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

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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.

Table 1 Prevalence of psychiatric disorders in schoolchildren from four Brazilian regions (n=1,676)

Child psychiatric disorders	Overall sample (n=1,623)	Southeast Caeté (n=434)	Center Goianira (n=406)	Northeast Itaitinga (n=382)	North Rio Preto da Eva (n=401)	p
Any psychiatric disorder	13.1 (11.4-14.7)	14.5 (11.3-18.2)	18.5 (14.8-22.6)	6.8 (4.5-9.8)	12.0 (9.0-15.6)	<0.01
Any anxiety disorder	7.2 (6.0-8.8)	7.8 (5.5-10.8)	9.4 (6.7-12.6)	4.2 (2.4-6.7)	7.2 (4.9-10.2)	0.12
Separation anxiety disorder	1.3 (0.8-2.0)	2.3 (1.1-4.2)	1.5 (0.5-3.2)	0.8 (0.2-2.3)	0.7 (0.2-2.2)	0.15
Specific phobia	3.8 (2.9-4.9)	3.7 (2.1-5.9)	5.2 (3.2-7.8)	2.4 (1.1-4.4)	3.7 (2.1-6.1)	0.23
Social phobia	2.0 (1.4-2.8)	2.5 (1.3-4.5)	3.0 (1.5-5.1)	1.0 (0.3-2.7)	1.2 (0.4-2.9)	0.27
Posttraumatic stress disorder	0.3 (0.1-0.7)	0.5 (0.1-1.7)	0.2 (0.0-1.4)	0.0 (N/A)	0.5 (0.1-1.8)	0.57
Obsessive-compulsive disorder	0.6 (0.3-1.1)	0.2 (0.0-1.3)	0.2 (0.0-1.4)	0.8 (0.2-2.3)	1.0 (0.3-2.5)	0.38
Generalized anxiety disorder	0.4 (0.1-0.8)	0.5 (0.1-1.7)	0.7 (0.2-2.1)	0.0 (N/A)	0.2 (0.0-1.4)	0.37
Any depressive disorder	0.5 (0.2-1.0)	0.9 (0.3-2.3)	0.7 (0.2-2.1)	0.3 (0.0-1.4)	0.0 (N/A)	0.21
Major depression	0.2 (0.0-0.5)	0.5 (0.1-1.7)	0.2 (0.0-1.4)	0.0 (N/A)	0.0 (N/A)	0.34
Dysthymia	0.1 (0.0-0.4)	0.2 (0.0-1.3)	0.0 (N/A)	0.0 (N/A)	0.0 (N/A)	0.43
Any ADHD	4.5 (3.5-5.6)	4.6 (2.8-7.0)	8.1 (5.7-11.2)	1.0 (0.3-2.7)	4.0 (2.3-6.4)	<0.001
Any oppositional/conduct disorder	2.3 (1.6-3.1)	2.8 (1.4-4.8)	4.4 (2.6-6.9)	1.0 (0.3-2.7)	0.7 (0.2-2.2)	<0.001
Oppositional defiant disorder	1.7 (1.0-2.7)	2.5 (1.3-4.5)	3.4 (1.9-5.7)	0.3 (0.0-1.4)	0.5 (0.1-1.8)	<0.01
Conduct disorder	0.6 (0.3-1.1)	0.2 (0.0-1.3)	1.0 (0.3-2.5)	0.8 (0.2-2.3)	0.2 (0.0-1.4)	0.16
Any disruptive disorder*	5.8 (4.7-7.0)	6.2 (4.1-8.9)	9.9 (7.1-13.2)	2.1 (0.9-4.1)	4.7 (2.9-7.3)	<0.001
Other disorders†	1.5 (0.9-2.2)	2.3 (1.1-4.2)	1.5 (0.5-3.2)	1.0 (0.3-2.7)	1.2 (0.4-2.9)	0.04

Data presented as % (95%CI).
ADHD = attention deficit hyperactivity disorder; N/A = not applicable due to 0.0% prevalence.
* Any disruptive disorder: any oppositional/conduct disorder and/or any ADHD.
† Other disorders: substance abuse, tic disorders, eating disorders, and/or psychotic disorders.

The next challenge is to translate evidence into action, scaling up services and human resources to deal appropriately with regional morbidity.

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Psychotic syndrome secondary to meningioma treated with a low dose of olanzapine

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In November 2010, a 60-year-old woman presented for psychiatric evaluation. Her only words were: "It was not my fault." She remained silent for the rest of the interview, with a suspicious look. Her husband added that she had been very