Pharmacologic Management of Aggression in Adults with Intellectual Disability

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Abstract: Introduction: Aggression is a common behavioral problem seen in patients with intellectual disabilities (ID). The safety and efficacy of second generation antipsychotics (SGAs), mood stabilizers and antidepressants in the management of aggression in these individuals have minimally been studied. This review aims to 1) summarize the studies conducted using second generation antipsychotics, mood stabilizers and antidepressants in treating aggressive behaviors in patient with ID and 2) determine based on the existing literature, which medications have been examined in the most rigorous study design that might suggest the most efficacy for use in clinical practice.

Methods: Literature searches using PUBMED Central, CINAHL Plus, PsychINFO, and Embase databases were conducted using the following terms: intellectual disability/disabilities, mental retardation, developmental disability/disabilities, aggression, agitation, behavior disorder, adult, treatment, management. Studies predominantly including children with ID, and autism/pervasive developmental disabilities spectrum disorders were excluded. Analyses were done by class of medication: SGAs, mood stabilizers and antidepressants. The primary outcome measure was reduction in aggressive or self injurious behaviors as measured by each individual study.

Results: The most rigorous study designs found using these agents were randomized controlled trials (RCT). A total of 10 RCTs were found, the majority being with risperidone (3) and lithium (2). Treatment with risperidone showed reduction in aggression when compared to placebo in most RCTs with the exception of one study in which risperidone was not better than placebo. Both lithium studies showed reduction in aggression when compared to placebo. The most abundant literature exists in retrospective chart reviews. The most commonly studied agent was risperidone which showed reduction in aggression in majority of the studies.

Conclusions: Limited data exists for treatment of aggression in adults with ID. There are very few studies examining pharmacologic agents using RCTs. Given that risperidone and lithium were the most commonly studied agents in the most rigorous experimental design, it is suggested that these two agents prove efficacious for treatment of aggression in patients with ID. Limitations to most of these studies included concomitant psychotropic administration with variations in types and dosing, severity of ID, and the idea that a wide variety of aggression scales were used to assess outcome. Further research with more scientific rigor is required in this field.

Keywords: intellectual disability, mental retardation, treatment.

INTRODUCTION

Aggression is a common behavioral problem seen in individuals with intellectual disability (IDD). Aggression is socially inappropriate physical or verbal behavior that can be directed either towards another individual, object or the self. Aggressive behaviors may be observed within the spectrum of agitation [1]. Aggression is often the primary reason that individuals are admitted or readmitted to institutional settings [2] and appears to be the primary reason why persons with intellectual disabilities are placed on psychotropic or behavioral control medications [3].

Behaviors including property destruction, physical aggression towards others and self injurious behaviors are commonly observed among IDD. This cluster of target symptoms has become defined as “challenging behaviors” [4]. These target symptoms exist in high rates among this patient population. The point prevalence for aggressive behaviors towards others or objects, using the Diagnostic Criteria for Psychiatric Disorders for Use with Adults with Learning Disabilities/ID (Royal College of Psychiatrists 2001), was reported to be 9.8% and 4.9% for self-injurious behaviors [5]. A study conducted in two areas of England determined that such behaviors are shown by 10–15% of people with intellectual disability who are in contact with educational, health or social care services for such individuals. According to Cooper, the most common forms of challenging behaviors reported are aggression (7%), destructive behavior (4%–5%) and self-injury (4%) [5]. The study also revealed that the majority of people identified showed two or more of these four general forms of challenging behavior and approximately two-thirds of the people identified were boys/men. Of those, two-thirds of the people identified were adolescents or young adults. Approximately 50%
of people identified as demonstrating challenging behavior were living with their families and were more likely to need greater levels of assistance in eating, dressing and washing, be incontinent and have more restricted expressive and receptive communication [6].

The cause of aggression in IDD can be difficult to ascertain as often, these individuals have limited communication skills, which results in ambiguity of symptoms and behaviors. This often leads to an unclear diagnosis or even misdiagnosis. A thorough examination of the differential diagnosis of aggression must be assessed, and can be divided into 3 major categories: psychiatric, medical and environmental. In considering the differential diagnosis of the aggression, the severity of ID as well and other medical and psychiatric comorbidities must be considered. Psychiatric causes of aggression include psychosis, anxiety, mood symptoms, frontal lobe dysfunction, as well psychopathology evidenced by personality disorders [7-10]. Medical causes might include fecal impaction, pain, seizure disorder with post-ictal confusion, delirium, and new onset dementia (typically seen in profound mental retardation such as Down’s Syndrome) [11]. Iatrogenic medical sources include disinhibition with benzodiazepines/steroids, drug-induced akathisia, or alcohol/illicit drug intoxication (seen mostly with patients with mild ID) [12-14]. Common causes for aggression in this population may include environmental triggers such as changes in staff in the residence, a new roommate, or interpersonal conflicts. Abuse and neglect are also present in the environmental settings of many of these individuals that might cause aggressive behaviors [15].

Given the complexity of determining the etiology of aggression in this population, it is difficult to treat aggressive behaviors in these individuals who very often require close monitoring and supervision in clinical settings. Though behavioral interventions are often most effective, pharmacologic interventions are required to target the three common core challenging behaviors of property destruction, physical aggression and self injury.

Several reviews have examined the utility of pharmacotherapy focused on treating adults with ID and these behaviors [16-20]. A study in Norway determined that many as 37% of people with administratively defined mental retardation were prescribed psychotropic medication. Antipsychotics were the most widely used, followed by antidepressants and anticonvulsants [21]. It is well documented that first generation antipsychotics have been used to treat acute aggression in this patient population, however clinical evidence supports that patients with ID are more susceptible to developing extrapyramidal side effects, particularly akathisia and tardive dyskinesia [22].

One of the main challenges with treatment of aggressive behaviors in individuals with ID with psychotropics is polypharmacy. It has been extensively documented that individuals with ID are very likely to be prescribed several psychotropics concomitantly [23]. Spreat, Conroy, and Jones calculated that psychotropic drug use in the Oklahoma ID system was 22.4% of all persons with ID [24]. More recent data show similar rates of psychotropic drug use with a shift to second generation antipsychotics and selective serotonin reuptake inhibitors (SSRIs) [25]. Understanding how much scientific rigor is used to experimentally study these agents is important in justifying why and how we use these agents to treat aggression in patients with ID.

Given that antipsychotics, mood stabilizers and antidepressants are the most commonly prescribed medications to treat aggressive behaviors in this population, it is critical to review the studies examining the safety and efficacy of these medications. This paper comprehensively examines the existing literature on use of second generation antipsychotics, mood stabilizers and antidepressants in the management of aggression in patients with ID on a spectrum from most to least rigorous experimental design. This review has two aims: 1) to summarize the studies conducted using second generation antipsychotics, mood stabilizers and antidepressants in treating aggressive behaviors in IDD 2) to determine, based on the existing literature, which medications have been examined in the most rigorous study design that might suggest the most efficacy for use in clinical practice.

METHODS

An English language literature search was conducted through PUBMED Central, CINAHL Plus, PsychINFO, and Embase databases for articles dating from 1980 to 2013. The search was conducted using the following keywords: intellectual disability/disabilities, mental retardation, developmental disability/disabilities, aggression, agitation, behavior disorder, adult, treatment, management.
Inclusion Criteria

All experimental designs were included. Adult subjects with an Axis II diagnosis of any severity of mental retardation or intellectual disability were included. Adult was defined as any individual above the age of 16. Only studies that targeted aggression (any severity of aggression noted) using a second generation antipsychotic, mood stabilizer or antidepressant were included. To identify additional studies, a hand-search of the reference lists of those studies included in other systematic reviews was included.

Exclusion Criteria

Given that many medications for aggression are not approved for use in children, children under the age of 16 were excluded for any study that had more than 50% of subjects under age 16. While overlap of ID with autism spectrum and pervasive developmental disorder occurs, it results in a heterogeneous study of children and adults and these disorders were not the focus of this paper. Therefore, studies with more than 50% subjects carrying a diagnosis of autism spectrum/ pervasive developmental disabilities disorders were excluded from this analysis. Studies targeting symptoms of mood disorders or psychotic disorders were excluded. Any articles for which full text was unavailable were excluded.

The primary outcome measure was reduction in aggressive or self-injurious behaviors as measured by each individual study. A p value <0.05 was considered significant in each study when available.

RESULTS

Results are presented below organized as follows: 1) trial design 2) drug class 3) order of most reported studies to the least reported studies. The most commonly used aggression scales found in the studies are summarized in Appendix 1. In total, 42 studies met the criteria described above and are detailed below.

Randomized Controlled Trials

A total of 10 randomized controlled trials using a double blind placebo controlled design were found using second generation antipsychotics (6), mood stabilizers (3) and antidepressants (1), and are summarized in Table 1.

Second Generation Antipsychotics

Of the 6 randomized double blind placebo controlled trials using second generation antipsychotics, 3 of these compared risperidone to placebo [26-28]. Only Tyrer’s study compared haloperidol to risperidone and placebo, showing that aggressive behavior in subjects given placebo showed no evidence at any time points of worse response than did patients assigned to either of the antipsychotic drugs. These results were not statistically significant (combined p=0.06) [26]. In each arm, the most common severity of ID was moderate. In contrast, two studies showed that risperidone yielded significant reduction in aggression compared to placebo based on ABC, BPI and CGI scores [27, 28]. Though some subjects dropped out due to sedation [28], and subjects were also on existing medications, both studies yielded statistically significant results (P <0.05).

Both risperidone and olanzapine showed reduction in aggression in a single blind study, however risperidone had a higher efficacy index than olanzapine and the results showed a statistically significant reduction towards self injury [29].

Clozapine has only been studied twice in controlled clinical trials, by Hammock. In a single blind study of two subjects, clozapine [30] showed significant reduction in self injurious behaviors and downward trend on 4 ABC subscales when randomized to dosage baseline. One subject had previously been in a double blind placebo controlled crossover trial in which his self injurious behavior was reduced from 148 per hour to 24 per hour at 225 mg of clozapine [31]. Since he had a seizure at 300 mg of clozapine, his dose had been reduced and valproic acid had been added. This combination resulted in lethargy and he was switched to risperidone without success.

Mood Stabilizers

Three studies have been conducted using lithium in a randomized control trial. A total of 2 studies were found comparing lithium to placebo [32, 33]. Craft’s study used the Dale score (1 = well behaved; 2=mood uncertain;3= overt aggression or attempted aggression; 4= additional medication required to control patient; 5=seclusion required) to measure reduction in symptoms but did not define specific target symptoms. Compared to placebo, subjects on lithium showed reduction in scores, P =0.002 [32]. In contrast, Tyrer’s double blind crossover study showed that when lithium
<table>
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<tr>
<th>Author</th>
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<th>Length and Blinding</th>
<th>Dose Range</th>
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<th>Subject Characteristics</th>
<th>Target Behaviors</th>
<th>Reduction in scale scores</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tyrer [23]</td>
<td>Risperidone</td>
<td>Double Blind Placebo Controlled</td>
<td>Risperidone 0.5-2 mg</td>
<td>86</td>
<td>17 males, 9 females IQ&lt; 75</td>
<td>recent challenging behavior and aggression (at least two episodes of aggressive behavior, with total MOAS score of at least 4 in the past 7 days)</td>
<td>MOAS 4 weeks haloperidol 6.5 risperidone 7 placebo 9 23 weeks haloperidol 11 risperidone 10 placebo 8</td>
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<td></td>
<td>Versus Haloperidol versus placebo</td>
<td>4-26 weeks</td>
<td>haloperidol 1.25-5 mg</td>
<td></td>
<td>Distribution of D in drug arms: Fbo: mild: 35%; moderate: 41%; severe: 17%</td>
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<tr>
<td>Gagiano [27]</td>
<td>Risperidone</td>
<td>Double Blind Placebo Controlled</td>
<td>Risperidone 1-4 mg Daily or placebo</td>
<td>39</td>
<td>Age 18-85, Axis I diagnoses: CD, ODD, ASP, DSD, IED, Axis II borderline intellectual functioning, mild or moderate MR IQ range 35-84, excluded those with psychosis</td>
<td>As assessed using ABC, BPI, CGI, VAS</td>
<td>ABC score: 27.3 point reduction (53 % improvement) with risperidone, 14.9 point reduction (31.3 % improvement) with placebo BPI =-0.4, 0.4 reduction in risperidone arm =-0.2, 0.3 placebo arm, P&lt;0.05</td>
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<td></td>
<td>versus placebo</td>
<td>for 4 weeks, then open label for 48 weeks</td>
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<tr>
<td>Vande Borre [28]</td>
<td>Risperidone</td>
<td>Double Blind placebo Controlled Crossover</td>
<td>Risperidone 4-12 mg</td>
<td>37</td>
<td>Age range 15-65 Mean age: 30.5 years (range 15-56) diagnosis of ID</td>
<td>Hostility, aggressiveness, irritability, agitation, hyperactivity, self-mutilation and autism (social withdrawal)</td>
<td>ABC checklist: total score declined 27.5% with risperidone; no effect in the PLO treated pts. CGI: reported a significant treatment effect. P&lt;0.05</td>
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<td></td>
<td></td>
<td>8 weeks</td>
<td>Risperidone 6 mg Olanzapine 20 mg</td>
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<tr>
<td>Amore [29]</td>
<td>Risperidone</td>
<td>Single Blind</td>
<td>Risperidone 6 mg Olanzapine 20 mg</td>
<td>62</td>
<td>Mean age = 48 yrs 45 male and 17 females profound ID: 100%</td>
<td>Verbal aggression, aggression towards others, self and objects OAS, CGI, DOTES</td>
<td>OAS scores 24 weeks: Olanzapine:37 (mean = 1.19 1.14) Risperidone 22 (mean = 0.71 0.90)</td>
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<td></td>
<td>Versus Olanzapine</td>
<td>4-24 weeks</td>
<td>Olanzapine 20 mg</td>
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<td></td>
<td>Mean age = 48 yrs 45 male and 17 females profound ID: 100%</td>
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<tr>
<td>Hammock [30]</td>
<td>Clozapine</td>
<td>Single Blind</td>
<td>Subject 1: 125-203 mg</td>
<td>2</td>
<td>Subject 1: 44 years old, blind, Subject 2: 53 years old nonverbal Both Profound ID</td>
<td>Subject 1: SIB hand to head hitting; aggression, hitting, kicking, biting, head-buttling; stereotypy; face rubbing Subject 2: SIB hand to head biting; hitting other parts of body</td>
<td>Downward trend on all 4 ABC subscales. SIB and PA, decreased frequency with 225 mg of CLZ, FR reduced when Depakote was added to subject 1</td>
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<td></td>
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<td>Subject 1: 29 weeks</td>
<td>Subject 2: 100-403 mg</td>
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<td>Subject 2: 36 weeks</td>
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(Table 1). Continued.

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<tr>
<th>Author</th>
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<th>Subject Characteristics</th>
<th>Target Behaviors</th>
<th>Reduction in scale scores</th>
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<tbody>
<tr>
<td>Hammock [31]</td>
<td>Clozapine</td>
<td>Double Blind Placebo controlled 93 week</td>
<td>1-6 mg/day</td>
<td>1</td>
<td>40 year old male profound ID, blind and ambulatory</td>
<td>Chronic self injurious behavior</td>
<td>SIB and PA, decreased frequency with 225 mg of CLZ</td>
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<tr>
<td>Craft [32]</td>
<td>Lithium versus Placebo</td>
<td>Double Blind Placebo Controlled 16 weeks</td>
<td>Lithium 800mg starting dose, adjusted to therapeutic level of 0.7mmol/L</td>
<td>42</td>
<td>Median age 32.5 placebo arm, 22 lithium arm 69% male, 31% female severe MR: 91%, mild MR: 9.5%</td>
<td>Aggressive behaviors, self mutilation</td>
<td>Date Score: lithium: 73% showed scores of 3 or less, 9% showed scores above 3, 18% showed no changes, placebo: 39% showed some reduction in level of aggression during trial as run-in period where 50% no change</td>
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<tr>
<td>Tyrer [33]</td>
<td>Lithium as add on to neuroleptic</td>
<td>Double Blind Crossover 20 weeks</td>
<td>Started 500 mg (titrated to therapeutic range of 0.5-0.8 mmol/L)</td>
<td>25</td>
<td>Age range 14-15 years (mean 27)</td>
<td>Non-physical aggression, destructiveness, rhythmic movement, self assault, physical aggression</td>
<td>58% showed improvement in lithium group as compared to placebo. 5/6 items on Behavioral Scale improved stereotypical movement showing most improvement hyperactivity showing no difference between lithium and placebo</td>
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<tr>
<td>Reid [34]</td>
<td>Carbamezapine</td>
<td>Double Blind placebo Controlled Crossover 32 weeks</td>
<td>Dosed to target level range from 25-42 μmol/L</td>
<td>12</td>
<td>Age range 14-50 Profound ID: 50%; Severe ID: 25% 42% with epilepsy</td>
<td>Overactivity</td>
<td>40% showed improvement in Carbamezapine group based on Nurses behavior rating. more noted in the patients who had elevated mood with overactivity</td>
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<tr>
<td>Lewis [35]</td>
<td>Clomipramine</td>
<td>Double Blind Placebo Controlled Crossover 19 weeks</td>
<td>Max dose of 3 mg/kg body weight</td>
<td>8</td>
<td>Ages 21-39 3 females, 5 males Profound ID: 75% Severe ID: 25%</td>
<td>SIB intensity, frequency of stereotypic movements, compulsion</td>
<td>6-8 subjects showed 50% reduction in repetitive and compulsive behavior</td>
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Pbo= placebo  MOAS=modified overt aggression scale  CD = conduct disorder  ODD= oppositional defiant disorder  ASP=Asperger’s disorder  DBD= disruptitive behavior disorder IED = intermittent explosive disorder  ABC =aberrant behavior checklist  BPI = behavior problem inventory  CGI = clinical global impression scale  COTES= Dosage Record and Treatment Emergent Symptom Scale  OAS= overt aggression scale  VAS= visual analog scale  CLZ = clozapine  SIB = self-injurious behavior.
was added on to a first generation antipsychotic, 58% of subjects had reduction in symptoms of destructiveness, self assault, rhythmic movements and physical aggression, as compared to placebo based on the behavior symptom checklist (p<0.05) [33]. Factors associated with good response to lithium were 1) less than one aggressive episode per week prior to treatment, overactivity, stereotypic behavior, female sex and epilepsy. In both lithium studies, no patients became toxic and the side effects did not necessitate discontinuation or a reduction in lithium.

Carbamazepine in a double blind placebo controlled crossover study showed 40% improvement in overactivity. It was noted that patient’s whose overactivity improved also had elevated mood prior to treatment (p<0.05) [34]. Three patients were on additional psychotropic medications. There was no relationship between response to carbamazepine and the presence or absence of epilepsy [34].

**Antidepressants**

Clomipramine was the only antidepressant studied in a randomized placebo controlled crossover design. This study targeted self-injurious behaviors in subjects with profound and severe ID and did not target aggressive behaviors towards others or property. The design involved a titration up phase, maintenance and titration down. Between 6-8 subjects showed 50% reduction in aggressive behaviors but no significant differences were found between treatment and placebo groups [35].

**Open Label Prospective Studies**

10 prospective studies were found using second generation antipsychotics (5), mood stabilizers (1) and antidepressants (4), and the findings are summarized in Table 2.

**Second Generation Antipsychotics**

The most studied medication was risperidone, with 5 prospective studies examining its efficacy in reduction of aggressive symptoms [36-40]. All subjects in these studies had ranges of ID from moderate to severe with the exception of the Durst study where IQs were not provided. All studies showed a reduction in symptoms of aggression with risperidone. There was one study in which subjects were nonverbal [36]. One study included subjects with Prader-Willi Syndrome, and the subject with the most reduction in aggression was also on androgen therapy and eltroxin prior to risperidone treatment [37]. Risperidone caused side effects of sedation, weight gain, akathisia and pseudoparkinsonim in some subjects [38], and reduction in tardive dyskinesia in other subjects [39]. Risperidone augmenting or replacing a first generation antipsychotic showed no change in aggression but improvements in side effects [40].

**Mood Stabilizers**

One open label prospective study showed subjects with aggression improve with valproic acid as an add to their current medication regimen [41]. The most common psychiatric diagnosis was mood disorder and eight patients had epilepsy or history of epilepsy.

**Antidepressants**

Three antidepressants, Fluoxetine [42, 43] and Paroxetine [44], Fluvoxamine [45] were studied in an open label prospective design. Bodfish et al. targeted compulsive behaviors of self injury. 44% of subjects responded to fluoxetine with reduction in suicidal ideation and aggression based on a facility-wide behavior management intervention monitoring system. Of note, 94% were receiving first generation antipsychotics throughout the course of their treatment [42]. Troisi reported aggression worsening in 47% of patients on fluoxetine [43].

Paroxetine in an open label prospective study showed that 62% of subjects responded on aggression severity and 42% on aggression frequency [44]. Based on individualized behavior logs, the largest change from baseline was in aggression frequency. Eight of these patients remained on their primary medications in this trial. Fluvoxamine did not show a significant reduction from placebo, and side effects were not significantly different [45].

**Open Label Retrospective Studies**

13 studies were found using an open label retrospective design using second generation antipsychotics (6), mood stabilizers (5) and antidepressants (2), the findings are summarized in Table 3.

**Second Generation Antipsychotics**

The most commonly studied second generation antipsychotic was risperidone and in retrospective studies also showed a reduction in aggression. Risperidone had a particular therapeutic window in doses of 6-8 mg a day. In this particular study, 88% of subjects were on other psychotropics [46]. Reudrich showed that risperidone, compared to olanzapine and
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<th>Target Behaviors</th>
<th>Reduction in scale scores</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cohen [36]</td>
<td>Risperidone</td>
<td>3 weeks</td>
<td>Not reported</td>
<td>8</td>
<td>Male: 75%, female: 25% severe and profound ID (% not provided) “probable diagnosis” on Axis I made based on patients verbal abilities</td>
<td>self injury, assault, property destruction</td>
<td>compared each pt before, then after tx; “Positive response” of improvement in self-injury and assault in 75% of patients; 2 non responders (previously treated with clozapine)</td>
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<tr>
<td>Durst [37]</td>
<td>Risperidone</td>
<td>37 week follow up period</td>
<td>1-3 mg daily</td>
<td>7</td>
<td>male: 29%, female: 71% Patients all had Prader Willi Syndrome, IQ was not provided</td>
<td>verbal aggression and physical aggression against objects, self or others</td>
<td>Reduction in ROAS and AS (weighted) in all subjects, largest change in a aggression score for a subject was 15 at baseline, and 3 at 32 weeks</td>
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<tr>
<td>Lott [38]</td>
<td>Risperidone</td>
<td>6 months</td>
<td>1-8 mg/day</td>
<td>33</td>
<td>Ages 25-66, male: 70% female: 30% 82% severe to profound ID,</td>
<td>aggression, assault, self-injury</td>
<td>±50% reduction in at least one target behavior frequency in 61%; 85% of patients rated “improved” and 15% were rated “unchanged,” 53% reduction in PA, 46% in SIB; 42% in property destruction. decreased aggression (staff work days lost); 444 during the 6 months before initiation of risperidone to 29 during the 6 months after initiation</td>
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<td>Khan [39]</td>
<td>Risperidone</td>
<td>1 year</td>
<td>3-8 mg</td>
<td>13</td>
<td>Ages 28-62, male: 23%, female: 77% moderate to profound ID (% not given) Axis I diagnoses included psychotic disorder NOS (5 patients), schizophrenia (3), dementia (2), bipolar type I disorder</td>
<td>biting, kicking hitting, spitting, grabbing, throwing food, self injurious behavior, eating tree leaves and cigarettes</td>
<td>Behavior of all 13 patients sharply improved compared to before tx within 2-3 months based on Target maladaptive behaviors according to staff report</td>
</tr>
<tr>
<td>Simon [40]</td>
<td>Risperidone</td>
<td>Variable</td>
<td>4-6 mg/day</td>
<td>10</td>
<td>Ages 22-67, male: 60%, female: 40%, mild ID: 30% moderate ID: 60%, severe ID: 10% 6 with psychosis, 1 with personality change, one with IED</td>
<td>aggression</td>
<td>6/10 completed study; worsening behavior</td>
</tr>
<tr>
<td>Author</td>
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<td>Length</td>
<td>Dose Range</td>
<td>N</td>
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<tr>
<td>Verhoeven [41]</td>
<td>Valproate add on</td>
<td>6–12 months</td>
<td>Mean dose 1345 mg</td>
<td>28</td>
<td>Ages 18–66, male: 64%, female: 36% mild to severe ID, previous psychiatric diagnosis of mood disorder, psychotic disorder, autism, panic disorder 28% of patients had epilepsy,</td>
<td>SIB, aggression, hyperactivity, Disorganized behavior, stereotypes, impulsivity</td>
<td>68% showed some degree of improvement 32% minimally improved or remained unchanged based of VAS and CGI score</td>
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<tr>
<td>Bodfish [42]</td>
<td>Fluoxetine</td>
<td>4 month</td>
<td>40-80 mg</td>
<td>16</td>
<td>Ages 21–43, male: 31%, female: 69%, mild ID: 6%, moderate: 6% profound or severe ID: 70% 10 with Diagnosis of compulsive behavior disorder</td>
<td>self injury, aggression</td>
<td>44% responded to fluoxetine with reduction in SI and aggression based on a facility-wide behavior management intervention monitoring system</td>
</tr>
<tr>
<td>Troisi [43]</td>
<td>Fluoxetine</td>
<td>8 weeks</td>
<td>20 mg daily</td>
<td>19</td>
<td>Ages 20–47 with moderate and severe ID</td>
<td>aggressive behavior</td>
<td>Marked changes in aggression over all phases of the trial</td>
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<tr>
<td>Davanzo [44]</td>
<td>Paroxetine</td>
<td>16 week follow up period</td>
<td>10-20 mg</td>
<td>15</td>
<td>Ages 32-56, 66% female, 33% male Profound ID: 80%, severe ID: 20%</td>
<td>biting, kicking hitting, scratching, throwing objects, pinching, pulling other’s hair (aggression) or self injurious behavior (head banging, biting self, choking self, hitting self, pulling own hair)</td>
<td>Largest change from baseline was in aggression frequency (5.068) with paroxetine based on individualized behavior logs</td>
</tr>
<tr>
<td>La Malfa [45]</td>
<td>Fluvoxamine</td>
<td>3 weeks</td>
<td>Mean dose 250 mg range 200 to 300 mg</td>
<td>60</td>
<td>mean age: 30.6 Men: 29 (48%), Women: 31 (51%). mild ID: 40 (67%); moderate ID: 20 (33%) 55 patients (92%) lived in an institution, 5 (8%) lived with their family.</td>
<td>as defined in the HBSS scale</td>
<td>The mean±SD HBSS score at the end of the week without medication was not significantly different from the score at the end of the placebo period (20.9±1.8 and 20.2±1.6, respectively)</td>
</tr>
</tbody>
</table>

ROAS = retrospective overt aggression scale  AS= aggression score  HBSS= Handicaps, Behavior, and Skills Schedule  DOTES= Dosage Record and Treatment Emergent Symptom Scale  SIB = self injurious behavior  VAS = visual analog scale  CGI = clinical global impression.
<table>
<thead>
<tr>
<th>Author(s)</th>
<th>Medication</th>
<th>Length</th>
<th>Dose Range</th>
<th>N</th>
<th>Subject Characteristics</th>
<th>Target Behaviors</th>
<th>Reduction in scale scores</th>
</tr>
</thead>
<tbody>
<tr>
<td>Natarajan</td>
<td>Risperidone</td>
<td>3 months</td>
<td>Range 2-12 mg/day</td>
<td>17</td>
<td>Male: 59%, female: 41% mild learning disability: 18% Moderate ID: 6% severe ID: 29%</td>
<td>Wandering, destructiveness, noisiness, temper tantrums, aggressive behavior,</td>
<td>Improvement in 12/17 patients in varying degrees; only at doses 6-8mg daily with worse outcomes &lt;5mg or &gt;8mg/day; 2 of 5 non-responders had no psychiatric disorder besides learning disability</td>
</tr>
<tr>
<td>Reudrich</td>
<td>risperidone</td>
<td>12 months</td>
<td>Not reported for each atypical antipsychotic</td>
<td>31</td>
<td>Ages 24-54 Male: 55%, female: 45% moderate ID: 13% severe ID: 29% profound ID: 58%</td>
<td>Aggression and self injurious behavior</td>
<td>Reduction in aggression target behavior from 32.9 to 27.0 was statistically significant</td>
</tr>
<tr>
<td>Cohen</td>
<td>Ziprasidone</td>
<td>24 weeks</td>
<td>Mean max dose 145 mg</td>
<td>45</td>
<td>Male: 84%, female: 16%</td>
<td>As listed on the MBS</td>
<td>MBS Score: 48% of 25 patients scores improved; 24% remained the same; 28% worsened MBS: 2.7 point reduction in patients with low to moderate frequency MBS: 1.3 point increase in patients with high frequency of maladaptive behaviors.</td>
</tr>
<tr>
<td>Buzan</td>
<td>Clozapine</td>
<td>0.5-46 months</td>
<td>50-700 mg/day</td>
<td>10</td>
<td>Ages 20-63 Male: 70%, female: 30% Mild ID: 20%, Severe ID: 10%, profound ID: 20%</td>
<td>Not reported</td>
<td>CGI decreased significantly from mean of 6.4 to 2.6 (p&lt;0.0001) GAF increased from an initial of 17 to 68 (p&lt;0.0001) BPRS decreased significantly from a mean of 66 to 39 (p=0.0069)</td>
</tr>
<tr>
<td>Thalayasingam</td>
<td>Clozapine</td>
<td>4 months</td>
<td>Mean max dose 485 mg/day, range 300-800 mg/day</td>
<td>24</td>
<td>borderline ID: 8% mild ID: 71%, moderate ID: 5%, severe or profound ID: 0% Comorbid: substance abuse: 33%; personality disorder: 13%; PDD: 8%; history of arson, sexually aggressive behavior</td>
<td>Physical aggression against self, violence directed at others, violence towards property and verbal violence</td>
<td>CGI: minimal improvement: 21%, much improved: 42% very much improved: 29% no change: 8%</td>
</tr>
<tr>
<td>Janowsky</td>
<td>Olanzapine</td>
<td>5 years</td>
<td>2.5-22.5 mg/day, mean dose 0.1 mg/day</td>
<td>20</td>
<td>Ages 18-55 mean age: 42.7 borderline ID: 0.07% Severe or profound MR (by degree of subnormality): 93%</td>
<td>Aggression, self injurious behaviors, destructive/disruptive property</td>
<td>Mean Scores on Global Behavior Rating: 6 months before 3.23 +/- 0.91, immediately before 3.54 +/- 1.38, 6 months after 2.49 +/- 0.70, study end 2.28 +/- 0.72.</td>
</tr>
<tr>
<td>Reudrich</td>
<td>Valproic Acid</td>
<td>2-73 months</td>
<td>500-4000 mg /day</td>
<td>28</td>
<td>Ages 20-63 Male: 54%, female: 46% mild ID: 14%, severe ID: 25%, profound ID: 36% PDD: 32%; organic mood disorder: 50%, psychotic disorder: 21%</td>
<td>Aggressiveness, temper tantrums, SIB, rituals, sexually inappropriate behavior, insomnia, anxiety</td>
<td>Monthly behavior counts: improved: 71% mildly improved: 21%; 1: worsened; 1: unchanged; 88% showed a significant reduction in aggression</td>
</tr>
<tr>
<td>Author(s)</td>
<td>Medication</td>
<td>Length</td>
<td>Dose Range</td>
<td>N</td>
<td>Subject Characteristics</td>
<td>Target Behaviors</td>
<td>Reduction in scale scores</td>
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<td>------------------------------------------------------------------------------------------</td>
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</tbody>
</table>
| Janowsky [53] | Topiramate | 5 years | mean dose 202 mg/d, range 150–350 mg/d | 22 | Age 25–70, mean age: 46.5  
male: 36%, females: 64% | hitting, biting, kicking, shoving, etc, self-injurious behaviors (i.e., self-hitting, self-biting, self-head banging, cutting on one’s skin, skin picking, skin scratching) destructive/disruptive behaviors (i.e., overturning or breaking furniture, screaming, yelling, uncontrollable running, tantrums, inappropriate stripping) | 78% improved based on cumulative frequency recordings, and global severity ratings;  
1 remained unchanged  
4 got worse |
| Dale [54]  | Lithium | 2 years | 0.4–1.2 mmol/l | 15 | Male: 73%, female: 27%  
borderline subnormal: 7%, severely subnormal: 93% | Aggression based on the subjects’ individualized scale. | All cases showed a significant change in the percentage of zero scores between period without lithium as compared to with lithium |
| Spreadsheet [55] | Lithium | 6 years | 600 mg/d to 1500 mg/d, with a mean daily dose of 1142 mg | 38 | 24 men and 14 women  
mild ID: 13%, moderate ID: 8%, severe ID: 47%, profound ID: 29% | socialization  
hyperactive tendencies  
violent and destructive behavior  
psychological disturbances. | 63% evidenced a greater than 30% reduction in the frequency of aggressiveness subsequent to the start of lithium therapy based on AGS. |
| Langon [56] | Lithium: add-on | 10 years | dose adjusted to achieve 0.7–1.2 mmol/L plasma levels | 74 | Severe to profound ID | Aggression, SIB, hyperactivity | Behavior Disturbance Index: improved: 40%, of whom 77% required additional medication |
| Janowsky [57] | Paroxetine, fluvoxamine, sertraline, fluoxetine, citalopram, domperidone | 6 years | Individual for each medication | 38 | Ages 18-74  
Mean age: 45  
Male: 53%, female: 47%  
74% with profound cognitive disability  
Diagnoses of Bipolar Affective Disorder, Major Depressive Disorder, Mood Disorder NOS, Autism, Schizophrenia, Behavioral Disorder NOS, and Conduct Disorder. | aggression towards others (hitting, biting, kicking, shoving, making aggressive threats), SIB (Self-hitting, biting, head banging, cutting on one’s skin, skin picking, skin scratching)  
destructive behaviors (overturning or breaking furniture, breaking windows)  
disruptive behaviors (screaming, yelling, uncontrollable running, tantrums, inappropriate stripping), other behaviors (masturbation, rectal digging, crying, whining, agitation, non-participation, non-compliance) | 18 out of 38 (47.4%) showed 25% decrease in global behavioral ratings (mean decrease = 24.8%) six of this group showed decreases of 50% or more. |
| Branford [58] | Fluoxetine or Paroxetine | 5 years | 68% received fluoxetine max 80 mg/day  
32% paroxetine (max 40 mg/day) | 33 | Mean age of 39  
Males: 67%, females: 33% | Aggression, destruction of property, self injury | Based on CGI:  
Very much improved: fluoxetine: 4% no benefit  
fluoxetine: 44%, paroxetine 34% |

MBS = maladaptive behavior scale  
GAF = global assessment of functioning  
SIB = self-injurious behavior  
PDD = pervasive developmental disorder  
CGI = clinical global impression.
quetiapine showed 74% more reduction in aggression when added to pre-existing psychotropics [47]. Ziprasidone showed that 48% of symptoms improved along with reduced adverse effects. Significant weight loss and reduction in total cholesterol and triglycerides was noted in the subjects receiving ziprasidone [48].

Clozapine showed reductions in CGI, GAF and BPRS in Buzan’s study; however 70% were on mood stabilizers concurrently [49]. All subjects had psychiatric diagnoses of psychosis or mania. Half the subjects experienced sedation and hypersalivation, but these symptoms were dose dependent, transient, and not sufficient to terminate treatment. Another clozapine study showed improvement in aggression with clozapine use, and no significant side effects were noted in 42% of patients [50]. Olanzapine added on to a first generation antipsychotic, mood stabilizer or antidepressant showed improvement though subjects who were on olanzapine for more than 6 months experienced weight gain [51].

**Mood Stabilizers**

The search yielded 5 studies of mood stabilizers (lithium, valproic acid and topiramate) in an open label retrospective design. All showed a reduction in aggressive behaviors. In studies examining valproic acid [52] and topiramate [53], subjects were on other concurrent psychotropics medications (including lithium/anticonvulsants). Three studies on Lithium were found [54-56]. Dale’s retrospective review on lithium showed reduction in certain behaviors in 73% of subjects; individualized rating scales were devised for 6 subjects showing reduction (p<0.05) within 9 weeks of treatment. One subject developed tardive dyskinesia which was the cause for discontinuation of the lithium, but otherwise no other side effects were reported [54]. Subjects in Spreat’s lithium study had a mean daily dose of 1142 mg/day and it was reported those with higher serum lithium levels had a more favorable response to the medication [55]. Langee showed a reduction in aggression, however the majority of subjects required additional medications [56].

**Antidepressants**

One retrospective chart review [57] examined 5 SSRIs (paroxetine, fluvoxamine, sertraline, fluoxetine, citalopram) and the tricyclic antidepressant clomipramine. Use of these serotonergic agents resulted in improvement in various ratings. Three months after initiation of the antidepressant, many of the SSRI doses were not maximized. These subjects were on other psychotropics including antipsychotics, mood stabilizers or beta blockers. Conversely, in Branford’s study, fluoxetine and paroxetine showed overall no change in aggressive behavior and 25% of subjects got worse with treatment [58].

**Case Series and Case Reports**

A total of 8 case reports and case series were found using second generation antipsychotics (2), mood stabilizers (3), and antidepressants (3), the findings are summarized in Table 4.

**Second Generation Antipsychotics**

Two case reports were found examining second generation antipsychotics. Brahm reports risperidone use in a 36 year old man with a history of fecal smearing as a means of nonverbal aggression [59]. The number of episodes of fecal smearing decreased post risperidone treatment. The subject was also on valproic acid, trazodone and naltrexone. Kamal reports on a 32 year old man with moderate ID whose aggressive behaviors of property destruction, self injurious and aggressive behaviors improved with 350 mg of clozapine [60]. It was noted that the reduction of his aggressive behaviors occurred concurrent with the reduction in his psychotic symptoms [60].

**Mood Stabilizers**

Two case series have been conducted for Lithium, both reporting on inpatient subjects who had failed trials of psychotropics [62], (Goetzl, Sovner). These subjects were all hospitalized due to dangerous behaviors including fighting with peers, elopement from home, school and aggression. In all cases, lithium showed improvement in aggressive behaviors. Side effects of nausea, diarrhea and tardive dyskinesia and bed wetting (one subject) were reported but did not necessitate the discontinuation of treatment. Mattes studied valproate in 2 individuals with mild ID, whose outburst behaviors improved after treatment at doses of 250 mg TID [63]. Both subjects were concurrently on neuroleptics and one additionally on lithium. Though the valproate levels were subtherapeutic at 250 mg TID, increasing the dose to 1000 mg showed no improvement in behaviors for one patient.

**Antidepressants**

One case series reported on subjects in whom self injury and aggression improved either with sertraline or clomipramine. Luiselli reported sertraline at doses of 250 mg/day resulted in improvement in aggression in one subject [64]. Trazodone was studied in two
### Table 4: Case Series and Case Report Studies

<table>
<thead>
<tr>
<th>Author(s)</th>
<th>Medication</th>
<th>Length</th>
<th>Dose Range</th>
<th>N</th>
<th>Subject Characteristics</th>
<th>Target Behaviors</th>
<th>Findings</th>
</tr>
</thead>
<tbody>
<tr>
<td>Brahimi [69]</td>
<td>Risperidone</td>
<td>1 year</td>
<td>4 mg/day</td>
<td>1</td>
<td>36-year-old Caucasian man with history of fecal smearing when he did not get his way or was upset. Profound mental retardation; also on Valproate, ziprasidone and mirtazapine</td>
<td>Fecal smearing</td>
<td>The mean number of episodes of fecal smearing per month decreased from 5.2 ± 3.0 pretreatment to 6.0 ± 1.8 at 6 months and 6.7 ± 1.2 at 12 months. Mean episodes per month in 3 and 12 months after risperidone initiation were significantly fewer than for 6 months pretreatment (analysis of variance with Tukey's post hoc analysis, p &lt; 0.05). A significant increase in fecal smearing rates occurred, precipitated by an extended absence of patient's preferred staff person.</td>
</tr>
<tr>
<td>Kamal [60]</td>
<td>Clozapine</td>
<td>1 year</td>
<td>350 mg/day</td>
<td>1</td>
<td>32 year old man</td>
<td>Aggressive and self-injurious</td>
<td>Improvement in global impression</td>
</tr>
<tr>
<td>Goetzl [61]</td>
<td>Lithium</td>
<td>Total time not reported at least 7 months</td>
<td>1200-1800 mg with range of 0.7-1.4 mg/liter</td>
<td>3</td>
<td>MILD to moderate ID</td>
<td>Aggressive, disruptive behaviors</td>
<td>Improvement in aggressive behavior with lithium, improvement in aggressive behavior with lithium, TD: aggressive behavior abated with lithium</td>
</tr>
<tr>
<td>Sovner [62]</td>
<td>Lithium</td>
<td>Level of 1.0-1.3 mg/liter</td>
<td>26 year old woman with severe MR (previous trials of neuroleptics, TCA and lithium)</td>
<td>2</td>
<td>Assautivie behavior and hyperactivity</td>
<td>Behavior improve den level of 1.35</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>26 year old woman with severe MR and seizure diso, previous trials of phenothiazine, benzodiazepines, sedatives and ECT.</td>
<td></td>
<td></td>
<td>Hyperactivity, sleeplessness and self-abuse</td>
<td>Behavior improved on level of 1.3</td>
<td></td>
</tr>
<tr>
<td>Mettes [63]</td>
<td>Valproate</td>
<td>6 months</td>
<td>750 mg/day</td>
<td>2</td>
<td>55 year old female with mid ID</td>
<td>Assaultiveness, dysphoria, anger, pica and rectal digging</td>
<td>Outbursts decreased from 8.5 to 2.8 per month</td>
</tr>
<tr>
<td></td>
<td></td>
<td>34 year old woman with profound ID</td>
<td></td>
<td></td>
<td></td>
<td>Outbursts decreased from 8.3 to 4.5 per month</td>
<td></td>
</tr>
<tr>
<td>Luiselli [64]</td>
<td>Sertaline</td>
<td>6 months</td>
<td>Up to 250 mg/day</td>
<td>2</td>
<td>20-year-old male who had been diagnosed as having severe mental retardation and a seizure disorder, nonverbal</td>
<td>Self-injury: (a) striking his head with fist of either hand, (b) striking his head with an object that was held in either hand, and (c) striking his head or face with the open palm of either hand; manipulation of clothing, aggression, and food refusal</td>
<td>SIT scale decreased by 17% with increased occurrences encountered when a higher dosage level (150 to 250 mg/ day) was prescribed.</td>
</tr>
<tr>
<td>Geyde [65]</td>
<td>Trazodone</td>
<td>2 weeks to again after trial 4 months</td>
<td>100 mg/day then 200 mg/day</td>
<td>1</td>
<td>58-year-old severe ID, with tissomy 21 Down's Syndrome developing signs of an Alzheimer's type dementia</td>
<td>Head slapping, head banging, hitting others, hitting walls/doors, kicking, throwing objects, and pushing over furniture.</td>
<td>Aggression decreased by 96%</td>
</tr>
<tr>
<td>O’ Neil [66]</td>
<td>Trazodone</td>
<td>3 weeks</td>
<td>200 mg/day (1-2 g/day)</td>
<td>1</td>
<td>22-year-old man with Cornelia de Lange syndrome, ID</td>
<td>Disrupted sleep and intense aggressive behavior directed towards himself and others.</td>
<td>2 weeks of trazodone and SHT showed a 4 fold reduction in target behavior</td>
</tr>
</tbody>
</table>

SIT = self-injurious trauma scale.
subjects [65, 66]. In both subjects trazodone was associated with a reduction in aggressive behaviors. Geyde used an on again off again trial design [65]. In O’Neil’s study, trazodone was used in conjunction with 5HT and the subject was being cross titrated from imipramine [66].

**DISCUSSION**

This review examined the various study designs of three drug classes (second generation antipsychotics, mood stabilizers and antidepressants) used to treat aggression in patients with ID. The aim was to determine based on the most rigorous study design which medications would suggest the best evidence for efficacy. This patient population is very difficult to examine in a literature review as it is a population that is heterogeneous and for whom the diagnostic nomenclature has been in flux. Given the comorbidity of Axis I with ID diagnoses, it was imperative to attempt to homogenize the subjects in the studies, therefore, studies predominantly including autism spectrum/pervasive developmental disorders and children with ID were excluded.

There are only 10 randomized controlled trials using these agents: second generation antipsychotics, mood stabilizers and antidepressants. There were two-arm studies comparing risperidone, clozapine, lithium, carbamezapine and clomipramine to placebo. Only 2 studies had more than 50 subjects: Amore (n=62) [29] and Tyrer (n=86) [26]. All but two of the 10 trials yielded statistically significant results [26, 35]. Risperidone and lithium were the two most studied agents and showed reduction in aggression showing the most statistically significant results. Given that these two agents were the most commonly studied in the most rigorous experimental design, it is suggested that risperidone and lithium prove efficacious for treatment of aggression in patients with ID.

There exists abundant data in either prospective or retrospective studies examining reduction of aggression in this patient population. Based on the existing literature, retrospective studies, consisting of mostly chart reviews, are most often reported; these studies do not reflect the rigor of experimental design seen in randomized controlled trials and lack a comparator arm. Several of these studies had no consistent longitudinal tracking of target behaviors using scales validated for aggression in ID, and there was no homogeneity of aggression scales used. As such, target behaviors might have varied from study to study and were often subjective reports from staff. Comparisons between studies could not be made as some focused on profound and severe ID whereas other studies focused on mild and moderate ID. Many studies targeted patients with severe and profound ID who had known communication limitations but were still diagnosed with axis I disorders on the psychotic or affective spectrum.

As very few randomized trials exist, it would be postulated that more case reports and case series would exist in the literature describing improvement in aggression with any of these agents, yet only a total of eight were found meeting the search criteria. This is likely due to the fact that a disproportionately larger number of reports have been written in children with ID or adults with autism spectrum/pervasive developmental disability.

There were several limitations to this review. All categories of experimental designs revealed that subjects received other medications (particularly as add-on to antipsychotics) with variations in types and dosing, resulting in a confounding bias. Several studies included subjects with epileptic disorders which may (in pre, post or ictal states) contributed to the aggressive and agitated behaviors seen in the sample size with improvement on certain agents that would treat both seizures and aggressive behavior. Relatively small sample sizes throughout classes of experimental designs suggest limited power. In several studies, not all agents used were maximized to therapeutic doses, which may have impacted the outcome on the aggression scales.

Given the limitation of communication skills in ID patients, it is difficult to determine patient reports of side effects from medications, potentially affecting compliance with treatment and dropout rates. Limited communication also leads to problems with informed consent. It was notable that only a few studies (e.g. Troisi [43]) made mention of a legal guardian signing for the patient. Given the complexity of assessing target symptoms in ID patients due to their limited communication skills, subjective rating scales make it difficult to assess for symptom reduction. Moreover, there was no homogeneity in aggression scales used across studies, and many of these scales used have not been validated for use in aggression with ID patients.

There remain several unanswered questions. Based on the data, comparing treatment response by gender
cannot be determined. Results appear to be study specific and no conclusions can be drawn as to who would respond better to pharmacologic treatments. It might be postulated that elderly patients are more susceptible to side effects of medications, and that the cause of agitation in the elderly might often more be related to medical sources rather than psychiatric or environmental cause, though this was not particularly addressed in any study with the given age ranges. Additional studies that focus on particular populations would help to answer some of these questions.

It is well known that behavioral and environmental interventions are effective for challenging behaviors in the ID population. As Antonaccll describes, behavioral interventions have been well studied with severe ID, however the challenges lie in implementing these interventions. He confirms environmental change and positive reinforcements are more effective than aversive consequences and punishment [67].

Given the prevalence of aggression in subjects with ID, it may not be realistic to expect to recruit larger sample sizes for future studies. Allowing for more objective and universal measures might encourage meta-analyses for stronger evidenced based recommendations.

CONCLUSION

This review confirms that pharmacological management of aggression in patients with ID is very much an area that is understudied. In a search of two decades of literature, there still exists a paucity of randomized controlled trials studying the most common agents used to treat this patient population. In the existing literature the two most studied agents in a randomized controlled experimental design are risperidone and lithium which suggests that these two agents may have efficacy for use in management of aggression in patients with ID. Additional research and a more standardized objective means of measurement are required to better serve this patient population.

DISCLOSURES

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REFERENCES


Cohen S, Fitzgerald B, Okos A, et al. Weight, lipids, glucose, and behavioral measures with ziprasidone treatment in a...


