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Pharmacotherapy of aggressive behavior.

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OBJECTIVE: To review the definition, clinical characteristics, prevalence, etiology, neurochemistry, and pharmacologic treatment of aggressive behavior, and provide recommendations regarding the use of specific pharmacologic agents for treating aggressive behavior. DATA SOURCES: Data from the scientific literature were analyzed, interpreted, and summarized. An English-language MEDLINE search yielded clinical trials, case reports, letters, and review articles addressing the etiology and pharmacotherapy of aggression. STUDY SELECTION: Because few well-controlled studies are available in aggression research, all literature addressing the pharmacologic treatment of aggressive behavior, as well as the neurochemistry and psychobiology of aggressive behavior, was reviewed. DATA EXTRACTION: The literature was reviewed on the basis of the particular pharmacotherapy and the specific population used. A separate review of the treatment of aggressive behavior in the elderly was included. DATA SYNTHESIS: The literature was assessed for applicability to clinical practice and usefulness to the general clinician. Recommendations were made from the primary literature in conjunction with trends in clinical practice. Pharmacotherapy is a primary mainstay of treatment for aggressive patients. In individuals for whom behavioral intervention alone is unsuccessful, drug therapy should be initiated along with continued nonpharmacologic intervention. Short-acting benzodiazepines and high-potency antipsychotic agents are effective in treating acute aggression on a short-term or as needed basis. Agents such as lithium, beta adrenergic blockers, carbamazepine, valproic acid, buspirone, trazodone, serotonin reuptake inhibitors, and clozapine may be useful in the chronic management of aggressive behavior. Every attempt should be made to streamline drug therapy in patients with chronic aggression and comorbid psychiatric disorders. CONCLUSIONS: On the basis of available research and extensive clinical experience, lithium or propranolol should be considered as first-line antiaggressive agents in patients without comorbid psychiatric disorders. A minimum trial period for assessing drug efficacy should last at least 6-8 weeks at maximum tolerated dosages. Patients responding to pharmacotherapy should be reevaluated every 3-6 months, and periodic medication tapers and/or drug-free periods should be attempted.

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