

the medicine cabinet: Risperidone...

This column addresses the use of medications in children and adolescents with an intellectual disability. It will attempt to cover the type of information helpful for non-medical people working with these children.

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Risperidone and other atypical antipsychotics

Generic Name: Risperidone
Brand Names: *Risperdal, Ozidal, Resdone, Rispa, Rixadone*

Risperidone is an *atypical antipsychotic* medication. Its primary use is in the treatment of psychotic illnesses such as schizophrenia. It also possesses mood stabilising and relaxant properties, and hence it is used in a variety of other situations, including aggression. Other medications in the atypical antipsychotic medication class include olanzapine (Zyprexa), quetiapine (Seroquel), amisulpride (Solian), aripiprazole (Abilify), ziprazidone (Zeldox), paliperidone (Invega) and clozapine (Clopine, Clozaril). They differ somewhat in the way they work and their side effect profile. They are called *atypical* because they are newer and much different to the original antipsychotics such as haloperidol (Serenace) and chlorpromazine (Largactil), which are nowadays less commonly used.

Risperidone, and to a lesser extent the other antipsychotics may be used in children with intellectual disability for the following reasons:

1) Children with intellectual disability are more likely to have psychotic symptoms (eg. hearing voices or feeling perse-

cuted) than other children. Rates of psychosis are less clearly known in children, but in adults, 3% of those with intellectual disability have a psychotic disorder, compared to 1% in the general population. Rates are likely to be less in children. Risperidone and other antipsychotic agents act directly on the brain to decrease psychotic symptoms.

2) Some children with intellectual disability and autistic disorders have troublesome symptoms such as aggression,

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self-injury, explosiveness, overactivity, irritability and poor sleep. In some cases, the child’s aggression may be related to their temperament or anxiety. In other cases, especially in children with communication problems, aggression can be the means by which they communicate their wants, distress or worries (much like a crying baby). Some syndromes such as the Smith-Magenis syndrome are specifically related to aggression, and this is believed to be related to neurochemical abnormalities in the brain. Risperidone has been thought to manage these symptoms by decreasing the body’s arousal.

Risperidone comes in various forms, including a tablet, quicklet (a tablet that dissolves in the mouth) and liquid. The long-acting injectable form is not often used in this population. The oral forms are usually given once or twice per day, in the

morning and/or at night. The most common side effects of risperidone are weight gain and sedation. Less common side effects include dry tongue, a tremor, restlessness, and in pubertal females, menstrual irregularities. The side effects of the other atypical antipsychotics are similar, with weight gain and sedation being particular problems for some.

The use of atypical antipsychotics to manage aggressive behaviour in children with intellectual disability is a controversial area. Most clinicians would agree that in cases where the aggression is driven by psychotic or bipolar mood symptoms, prescribing these agents is entirely appropriate. In the other cases mentioned, the indication for medication is less clear. Most children with intellectual disability suffer other mental health problems such as ADHD, anxiety, depression and changes of mood which may indicate the use of other medications before considering an atypical antipsychotic.

In all fairness, in many of these children it is very difficult to ascertain what is driving the aggressive behaviour. Often it is a combination of factors. Hence, it is imperative for medical and other professionals looking after children on antipsychotic medications to look for contributors to aggressive behaviours, such as:

- Pain or other medical problems;
- Changes in medication;
- Changes in their environment, such as a change in carer or residence;
- Bullying by peers; or
- Stressors in the home environment.

Hence, use of these medications in these children should be accompanied by use of behavioural interventions and a supportive, nurturing environment. These may include:

- Modifying the environment to help make it feel safer;
- Applying consistent parenting/caring strategies so that the child feels more contained, whilst being encouraged to use more adaptive ways to express distress.

Teachers and other non-medical professionals can assist in the assessment and management of aggressive behaviour by looking out for contributors of aggression or distress, and by being part of the team that implements the behavioural interventions. Regular communication and thoughtful planning involving all agencies is hence imperative to optimally treat aggressive behaviour. The considered use of risperidone or related agents can be a useful adjunct in these cases.

