as impulsivity, a disrespect for social norms, and a poor ability to appraise risk. Disinhibition has symptoms and indicators that are similar to the diagnostic criteria for mania and affects motor, instinctive, emotional, cognitive, and perceptual elements. Aggressive outbursts, hyper sexuality, and hyperphagia are signs of unrestrained instinctive urges. Disinhibition is a common sign of brain damage or lesions, especially when the frontal lobe and orbitofrontal cortex are affected. Following a brain injury, neuropsychiatric consequences may include diffuse cognitive impairment, with more obvious deficiencies in attention, memory, cognitive flexibility, and problem-solving speed. Injuries to the frontal, temporal, and limbic areas typically result in prominent impulsivity, affective instability, and disinhibition. These sequelae describe the frequently observed "personality changes" in TBI (Traumatic Brain Injury) patients, along with the standard cognitive deficits [1].

Depending on the damages to certain brain regions, disinhibition syndromes in brain injuries and traumas such as brain tumors, strokes, and epilepsy range from minimally improper social behavior, lack of control over one's behavior, to full-blown mania. Disinhibition disorders have been linked to malfunctioning of the orbitofrontal and basotemporal cortices, which impair visuospatial functions, somatosensation, and spatial memory, as well as motoric, instinctive, affective, and intellectual behaviors [2].

Injury to the orbitofrontal and basotemporal cortex, which includes limbic and frontal connections (orbitofrontal circuit), particularly in the right hemisphere, has been linked to disinhibition syndromes with mania-like features in older adults. Alcohol consumption and the use of drugs that depress the central nervous system, such as benzodiazepines, can harm the frontal lobes and result in behavioral disinhibition because they take away the frontal cortex's capacity to regulate and control behavior. This disinhibition has been linked to a number of morbidities or complications of Attention-Deficit Disorder (ADHD), including conduct disorder, antisocial personality disorder, substance abuse, and risk-taking behaviors. It has also been linked to the hyperactive/impulsive subtype of ADHD, which is characterized by a general lack of behavioral inhibition that extends beyond impulsivity [3,4].

Positive Behavior Support (PBS) is a therapeutic strategy that considers the most effective technique to assist each disabled person. Instead of focusing solely on reducing problem behavior, a behavioral therapist does a functional analysis of behavior to assist identify strategies to improve the person's quality of life. PBS is most frequently used to solve issues in educational settings and is predicated on the idea that people can change [5,6].

This is a simple guide for employees to use as a reminder of important aspects of a person with disabilities' treatment. The two major goals are to respond situationally when the behavior occurs and then take proactive measures to stop it from happening in the future.

Reactive

Redirection: By suggesting a different activity or switching the subject of conversation, you can divert their attention. Give them a choice between two or three options, but don't give them more than three because that can be overwhelming.Make careful to wait after presenting a choice to give the recipient time to consider the options and respond, talking to the person and finding out what the problem is, determining the message that the individual is trying to convey with their behavior, crisis intervention.

Proactive

Change the environment: This can involve expanding opportunities for participation in a variety of activities, balancing mentally and physically taxing activities with downtime, creating a predictable environment to lower cognitive demands on the individual, attempting to establish consistent routines (being aware of events that might not happen, trying not to make promises you can't keep, and saying no if you can't go out at a certain time, for example), checking on the individual frequently, and so on.

Teaching of a skill: Such as how to build general skills, effective communication techniques, or coping mechanisms (e.g. teach the person what to do when feeling angry, anxious)

Individual behavior support plans: These involve encouraging specific desired behavior and ignoring specific undesirable behavior (unless it is dangerous; in that case, the priority is to keep both people safe through a crisis plan, which might involve removing sharp objects or weapons, escaping to a safe place, giving the person time to calm down), as well as techniques to increase engagement in activities.

REFERENCES

1. Hayreh SS.Blood flow in the optic nerve head and factors that may influence it. Prog Retin Eye Res.20: 595-624.
2. Yang JM, et al.Postural effects on intraocular pressure and ocular perfusion in patients with non-arteritic anterior ischaemic optic neuropathy. BMC Ophthalmology.2017;17:2.

3. Lee JY,et al. The effect of lateral decubitus position on intraocular pressure in patients with untreated open-angle glaucoma. Am J Ophthalmol.2013;155:329-335.
4. Hayreh SS.Ischemic optic neuropathy.Prog Retin Eye Res.2009;28:34-62.
5. Vital P.Ocular perfusion pressure in glaucoma.Acta Ophthalmol.2014;92:252-266.
6. Hayreh SS.Inter-individual variation in blood supply of the optic nerve head.Doc Ophthalmol.1985;59:217-246.