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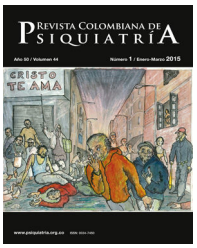

Letter to the Editor

Psychopharmacology of Intellectual Disability—Defamed, Debased or Debated?

Psicofarmacología de la Discapacidad Intelectual: ¿Difamada, Degradada o Debatida?

To the Editor,

Children with intellectual disability (ID) constitute a significant minority yet a heterogeneous population. They are commonly referred to child psychiatrists for behavioural decompensation. These children have the popular problem of diagnostic overshadowing, where ID masks comorbidities. Psychopathology, in contrast to upheld clinical lore, tends to be 3- to 6-fold overrepresented in this population—dual diagnosis.[1] This, in turn, negatively impacts adaptive functioning, interferes with skills training, and adds further to caregivers' distress. Contrariwise, some skewed practices are fraught with diagnostic slippage, a rather hasty 'labelling' approach where all agony for e.g. would translate 'monothetically' into depression. Besides, it remains difficult to conduct a routine MSE with these children. Diagnostic challenges in this population are protean and beleaguered by intellectual distortion, cognitive disintegration, baseline exaggerations and psychosocial masking. Diagnostic criteria in the current major classificatory systems (DSM-5 and ICD-11) are sorely developmentally insensitive—do not take into account the pathoplastic effect of ID on clinical presentation of varied diagnostic syndromes with 'atypicalilty' being the rule.[2]

Educational and behavioural interventions (with developmental adaptations) remain first-line. Inaccessibility (e.g., logistic difficulties in governmental services), unaffordability of these modalities or at times upon parental request, has titled practice, as we see, towards 'overmedicating' children with ID presenting with challenging behaviours. Sorely, trend of utilization of psychotropic agents, especially antipsychotics, in this population is alarmingly on the rise.[3] This practice has manifold downsides and pitfalls. ID population (especially with IQ <50-55) are at a heightened vulnerability to adverse drug reactions (neurohormonal, cardio-metabolic...) by virtue of neurodisability. Failure to pinpoint a function or pattern for these behaviours typically culminates in polypharmacy, further iatrogenic burden, and 'masking' underneath problems. 'Do not rock the boat' and 'psychopharmacological purgatory' are only few examples of commonly observed 'prescription traps' on clinical grounds that result in these children kept on medications for longer than intended periods of time.

Some caveats regarding psychopharmacology of ID are noteworthy mentioning. The same level of evidence of efficacy for psychotropic agents is broadly not available for ID population. Provided medical/environmental causation are ruled out beforehand, any treatment plan should be time-bound, symptom-targeted (in case of diagnostic ambiguity), and preferably measurement-based with a clinical end-point. Baseline data to compare against is crucially important. It should be clearly emphasized that medications are only part of a multi-modal treatment plan including behavioural and educational arms. Caregivers need to be actively engaged. An ample opportunity for monitoring of side effects with closer follow-up appointments is strongly recommended. While prescribing, 'start low and go slow' adage neatly applies in this context. Regular reviews of clinical progress (or lack thereof) and the continued need for medications are highly indicated. Agents notoriously impacting the cognitive reserve (e.g., those with anticholinergic load) or functional status are generally best avoided. A close eye on paradoxical reactions, tolerability issues (given the demonstrated higher drop-out rates of ID patients in clinical trials), and pharmacological interactions is warranted. Dilemma of assent or informed consent in this population remains an unresolved area of hot debate.

It then behoves clinicians to avidly probe psychiatric comorbidities or behavioural phenotypes of ID and to limit psychotropic medications to situations where such diagnoses are made clear or occasionally in case of severe challenging behaviours where medications can be used on specific symptom-targeted basis.

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