

Source of Aggression Should Determine Treatment

It may be helpful to consider aggressive behavior in the context of a child's other traits.

BY BETSY BATES
Los Angeles Bureau

VANCOUVER, B.C. — Aggression is not a diagnosis, it's a symptom.

It may be secondary to a psychiatric diagnosis, or unrelated.

It may be a temporary response to the environment, or deeply woven into a child's personality.

Physicians need to know the whys of aggression before they can devise a plan to help, Dr. Susan Lomax said at a conference sponsored by the North Pacific Pediatric Society.

"What's driving the aggression makes a difference with the intervention," said Dr. Lomax, an adolescent psychiatrist at British Columbia Children's Hospital and a faculty member at the University of British Columbia in Vancouver.

It may be helpful to look at aggression in the context of a child's other traits.

The Antisocial Child

You may see deliberate, proactive, or predatory aggression in an antisocial child. In this context, aggression isn't explosive, but controlled, goal-oriented, and often planned. It's rewarding to the child in some way, perhaps as a release from boredom. This type of aggression is seen when a child methodically injures animals or other children. It is the most difficult form of aggression to treat.

When contemplating a treatment plan, keep in mind that antisocial children want to know "what's in it for me?"

Therefore, concrete, reward-based therapy within a highly structured program makes sense.

One-on-one psychotherapy is rarely useful because these children "often don't have the ability to talk through problems internally," said Dr. Lomax. Group therapy may be more helpful because these children may be sensitive to peer approval or disapproval.

Because their aggression may arise from a desire for stimulation, encourage time-consuming, prosocial activities such as organized sports, "where they can re-

inforce skills ... and acquire skills they can feel good about."

The Anxious Child

In sharp contrast to an antisocial child, aggression in a jittery child erupts as a fear reaction. Blowups in the morning before school represent avoidant behavior. These children may have an anxiety disorder, posttraumatic stress disorder, depression, or, rarely, psychosis. Treatment of the psychosis may reduce the high level of arousal that leads to aggressive behavior, Dr. Lomax said.

The Rigid Child

"These kids want things their way or no way," she explained.

They may become infuriated at having to leave the computer to come to dinner.

"They think they're picked on, that there's no justice," she said.

Rigid children "habitually misinterpret cues" from parents, teachers, and peers. As a result, they fly off the handle in anger.

Associated diagnoses may include oppositional defiant disorder, the autism spectrum, obsessive-compulsive disorder (when anger arises from interference with rituals), and nonverbal learning disabilities.

Their temperaments tend to be inflexible and stubborn.

The Impulsive Child

Frontal lobe dysfunction plays a role in the aggression of a child who becomes very angry very fast and cannot self-calm.

Beyond their inability to inhibit their impulses, "These children have a hard time planning or envisioning consequences," said Dr. Lomax.

Possibly associated diagnoses might include ADHD, fetal alcohol syndrome, brain injury, or substance abuse.

The Dysregulated Child

Irritability, agitation, volatility, and mood instability underlie aggression in dysregulated children. Developmental or genetic issues should be explored.

For example, dysregulated aggression is common in children who experienced few

nurturing, calming experiences in the first years of life.

Dysregulation may be an early sign of bipolar disorder, even if classic adult signs of euphoria and grandiosity are not present. In children, aggression and sleeplessness may alternate with depression and lethargy in a pattern of rapid cycling.

The Abused or Traumatized Child

Aggressive behaviors in such children make sense within the context of their lives, since the "fight" response to a survival threat naturally requires quick and decisive action.

"Their autonomic system is on overdrive. They become panicked if someone tries to control them," said Dr. Lomax.

They are hypervigilant, distrustful, and show diminished cognition and a loss of impulse control when they perceive a threat.

Seemingly "minor" events may precipitate catastrophic reactions in these children, she said.

Children Whose Lives Are in Flux

It is also important to remember that aggression may be symptomatic of a situational upheaval in a child's life: a parent's divorce, for example, or a serious illness.

Consider, too, the family context in which aggression occurs.

Aggression may be a learned behavior, modeled by parents with their own history of violence and/or Axis I diagnoses.

Be forewarned: Parents may take "deep and grievous offense" at the notion that the family dynamic may be a contributor to the child's aggressive behavior. Dr. Lomax suggested a careful assessment of whether they are intellectually capable of insight and stable enough to accept suggestions about how to learn and practice anger management and training in parenting skills such as boundary and limit setting.

Sometimes, it may be necessary to go outside the immediately family for help, to grandparents or spouse equivalents, she said.

Psychoeducation, enhancing attachment, marital therapy, and parent support groups are all helpful adjuncts for parents of aggressive children.

"These families are often held hostage

to their child's behavior," Dr. Lomax said.

The treatment of a child with impulsive or affective aggression may be successful in one-on-one sessions or in group therapy. Principles include anxiety management, correction of cognitive distortions, assertiveness training, impulse control strategies, stress reduction, and, if applicable, therapy to address trauma.

In extreme cases, medications may be both necessary and helpful.

Treat any primary psychiatric disorder first, then consider risperidone in very low doses (0.5-2 mg/day), a mood stabilizer if the child is irritable and volatile, or a β -blocker in the context of hyperarousal, Dr. Lomax said.

She cautioned that antidepressants can sometimes have activating effects that exacerbate aggression in some children.

Lorazepam should be avoided for this reason in aggressive children, and children prescribed other antidepressants should be monitored very closely early in therapy for signs of akathisia, sleep problems, and "rage reactions" out of character for the child. ■

Questions That Should Be Asked

- ▶ When did the behavior start? What was the context? What is the child's age?
- ▶ Is the child capable of empathy and/or real regret? Does he or she laugh when confronted with the consequences of the aggressive behavior?
- ▶ Is the aggressive behavior situation specific?
- ▶ How is the child's general tolerance for frustration? (Is this a rigid child?)
- ▶ Has the child had a traumatic experience? Was he/she nurtured early in life?
- ▶ Do other children in the family have problems with aggression?
- ▶ How readily does the child adjust to changes in routine?

Source: Dr. Lomax

Diabetes Control May Suffer in Children Who Are Bullied

BY HEIDI SPLETE
Senior Writer

Diabetic children and adolescents who are bullied are significantly less likely to adhere to glucose testing or attend to their diets, reported Eric A. Storch, Ph.D., and his associates at the University of Florida, Gainesville.

Previous studies have shown that bullied children often avoid situations where they are more likely to be bullied.

Similarly, Dr. Storch, who is

with the department of psychiatry at the university, and his colleagues suspected that diabetic children might avoid overt self-management behaviors, such as dietary limitations or insulin shots, which would attract the attention of bullies (J. Pediatr. 2006;148:784-7).

Reports of diabetes-related bullying were significantly associated with overall poor diabetes care and increased HbA_{1c} concentrations. Children

and their parents completed questionnaires designed to assess diabetes management and experiences with bullying.

Physicians may need to ask about peer relationships when a child with diabetes struggles to maintain treatment adherence.

Specifically, diabetes-related bullying significantly predicted 9% of the variation in self-management and nearly 6% of the

variation in self-reported depression in a review of 167 type 1 diabetic patients aged 8-17 years. The results were based on measures of bullying and depression that included statements such as "Other kids tease me about not being able to eat certain foods."

Self-reported depression mediated the link between diabetes-related bullying and diabetes self-management, but it did not reduce the significance of bullying to poor

self-management in this study, Dr. Storch and his associates said.

The results suggest that physicians need to ask about peer relationships when a child with diabetes struggles to maintain treatment adherence.

It remains unclear, however, whether a diabetic child is automatically more susceptible to bullying or whether having diabetes increases the risk of bullying in a child who is vulnerable to bullies for other reasons, the researchers noted. ■