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How to treat fear aggression directed towards unfamiliar people

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Introduction

No two cases are the same in behavioural medicine. Every patient is an individual and they all have different presentations and concerns, but we put a label (diagnosis) on each case to help us define and classify their presentation. Within each diagnosis there can be many different forms/presentations. This presentation will discuss how I approach fear aggression directed towards unfamiliar people and the differences in response to treatment and prognosis seen with different presentations within this diagnosis.

Discussion

Fear and anxiety are normal. Aggression is also normal and can be an appropriate response in the right context and in response to a threat. Normal behaviours such as aggression are generally more varied depending on the situation, while inappropriate behaviours are often less variable and flexible [2]. For example, a dog becoming aggressive towards someone acting strangely, yelling or being threatening would be normal and appropriate in that context. A normal individual would then recover from that incident and shouldn't then worry that all people could be a threat.

However, a dog that is reacting to all/most unfamiliar people who pass by, approach them in public or enter the house is abnormal. We often see the behaviour progress from occasional incidents to more frequent incidents once they reach and progress through sexual (6-12 months old) and social maturity (12-36 months old). Dogs who are anxious and fearful can either run away from an individual (flight response) or become aggressive to try to repel the individual (fight response).

A lot of people feel that dogs who are choosing aggression are just nasty, aggressive dogs, not realising or remembering the motivation and reason behind the aggression – fear. This is easy to do as the animal can look quite confident – it is approaching, tail high and wagging, lunging, snarling, barking etc. This can be the case in the veterinary hospital too, people forget the reason for the aggression and just classify the dog as 'nasty'. The dogs who avoid/retreat or hide are less likely to be presented as they are less obvious in their fear, less of a safety risk and have less impact on the owner's lives. Ultimately though their mental health is compromised, and they should also be treated to improve their quality of life.

Some dogs are what I call "all talk". They're full of bluster, barking, lunging etc but they don't bite unless pushed, or if the person turns the other way they may nip from behind. They are very loud and vocal in their fear. They are also very explosive in the consultation room and bark intensely and excessively at us, even if we don't move or do anything provocative. This can continue for the duration of the 2-3 hour long consultation. The owners are tense and holding on to them for dear life, worried what may happen. We usually try to finish the consultation in as short a time as possible due to the stress on everyone. These dogs are also often less reactive when off lead compared to when on lead as they can keep their distance and don't feel so trapped. At home though they are still "trapped" in a narrow entryway or within the house so they may behave the same as when on lead in public. They

aren't necessarily being "territorial". They are fearful of strangers in and out of the house and those strangers are coming in close proximity to them and invading their home, which just like us should be their "safe space".

I have treated a number of these cases who are very vocal in their fear and they respond very nicely over time. I have used fluoxetine and clonidine in combination along with behaviour modification and environmental management in these patients. Fluoxetine is a selective serotonin reuptake inhibitor (SSRI) which we use as a 'baseline medication' to help reduce their anxiety. It can be very effective as a sole therapy in reducing anxiety, but in cases like this with very explosive and intense fear and reactivity, further help is needed with an adjunctive medication.

There are multiple adjunctive medications that can be used, but in these cases, clonidine is something reached for first and can be very helpful to reduce their explosive response. Clonidine is a centrally acting alpha 2 agonist, reducing noradrenaline release and subsequent sympathetic outflow resulting in reduced heart rate, blood pressure and peripheral resistance. It is commonly used as an antihypertensive agent in people as well as in psychiatry to reduce the sympathetic hyperarousal state present in ADHD, impulsivity and aggression among other things [1]. We generally find it helps slow down their reaction time, it is less intense, and they settle much faster afterwards. We always start the clonidine at a low dose and titrate up, as there is a lot of variability in tolerance/sensitivity to clonidine and the sedative side effects. With the rapid onset of action of clonidine, we quickly see a response and a significant improvement in the dog's response to unfamiliar people. The owners also quickly feel much happier and more confident.

The dog's behaviour in the consultation room at revisits is also much calmer, less reactive and explosive. They are faster to settle and are more responsive to the owners. The medication can't completely eliminate their worry and reactivity, but it helps reduce it and they become much more manageable and better able to learn.

Behaviour modification is aimed at changing their emotional response to people. We want to make the presence of people mean great things are coming, whether games or high value treats and they aren't forced to interact with them. Asking for a behaviour also gives them an alternative response to do and allows the dog to focus on something other than the scary thing.

The dogs who bite first with little warning and who are very unpredictable and more variable in who they react to are the ones with a poorer prognosis and the ones owners are more likely to euthanise. After a couple of incidents, owners can't cope with the stress of anticipating the next incident and the guilt of not doing something earlier. A thorough investigation of the behaviour is key. Use a questionnaire and take a comprehensive history. Ask for a description of exactly what happened in each incident, when/where/what age and who was present etc. We need to know when the incidents occurred, how the patient reacts in various other situations and how its behaviour has progressed over time. The more information you gather the clearer you can be on the clinical picture and prognosis.

Owners need to be warned and prepared that the problem will need lifelong management and there is no 'cure'. The dog won't suddenly love every person. A discussion about how easily this will be for them to manage in their environment and with their pet is important. How manageable the problem is will depend on various factors and varies from household to household. There are a lot of tools that can be used to aid in management and keeping people safe – baby gates, play pens, locks on gates, muzzles etc.

Conclusion

While I believe you can and should start treatment for these cases in general practice, a lot of these patients will involve significant, ongoing, medication and treatment adjustments, client support and management. They should not be started on psychotropic medications such as fluoxetine and then left be. This will result in treatment failure and clients that become disheartened and cynical of the role of medication in the treatment of behaviour problems. If this ongoing support isn't possible or no progress is being made, referral to a veterinary behaviourist is needed.

References

1. Ogata, Niwako, and Nicholas H Dodman. "The Use of Clonidine in the Treatment of Fear-Based Behavior Problems in Dogs: An Open Trial." Journal of Veterinary Behavior: Clinical Applications and Research 6.2 (2011): 130–137. Web.

2. Overall, Karen. Manual of Clinical Behavioral Medicine for Dogs and Cats. London: Elsevier Health Sciences, 2013. Print.