The Developmental Psychiatric Approach to
Aggressive Behavior Among Persons With
Intellectual Disabilities

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Aggressive behavior is encountered relatively often among persons with intellectual disabilities and can cause great difficulties in the care management of these persons. By applying a developmental psychiatric approach to the assessment and diagnostics of persons with intellectual disabilities who display aggressive behavior, the author points out how one may come to a better understanding of the onset mechanisms, presentation, and course of this disorder. A schema of emotional development is presented and different manifestations of aggression and their relationship to personality development is revealed. By means of a developmental psychiatric examination, various psycho-social aspects such as the basic emotional needs, adaptive and maladaptive traits, and coping strategies come to light. This serves as the background from which more accurate diagnostics and more appropriate planning of an integrative treatment can take place. Integrative treatment is multidimensional, implying that it is based on the biological, psychological, social and developmental aspects of the individual.

The intention of the article is to stimulate the application of the developmental perspective in the diagnostics and treatment of persons with intellectual disabilities who have mental health problems and to challenge professionals to carry out more scientific research in this field.

Keywords: aggressive behavior, developmental perspective, developmental psychiatric approach, integrative treatment, intellectual disability, mental retardation, self-injurious behavior

Aggressive behavior is a social interactional problem present in individuals at all ages, at all developmental levels, and in all societies. In persons with intellectual disabilities (ID) the prevalence rate appears to be remarkably higher than is the case in the general population, varying from 2 to 20% higher dependent upon the sampling procedures adopted. ¹,¹² The prevalence rate appears to rise as the severity of ID increases. The number of scientific studies investigating aggression in people with ID has grown recently. ¹,¹³,²²,²⁴,²⁶,³⁸ However, practitioners still miss a solid approach for treating these problems. The diagnostic systems currently in use such as DSM and ICD do not cover the diversity of the manifestations of aggression in this population. This hampers understanding and explanation of the phenomenon and makes it very difficult to stipulate the appropriate treatment approach. For this reason a necessity is growing to find alternative approaches which, by augmenting the existing diagnostics within DSM and ICD systems, could bring more clarity into the mechanisms, presentation form and course of this disorder (see also Gardner²³).

In our daily practice¹⁶,¹⁹ we have been utilizing a developmental psychiatric approach in which the biological and psycho-social development of the individual plays a central role. This approach has been elaborated upon by Cicchetti,¹⁰ Cicchetti and Toth,¹¹ Rutter ³³ and Srourue and Rutter,³⁷ and was recently discussed in the books of Bradley,⁵ Cummings et al.,¹² and Harris.³⁵ It can be defined as being "...the study of the origins and course of individual patterns of behavioral maladaptation." ³⁷ (p.18), implying that developmental psychiatry explains how maladaptation occurs and what the consequences are for the functioning of the person involved. In our practice we have developed an assessment, diagnosis and treatment method based on the developmental psychiatric conception. For a better understanding of our approach, some general remarks regarding the phenomenon of aggression in the general population are warranted.

Speaking in general terms and according to current knowledge, the factors which play a role in the onset of aggression in human beings are diverse and may be broadly divided into individual conditions and environmental conditions. (see Table 1)
### Table 1. Conditions in the Onset of Aggression

**Individual Conditions in the Onset of Aggression:**

- Genetic factors: chromosomal aberrations, aggression in the family history.
- Dysfunction or damage of the CNS: dysfunction of the frontal and temporal lobe, dysfunction of the amygdala and lesion of the hypothalamus and orbital prefrontal cortex.
- Neuro-biochemical conditions: low serotonin, increased activity of noradrenergic, dopamine and cholinergic structures.
- Intellectual functions: decreased IQ, skill deficits, communication problems.
- Social conditions: social deprivation, social incompetence, social isolation, abuse.
- Emotional and personality conditions: delay in emotional and personality development, particular temperaments, maladaptive coping strategies.
- Sensory and perceptual disturbances: visual and visual perceptual difficulties (causing academic difficulties), auditory and auditory perceptual problems (leading to speech difficulties).
- Psychiatric conditions: attachment disorder, oppositional defiant disorder, attention-deficit hyperactivity disorder, conduct disorder, depression, psychosis, personality disorders that heighten risk.

**Environmental Conditions in the Onset of Aggression:**

- Sensory overloading
- Inappropriate interaction style
- Lack of structured activities
- Modeling of aggression
- Aversive social contacts (rejection, abuse, neglect)
- Poor pedagogical conditions
- Parental psychopathology
- Peer rejection
- Stressful events

Aggressive behavior can emerge at any age. Relatively often the onset is during childhood and tends to continue on into adulthood. At different developmental stages, aggressive behavior will be manifested in different ways.

During infancy (0-3 yrs.) it will be evident in excessive irritability and crying, head banging, temper tantrums, aggression towards bonding figure, aggression towards peers, destructiveness. For toddlers and pre-schoolers (3-7 yrs.) it will be evident in impulsive aggression, unpredictable and disruptive behavior, symptoms of oppositional defiant disorder (ODD) and attention-deficit hyperactivity disorder (ADHD).

During school age (7-12 yrs.) it will be apparent in features of ADHD and conduct disorder (CD), and during adolescence (12-18 yrs.) in features of antisocial personality disorder.

Recently some authors have attempted to differentiate two subtypes of aggressive behavior: affective, defensive, impulsive or reactive aggression, and controlled, proactive, offensive, predatory or antisocial aggression.

Each of these subtypes has its own onset mechanism and specific biological and psychosocial background. Affective aggression is induced by irritability and fear; a high level of arousal and cognitive distortion serve as the background. A fight-flight stress reaction may be seen often. The biological background is characterized by a high level of dopaminergic and adrenergic activity and a low level of serotonergic CNS activity.

Controlled aggression is usually motivated by the desire to achieve a particular goal and is often rewarded positively. Persons manifesting controlled aggression show a low level of arousal, typically have no cognitive distortion and have increased cholinergic CNS activity.

The general differentiation of aggression types described above form the basis for our practical approach to the phenomenon among persons with ID. The intention of this article is not only to encourage the practical use of the developmental...
psychiatric approach to persons with ID but to stimulate scientific research as well.

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<th>TABLE 2. SOCIO-EMOTIONAL PHASES AND STRUCTURING OF PERSONALITY</th>
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<td>♦ 1st phase (0-6 months) is the adaptation phase in which the personality structure referred to as physiological and psychological homeostasis is formed.</td>
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<td>♦ 2nd phase (6-18 months) is the socialization phase in which the structure of attachment is formed.</td>
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<td>♦ 3rd phase (18-36 months) is the individuation phase, self-differentiation and the objective-self are formed.</td>
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<td>♦ 4th phase (3-7 years) is the identification phase within which the Ego construct is formed.</td>
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<td>♦ 5th phase (7-12 years) is the reality awareness phase within which further Ego differentiation takes place.</td>
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**A Schematic Approach to the Occurrence of Aggression in Persons With ID**

Recently Charlot discussed the impact of developmental level upon the clinical features of a mental health disorder and stressed that using a developmental perspective can help improve psychiatric diagnostic assessment of individuals with ID. She compared the behavior of persons at different developmental levels of ID with the behavior exhibited by persons having an average level of intelligence at different chronological ages, emphasizing that the nature of aggression displayed by adults with severe ID may be similar to aggressive behavior exhibited by children of normal intelligence at a corresponding chronological age lower than four years.

Reasoning in the same fashion, and in an attempt to make the onset and the course of psychopathology in persons with ID easier to comprehend, we developed a schema for emotional and personality development that we have repeatedly applied to developmental psychiatric assessment and diagnosis. In making this schema we utilized several psychological and neuro-developmental theories of the development of the average child. In this schema socio-emotional development from birth to 12 years of age is divided into a number of phases or stages. The assumption is made that a particular personality structure is formed in a particular phase. (see Table 2)

This schema has been applied to the examination and diagnosis of aggressive behavior in persons with ID. From the developmental psychiatric perspective we view the onset of behavioral and psychiatric disorders as follows:

In order for optimal development to take place, the average as well as the intellectually disabled child must undergo new psycho-social adaptations at each developmental stage. The capability of making adequate adaptations depends upon the bio-psycho-social conditions of the child and environmental stimulation. At each stage the person shows characteristic behavior which, under favorable circumstances, leads to the experiences necessary for cognitive, emotional and social growth. The regulation of affect and aggression is different at every stage. Within a favorable environment, the style of regulation of affect and aggression is socially acceptable and is supported. In this way the child is stimulated to learn to control affect and aggression in accordance with environmental expectations.

In cases in which difficulties are encountered with regard to adaptation to and coping with harmful stimuli, maladaptive behavior may occur. Each stage entails different maladaptive behavioral features, which we call maladaptive traits. These traits are also called Challenging Behavior. When a worsening of the psychic condition of the person takes place (e.g., due to increased or prolonged harmful events), the maladaptive traits may smother color or become concurrent with many other behaviors, seriously disturbing the functioning of the person and causing psychic suffering which may then lead to a psychiatric disorder. The maladaptive traits may increase strikingly in intensity and be seen as
being the symptoms of a psychiatric disorder.\textsuperscript{19} For example, a child with severe ID and occasional self-injurious behavior (SIB), when exposed to prolonged severe stress, may react with an increase in SIB and in time with withdrawal, an apathetic reaction comparable to a depressive disorder. Similarly, persons with underlying separation anxiety often react to very stressful situations with behavior which may be interpreted as the onset of an acute general anxiety disorder with psychotic features.

According to this model, in cases of maladaptation, the aggression regulation may become disturbed, causing typical stage specific manifestations of aggressive behavior:

- At the level of homeostasis: aggression is elicited by anger and rage, is diffuse and often directed towards the self or to the surroundings.
- At the level of attachment: aggression is elicited by frustration, is diffuse and directed towards the bonding or familiar figures or to the self.
- At the level of self-differentiation and objective-self: the aggression occurs as a reaction to anger and anxiety, is impulsive, directed towards other people and is uncontrolled.
- During the ego-formation stage: aggression results from anger and anxiety or can be motivated by a particular learned goal; it may be impulsive, but is usually directed towards particular people or objects and is often controlled.
- During the ego-differentiation phase: the aggression may be elicited by anger and anxiety or is motivated by particular learned goals; and is controlled and directed towards particular people and objects.

In this schema of hierarchically differentiated levels of emotional development, we have distinguished two subtypes of aggression as described by Vitiello and Stoff.\textsuperscript{38} According to this model, affective aggression prevails in children at developmental levels lower than seven years, while controlled aggression prevails at higher levels. Nevertheless a mixture of both types of aggression is conceivable and probably occurs quite often depending upon the personality characteristics of the person and the environmental and social situation at hand.

**Aggression at Different Levels of Intellectual Disabilities**

Based upon the schema presented above, persons with ID at a developmental level lower than that of two years (profound ID) manifest aggression in a fashion that is comparable to that exhibited by children who are in the first and second phase of emotional development. That is to say, their aggression is of an affective type and is often directed towards the self and the immediate surroundings.

Persons with severe to moderate ID (at a developmental age of 2-7 years) show both affective as well as controlled types of aggression. For these persons, impulsivity prevails, while the directedness and control over aggression may be incomplete and weak.

Persons with a mild level of ID (at a developmental age of 7-12 years) predominantly manifest controlled types of aggression. However, affective aggression is conceivable among these persons as well, particularly in cases in which intense anxiety or stress are present or when elicited by other intensive negative emotions.

A complex situation may arise in cases in which cognitive and emotional development are discrepant. The developmental personality level of these persons is usually lower than the cognitive level, which may make the person socially and emotionally vulnerable. In our experience, in these cases the person usually exhibits aggressive behavior corresponding to the level of emotional or personality development.

Recently some investigators\textsuperscript{6} have pointed out that a relatively high percentage (in 32% of the cases) of delayed development of social-emotional skills could be found among non-intellectually disabled children who had emotional and behavioral problems. These findings are comparable to what we found in our patients with ID: discrepancies between cognitive and emotional development and an increased risk of psychiatric and behavioral disorders.

**Case Examples**

**Case 1:** A 21-year-old man with mild ID was referred to us for his abrupt and sometimes dangerous aggressive explosions. These behavioral problems had been present from childhood. During adolescence the aggressive explosions took on a severe form. He was hospitalized repeatedly and
received a high dosage of psychotropic medication without evident positive results.

From his history it became clear that he had probably been affectively neglected during the first years of his life. At the age of four, he had been placed in an institution. In the years that followed he changed institutions and foster homes many times.

Examinations by cognitive psychological tests showed an IQ of 60. On developmental emotional tests he scored lower than two years equivalent.

Our observations made it evident that his aggressive behavior could be characterized as affective aggression. The features of aggression regulation that were exhibited were similar to those taking place during the socialization phase (attachment). These findings were important and helpful in gaining more insight into his basic emotional needs as well as into his existential socio-emotional problems. The treatment which followed was directed towards the amelioration of his emotional problems and to a better understanding of the problems he had within his surroundings (see the section Treatment).

Case 2: Another example is a young woman, aged 28, who suffered from Down’s syndrome and mild ID. The problem was her stealing behavior and frequent irritability and anger.

The woman lived at her parents’ home until five years ago. She spent the first three of these years in a group home and had lived in an apartment on her own for the past two years. At her apartment she received a slight amount of assistance from professional caregivers. She worked at a catering service.

Her stealing behavior began shortly after she had moved into the group home and increased when she moved to her apartment.

The woman told us that she was often very angry at the people who helped her at home with the housekeeping. When she got angry she felt that she must steal something from that person. She even stole from her mother when she was angry with her, but never from her father. After stealing she felt bad and sad.

The IQ of this young woman was 55, (developmental age seven years) and globally her emotional development could be seen as being less than three years (predominantly 3rd and 2nd phase, with some features of the 4th phase).

Our conclusion was that the young woman’s behavior was caused by overdemanding by her parents and others with whom she had frequent contact. The aim had been to make her maximally independent and autonomous by having her live on her own. However, this required too much of her, leading to enduring frustrations. Her frustrations eventually resulted in an impulse control disorder (affective aggression type), as well as controlled and goal-directed aggression.

By establishing the level and type of her aggressive behavior and discovering what her basic problems were, we could plan the proper treatment approach (see the section Treatment).

In cases of psychiatric disorders in which emotional problems prevail it can be expected that, as can be seen in the developmental schema, an affective type of aggression will be manifested. In many psychiatric disorders such as depression, psychosis, and anxiety disorders found among people with ID, aggression may be a leading symptom, overshadowing other features of the disease. SIB has often been seen in persons with severe and profound ID who were suffering from depression or psychosis. Property destruction and aggression towards other people can be seen in persons at higher levels of ID who suffer from the same disorders. The severity of these features may mislead a diagnostician into focusing treatment efforts on the symptom of aggression while in the meantime the underlying disorders is overlooked.

Assessment

In order to be able to utilize the present schema in daily practice a professional needs to have adequate assessment tools which examine the developmental levels of different psycho-social aspects of the individual.

A variety of instruments for measuring cognitive abilities are available, as are tools for estimating social skills development. However, tools for measuring emotional development are still very scarce. In addition to the lack of adequate tools, another serious problem is that professionals are not attuned to the role that emotional and personality development play in the onset of behavioral and psychiatric disorders in persons with ID.

Currently a number of scales are being used in day-to-day practice, for example, the Vineland Adaptation Behavior Scale (VABS), the Infant-Toddler Social Emotional Assessment (ITSEA) and the Aberrant Behavior Checklist (ABC).
These scales measure different aspects of behavior, and may be applied to gain global insight into the behavior of the person in question. We developed the Scale for Appraisal of Emotional Development (SAED).17 Developmental levels in the scale are divided into the five corresponding stages of development delineated in the schema described above. This scale has not been validated as yet, but has been used for a long time now by many Dutch and Belgian professionals who report predominantly positive results when using it. We use this scale in addition to Socialization domain of the VABS and there appears to be good inter-scale agreement.

With the SAED we are able to make an appraisal of the developmental level of different emotional aspects. We use the insight gained into these aspects to help us make an appraisal of the level and the stability of personality development. Insight into the level of personality development contributes greatly to diagnostic considerations.

In cases of aggressive behavior, we attempt to discover what basic emotional needs and essential problems of the person are involved. To gain insight into the onset mechanism of aggression, we appraise personality development. All these aspects play an important role in planning treatment.

**Diagnostic Considerations of the Developmental Perspective**

As mentioned above, when behavior is viewed from the developmental perspective, it becomes evident that the form of aggression is different for each of the levels of ID. Unfortunately, existing diagnostic systems (DSM and ICD) do not differentiate between these various forms accurately, which makes diagnosis and treatment a very difficult task to fulfil. In this section we will discuss the DSM-IV diagnostic categories that are usually applied to persons with ID who exhibit aggressive behavior from a developmental perspective, as well as other different forms of aggression which are not explicitly diagnosed within this system.

SIB is a relatively frequently occurring form of aggression which prevails at low developmental levels (severe and profound ID). In the DSM-IV, SIB is placed into the diagnostic category of Stereotypic Movement Disorder. We see the SIB as being the consequence of maladaptive coping strategies emanating from the personality developmental level of homeostasis. It also appears when there is severe frustration at the attachment level. The fact that the SIB usually becomes a serious problem when the child is a toddler or later on in life, might mean that a certain level of CNS development must have taken place before this type of behavior could be manifested. Probably due to a discrepancy between very low emotional development (homeostasis, attachment) on the one hand and some more highly developed psychosocial aspects on the other, the person in question will respond to perpetual and unsolvable stress situations by exhibiting a maladaptive reaction; in this case aggression directed towards the self. As time goes by this maladaptive behavior may become the normal pattern of interaction, causing increased suffering by the person, and may eventually lead to psychiatric disorder.

Currently various theories try to explain the onset of SIB. Nevertheless, we do not really know enough about this phenomenon. A strategy that was derived from the developmental perspective has been applied to persons suffering from SIB in our daily practice and has yielded favorable results. In our opinion these results call for more scientific investigation. Numerous studies have already been done on the phenomenon of SIB. Unfortunately, the center of attention of most of the studies was the phenomenon as such and not the person suffering from this disorder. In our opinion, overlooking basic physiological and psycho-social needs of children who have a severe handicap at a very early stage of their development can have serious repercussions for the further development of the child. It is crucially important that educators and professional caregivers understand these basic needs so that appropriate and early stimulation of development can take place and maladaptive behavior patterns can be prevented.

The aggressive behavior of non-intellectually disabled persons with attachment problems has been receiving an increasing amount of attention by investigators.5,15 Unfortunately, investigations of this issue amongst people with ID are scarce. Relatively often in our daily practice we have identified cases of impulsive and severe aggressive behavior with an onset basis of disturbed attachment. Bearing in mind that attachment disorders probably occur more frequently in this population than among other people, we would expect this type of aggression to be present more often in persons with ID. Usually these individuals are diagnosed with impulse control disorder. In these persons’ histories we have often
found behavioral problems occurring during infancy or toddlerhood. These problems included restlessness, anger, anxiety, and impulsive aggressive outbursts, even though affectionate, dependent and at times socially desirable behavior was present as well. As has been described in the case vignette, after puberty aggressive outbursts usually become more severe, leading to frequent isolation. There is a loss of the familiar environment, punishing ensues, and this in turn leads to a further escalation of impulsive explosions.

At assessment these persons may show relatively advanced cognitive development (mild ID, or bordering on normal range intelligence). But what is striking here is that there is a discrepancy between high cognitive and low emotional development (level lower than 18 months - attachment). The diagnostic category Reactive Attachment Disorder does not apply to these individuals because they show different symptoms (predominantly aggressive behavior) despite the fact that the underlying disturbance in emotional development is the same.

Recently many articles on ODD have been published in child psychiatry journals. Twenty years ago this diagnostic category was hardly ever discussed in the professional literature. The disorder is being recognized as such more often among children with ID. Unfortunately, scientific articles on the subject are rare. Some time ago, we investigated 146 children who were referred to our clinic for their behavioral and psychiatric disorders.\(^\text{16,17,18}\) The average age of the children was 6.5 years (3-16 yrs.), their cognitive development varied from severe ID to intelligence bordering on the normal range. We found symptoms which could be classified under the diagnosis ODD in 20% of the cases. Aggression and destructive behavior were the usual symptoms exhibited by these children, in addition to hyperactivity and the constant attention seeking. Onset of the disorder was between the ages of 2 and 4; emotional development of all the children was lower than the age 3.

Keenan and Wakschlag\(^\text{28}\) described the onset mechanism of ODD in non-intellectually disabled children as follows: “The emergence of increasingly sophisticated verbal skills, self awareness and goal directed behavior contribute to a strong push for independence on the part of the child. At the same time, parents begin to impose rules and limits, both in response to the child’s newfound autonomy and as a natural part of the socialization process. These simultaneous processes contribute to frequent clashes between the child’s self-assertions and the parents’ limit setting, leading to frequent episodes of frustration and upset.” (p. 352)

In our experience a similar onset mechanism is present among intellectually disabled children who have ODD as well. One must take into consideration that in addition to the aforementioned social aspects, other serious emotional problems are also present among these children. We may assume that, probably due to insecure attachment or other emotional and environmental problems, these children are not emotionally mature enough to take the next steps in individuation and autonomy. They need autonomy and distance themselves from important others, but they are still too dependant upon the proximity of a bonding figure. This ambiguous position is an enduring source of conflict with the surroundings; we found that ODD could often remained unchanged until adulthood.

**Case Example**

**Case 3:** A 40-year-old man with mild ID was referred to us because of his tiresome and aggressive behavior. From his history we discovered that his behavior had always been attention-seeking, tiresome, and verbally and physically aggressive in nature. Until the age of 35 he had lived and worked at his father's farm; his father died five years ago, his mother 10 years ago. During the last five years he had changed residence several times and moved from one group home to another due to his very difficult behavior and frequent conflicts with other residents. He was under psychiatric treatment and used different psychotropic drugs to counteract this behavior. These did not, however, yield the desired effects.

The caregivers reported that he was constantly seeking attention from important others, could not be alone, and played the role of a clown in the group. He was also very irritable and could react to relatively small provocations with uncontrolled anger and rage.

The patient told us that he felt good in this group home despite troubles with the other residents. He worked in the garden with pleasure and sold by far the most garden products.

The assessment process showed him to have an IQ of 65 and his emotional development level,
according to the SAED, was predominantly in phase 3 (lower than 3 years), while his VABS socialization domain was similar, at 3.5 years.

The diagnostic criteria for ODD were fulfilled. The symptoms of ODD corresponded to the traits of the personality structure exhibited during self-differentiation and objective-self. By establishing his personality developmental level and psychiatric diagnosis, the base for planning the treatment approach was formed (see the section Treatment).

Some investigators studying children without ID found that there was a relationship between early onset of ODD and ADHD. They also noted that later, at school age, an ODD disorder could change into CD and during adolescence into antisocial personality disorder. Secondary psychiatric disorders, like anxiety and mood disorders, were found at a later age as well.

In our daily practice serving children with ID, hyperactive behavior was found relatively often among children with ODD. We assumed that the hyperactive behavior of these children was a symptom of the ODD rather than a separate co-morbid disorder like ADHD. We also found that children with ODD could suffer from other psychiatric disorders like depression later on in life. Similar findings on children with ID have been reported by other investigators.

CD and antisocial personality disorder are found relatively often among youngsters with mild ID. Offending behavior has been found to be present among these individuals three times as often as among their peers without ID. There are probably various biological, psychological, and environmental reasons for why there is such a high prevalence of offending behavior among these youngsters. However, from our findings on the emotional development of these individuals we have come to the conclusion that emotional and personality immaturity play an important role.

In an assessment of 20 young offenders (between the ages of 16 and 24) with mild ID who were referred to our clinic for minor offenses involving aggression towards other people, destructiveness, sexual misconduct, arson and theft, we found that in 50% of the cases there were problems relating to attachment formation and in the other 50% the problems were rooted in the stages of individuation (self-differentiation) and identification (ego-forming). Psychiatric diagnoses were established for a number of these persons as well. These diagnoses included dysthymic disorder, reactive attachment disorder, ODD, ADHD, CD and impulse control disorder. Immature personality formation was established in all these persons.

Day describes these persons as follows: “The typical ID offender is a young male functioning in a mild to borderline intellectual age, from a poor urban environment, with a history of deprivation, behavioral problems and personality disorders.” (p. 117) We agree with this description, with the addition that the emotional problems of these persons usually are not understood by their caregivers. Their behavioral difficulties usually overshadow their emotional problems. Consequently, the reactions of caregivers may be directed exclusively towards the behavioral problems, often resulting in restrictions, medication, punishment and social isolation. These measures in turn, often result in an increase in emotional problems and psychiatric illness. Unfortunately, this issue has been insufficiently scientifically investigated.

**TREATMENT**

The treatment strategy we apply in cases of aggressive behavior is integrative in its nature. The problem of aggression is viewed from different perspectives: biological, social, psychological and developmental. These four dimensions of treatment take form in the multiprofessional cooperation of the psychiatrist, psychologist, social worker, nurse and other professionals.

Experience has taught us that in cases of aggressive behavior, monotherapy from one professional discipline, for example, the application of psychotropic medication or behavioral modification, does not usually yield the desired results. Obviously this very complex behavioral phenomenon calls for a more complex treatment approach.

In integrative treatment we start with an integrative diagnosis in which bio-psycho-social and developmental aspects are clarified. To be able to designate the appropriate treatment strategy it is important to establish the developmental levels of the person (cognitive, social, emotional), the level of personality development, and the onset mechanism of aggression and the subtype of aggression (affective, controlled, mixed).

In the case of affective aggression, the practitioner should know what the basic psycho-social needs of the person are and what the stressful events in his environment are as well.
During therapy, attempts should be made to adapt therapeutic methods to the person’s developmental level, respond to his needs, and help him adapt to present given circumstances. At the same time, attempts should be made to adapt the surroundings to better respond to the basic needs of the person. Psychotherapeutic help or a pedagogical approach may also be indicated in particular cases. If necessary, psychotropic medication can be prescribed as a support to these therapeutic attempts. 20

The integrative treatment strategy for affective aggression is as follows: first line—developmental aspect (meeting the person’s socio-emotional needs); second line—social aspect (adaptation of the surroundings); third line—psychological aspect (psychotherapy, training, pedagogical approach); and fourth line—biological aspect (medication and other medical interventions).

Case Example

Case 4: A 7-year-old boy with profound ID was referred for his SIB, restlessness, fast switching of mood and difficulties with sleeping and eating. The difficulties had begun three months ago and were increasing.

The boy lived with his parents and attended a special kindergarten. His development was delayed from the beginning, without a clear aetiology. There were no motoric or sensoric impairments. The last two years he showed a clear improvement of his social and emotional development. However, during the last three months his social interactions worsened. He had no interest in people around him anymore, showed increasing withdrawal and above mentioned behavioral features.

After a multidisciplinary assessment we established a diagnosis of adjustment disorder of a child at a very low developmental level, occurring as a consequence of stressful changes in his environment (six month attendance at an over-demanding communication training; three months ago he was moved from one group of children to another; during this time his mother became ill). His cognitive level was two years and emotional level lower than six months.

Treatment was directed towards establishing the previous state in which the boy showed social and emotional improvement. At the first line of the treatment the caregivers were urged to recognize the boy’s basic socio-emotional needs and to meet him in his needs. The parents and the teachers at the kindergarten were informed concerning his different developmental aspects, accentuating a discrepancy between his cognitive and emotional levels. The lowering of his emotional level was explained as a regression due to stressful experiences. He lost his previous basic security and fell into a state of emotional, sensoric and physiological dysregulation. His primary need was protection against the stress, and at the same time he required help from his surroundings to find his psychological and physiological homeostasis again.

At the second line of the treatment efforts were undertaken to make particular changes in the boy’s environment (at home and in the kindergarten) in order to adapt environment to his current needs. The communication training was discontinued, he was placed back in his previous group and his mother got assistance in housekeeping, so that she could give more attention to her child. Here the caregivers were taught how to help the boy to improve his sensoric integration and emotional balance (e.g., by selective sensoric stimulation, by structuring time, place, social interactions and activities, and by stimulating positive emotional experiences).

At the third line the treatment was directed towards a cautious stimulation to interact with the surrounding people; beginning with one particular person through bodily contact and material objects and gradually spreading to more intensive and broader social interactions. The aim was achievement of the previous level of interactions.

At the fourth line of the treatment we usually prescribe in similar cases psychotropic medication as a support of the treatments on other lines. In this boy the medication was not used because within several weeks he showed a positive reaction to the treatment on the first three lines. The features of SIB diminished significantly. After three months the boy completely recovered.

The treatment of the earlier described 21-year-old man with dangerous aggressive explosions was started at the first line by explanation to the caregivers of the onset mechanism of his impulsive aggression. Weakness of affect and aggression regulation was seen as a consequence of delayed emotional development. The demands of the surroundings, not counting his basic emotional needs at attachment level, were usually a trigger for his impulsive aggressive reactions. The caregivers were instructed to give him a sense of
security, acceptance and favor by an individual proximate approach.

At the second line the treatment was directed to adapt the environmental conditions to this man’s needs. His living space, material objects, activities and social interactions were structured on the way warranting positive result of the activities. The aim was to increase the patient’s trust in the environment.

At the third line of the treatment the patient was taught to recognize his own feelings and to verbalize them. Also he was trained to recognize the first signals of his frustration and anger and encouraged to undertake appropriate activities to diminish and control these feelings.

At the fourth line the mediation (valproic acid) was prescribed to diminish the patient’s enduring irritability.

The treatment result was favorable; aggression diminished significantly.

In the young woman with Down’s syndrome (see earlier Case 2 description), the treatment strategy was as follows:

At the first line of the treatment the patient’s basic emotional needs were discussed. Her emotional development was found at the stage of attachment and individuation. We understood that the young woman showed a tendency to take distance from her attachment figures, but at the same time she was still much too dependent on the important others. Because of a need for a certain degree of autonomy, this woman was also in need of proximity and support of familiar persons. Apparently, living alone in an apartment was too far from important people, and probably frightening and stressful.

At the second line the parents and other caregivers were urged to change their minds concerning autonomic living for this young woman, and to accept the opinion that for her, in this situation, it was better to take a step backward and live again in a group home.

At the third line the patient was taught to recognize tension and anger by herself, and verbalize and control them. She was also stimulated to discover pleasant aspects of living together with other people, and motivated to make the choice to go back to the group home.

The fourth line treatment was not necessary.

In the example of the 40-year-old man with the diagnosis of ODD (see Case 3 description) the treatment planning was as follows:

At the first line the caregivers were informed regarding the assessment findings, in particular concerning the meaning of the delay of his emotional and personality development for his aggressive behavior. The ambiguity between the autonomy and dependency was seen as a central problem. Concrete plans have been made as to how to give him a feeling of autonomy under surveillance of important others.

At the second line the surrounding was structured in a way that agreements were made with particular mutual expectations and responsibilities. The boundaries and needed distance between the patient and his caregivers were established and discussed.

At the third line the treatment was directed to support his feeling of his own value by encouraging and appreciating his work in the garden and selling of the garden products.

At the fourth line a neuroleptic medication (pipamperone) for diminishing of irritability and excitement was prescribed.

As may be clear from these examples, our approach to the treatment of the phenomenon of aggression was not a primary but rather a secondary treatment goal. This attitude is similar to Gardner’s consideration which claimed not to treat aggression but the antecedents and the inner and external conditions of the person. In our cases the aggression was indirectly treated by the treatment approach directed to meeting the person in his/her emotional needs, taking away stressful events through adaptation of the environment, and improving the person’s coping strategy.

In cases of controlled aggression it is necessary to lead the client and help him find motivation for changing his own behavior. That will only be possible when one understands his basic psycho-social needs. The social surroundings should cooperate and be supportive in motivating the person. Within this realm, various behavioral, cognitive and other types of therapies and training may be applied.

When there is an underlying psychiatric disorder, treatment should be directed primarily towards the psychiatric illness.
It is evident that within integrative treatment and from a developmental perspective, pharmacological therapy is usually not the main form of treatment, but instead supports other treatment methods. There are at least two reasons for taking this stand: aggression is not only a product of biological processes but also of psychological and social processes, and there are no specific anti-aggression drugs available. However, in the average daily practice in which individuals with ID are treated for displaying aggression, professionals very often prescribe psychotropic drugs. This becomes the main and sometimes only form of therapy. The developmental psychiatric approach could aid these professionals in seeking other more appropriate treatment strategies.

It is our opinion that the prevention of aggressive behavior in this population has seriously been neglected. Real and effective prevention will only be possible when professionals know more about the basic psychosocial needs, motivations and coping abilities of these persons. Early assessment and diagnostics are preconditions for such prevention.

**Conclusion**

The aggressive behavior of persons with ID can manifest in different ways, and, to a certain extent, has a different onset mechanism than aggression manifested by average people. This is because there are differences present in the biological substrate, in interactions with the surroundings, and in basic psycho-social needs of persons with ID. A schematic framework of the onset and manifestations of aggression as seen from a psychiatric developmental approach can be helpful in understanding these differences.

For proper diagnosis, in addition to examining the biological and environmental circumstances, it is necessary to understand the developmental levels of different psycho-social aspects, in particular of emotional development and personality. An obvious problem in the assessment and diagnosis of aggressive behavior is a shortage of adequate tools for assessing emotional and personality development. Another, probably even bigger problem, is that there seems to be a lack of professional interest in the emotional and personality development of this population. Consequently, research on the role these aspects play in the onset of the behavioral problems and psychiatric disorders of these people has been neglected.

By discovering onset mechanism, which type of aggression is being expressed, and the basic psycho-social needs and environmental circumstances of the person in question, a practitioner is usually able to delineate a treatment strategy based on an integrative treatment approach.

The increasing number of publications on the developmental perspective within general psychiatry during the last decade make it clear that mental healthcare professionals have a growing interest in insights and treatment possibilities which can be achieved through this approach. Hopefully these developments within general psychiatry will serve as a challenge to colleagues in the field of mental healthcare and ID to apply the developmental perspective to their practice and deepen their insights into the mental health problems of this population by means of more scientific research on the natural development of these individuals.

**References**


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