LETTERS TO THE EDITORS

Impulsive aggression in Brazil: losing opportunities to intervene

Rev Bras Psiquiatr. 2015;37:177–178
doi:10.1590/1516-4446-2014-1609

High rates of violence are widespread in Brazil.[1,2] In 2012 alone, an average of 154 homicides were committed per day in the country.[1] Furthermore, approximately 50% of all injuries suffered by women are due to physical aggression; verbal aggression against females is also a common occurrence in Brazil.[3] In the city of São Paulo alone, the Military Police receive up to 70 calls per day for severe road-rage incidents, which often result in physical injuries or even death.[3] Despite the prevalence of these problems, there is a large gap in the current psychiatric understanding of aggressive behaviors in Brazil.

Aggression can be classified either as pathologic or as incidental/situational, as is the case in defensive responses.[4,5] Pathologic aggression is divided into two types: premeditated aggression and impulsive aggression (IA).[4,5] Premeditated aggression is characterized by planning prior to the aggressive act and is classically associated with antisocial personality disorder. Conversely, IA is characterized by unplanned outbursts, and the aggressor's empathic capacity is usually preserved. Negative feelings such as guilt, sadness, and regret often follow the outbursts.[4,5] IA is also characterized by a significantly different neurobiology and phenomenology in comparison with premeditated aggression.[4,5]

Intermittent explosive disorder (IED) is the paradigmatic disorder of IA.[4,5] Typical patients with IED present with recurrent and problematic aggressive behaviors, including both verbal and physical aggression, as well as destruction of property.[4,5] IED is associated with substantial distress, difficulties in social and professional functioning, and monetary and legal problems.[4,5] Studies of the U.S. population have estimated the lifetime prevalence of IED as 5 to 7%, and found that most of these individuals do not seek treatment.[5] However, to the best of our knowledge, no study has addressed IED in Brazil.

In this letter, we report the case of a patient with high levels of IA and a formal diagnosis of IED according to DSM-5 criteria.

A 30-year-old male presented with repetitive aggressive behaviors evident since late adolescence. The patient sought treatment voluntarily after having verbally and physically assaulted his last three girlfriends, which precipitated the end of the relationships as well as legal issues. The patient described his IA as follows: ''When I become angry, I just don't think'', and reported that, when irritated, he ''does things blindly''. Other notable incidents of IA included having broken more than 10 cell phones and intentionally crashing his car into other drivers on several occasions due to perceived ''disrespect'' while in traffic. The patient also noted that he had lost his job after an intense argument with his boss due to a minor issue.

The patient reported feelings of deep regret and guilt after his outbursts of anger. He began individual cognitive behavioral therapy (CBT) in June 2013, but despite improvement, still experienced some relapses. After starting fluoxetine in February 2014, he acknowledged further improvements in

Table 1 First-line therapeutic approaches for intermittent explosive disorder

Therapeutic approach*	Details
Psychotherapy: CBT	Format: Administered in-group or individually. Patients usually receive 8 to 20 sessions, with each CBT session lasting approximately 60 minutes. Skills developed: - Anger management and relaxation techniques such as diaphragmatic breathing to help avoid extreme levels of irritability and enhance coping skills. - Work on dysfunctional thoughts and irrational beliefs. The most common irrational cognitions are related to perceived disrespect and provocations. - Analysis and reinforcement of assertive responses that appear during the therapeutic encounter or between sessions. The therapist analyzes practical situations and reinforces situations where the patient affirms their rights without aggressiveness, pointing out advantages of this new behavior. Practice in between sessions: The psychotherapist asks the patients to practice the techniques developed in therapy between sessions. The first 10-15 minutes of each session are dedicated to recalling the highlights of the previous session and how the skills learned were applied during the week. Termination of CBT: If patients are not compliant with CBT (e.g., skip appointments without calling ahead or do not complete homework), the therapist may consider termination of psychotherapy. Patient motivation is essential for positive outcomes.
Medication: SSRI	- Fluoxetine is the most studied medication in this context. - The average dose is 60 mg per day. - All other SSRIs also have the potential to reduce aggressive drive.

CBT = cognitive behavioral therapy; SSRI = selective serotonin reuptake inhibitor.
* The best treatment is the combination of psychotherapeutic and pharmacological approaches.

anger management. At the time of writing, the patient had not experienced any anger outbursts in the preceding 6 months and was in a stable relationship with a new girlfriend.

Table 1 summarizes first-line therapeutic approaches for IED.[4]

As illustrated in this case, IA is associated with substantial physical and psychosocial harm to the aggressive patient, the victims of the aggression, and society in general.[4,5] There is a need for better understanding of the role of IA in the high rates of violence observed in Brazil. As IA usually appears in adolescence or early adulthood and effective therapeutic approaches are available for its management,[5] proper treatment may significantly reduce personal and social distress.

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Submitted Nov 08 2014, accepted Dec 03 2014.

Disclosure

The authors report no conflicts of interest.

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Prevalence of psychiatric disorders among children and adolescents from four Brazilian regions

Rev Bras Psiquiatr 2015;37:178–179
doi:10.1590/1516-4446-2014-1606

Childhood psychiatric disorders usually persist through adolescence and adult life,[1] and have a deleterious impact and longstanding costs to individuals and society.[2] Ninety percent of the world's children and adolescents live in low- and middle-income countries, where methodologically sound data about the prevalence of child psychiatric disorders are still lacking to guide improvement in services planning.[1]

In Latin America, studies examining the prevalence of psychiatric disorders in children using diagnostic instruments are very scarce. In Brazil, only three prevalence studies involving children's mental health and using diagnostic instruments have been conducted,[3] none of which involved more than one region of the country. Thus, the purpose of the current study was to ascertain the prevalence of psychiatric disorders in schoolchildren from grades 2-6 living in four municipalities from four Brazilian regions (Southeast, Center, Northeast, and North), using probabilistic samples.

Considering that education is compulsory for all Brazilians aged 4 to 17 years and that 83.5% of this population is enrolled in public schools, this multicenter, cross-sectional study enrolled 1,676 6-to-16-year-olds (response rate: 81.1%). Trained psychologists administered the Brazilian version of the Schedule for Affective Disorders and Schizophrenia for School-Age Children/Present-and-Lifetime-Version (K-SADS-PL) to mothers/main caregivers to identify current child psychiatric disorders. The Universidade de São Paulo Research Ethics Committee approved the study protocol. Data collection lasted 15 months, and was completed by December 2011. A detailed description of the methodology is available elsewhere.[4]

Prevalence rates were obtained for the overall sample and stratified by municipality/region, including any psychiatric disorder (excluding enuresis/encopresis), specific groups of disorders, and single disorders (Table 1). The observed overall prevalence of one or more psychiatric disorders (13.1%) was similar to most estimates reported for children around the world,[2,5] including rates from Brazil.[3] In comparison with one of the most important reviews in the field,[5] our estimates were similar in magnitude regarding any anxiety and any ADHD, somewhat smaller for any disruptive disorder, and smaller for any depressive and any oppositional conduct disorder.

Surprisingly, certain differences in prevalence rates by municipality/region were observed. The rate of any psychiatric disorder was lower in the Northeast municipality than in any of the other three sites. The rates of ADHD and disruptive disorders were higher in the Center of Brazil and lower in the Northeast, while oppositional/conduct disorder was more prevalent in the Center and less prevalent in the Northeast and North. These differences are difficult to interpret, as participating municipalities were similar in terms of population (having fewer than 50,000 inhabitants, as do 84.7% of Brazilian municipalities), were all located near a state capital, and had a Human Development Index near the countrywide average.

In conclusion, this was the first epidemiological study conducted in four Brazilian regions to investigate the prevalence of different types of psychiatric disorders among schoolchildren. Further studies are necessary to confirm or refute the differences observed by region. Because Brazil is a large and heterogeneous country in terms of socioeconomic status and availability of resources, local contexts must be examined to better capture differences in children's mental health needs.