

# Aggression - Treatment

**Breck Borcherding MD** 

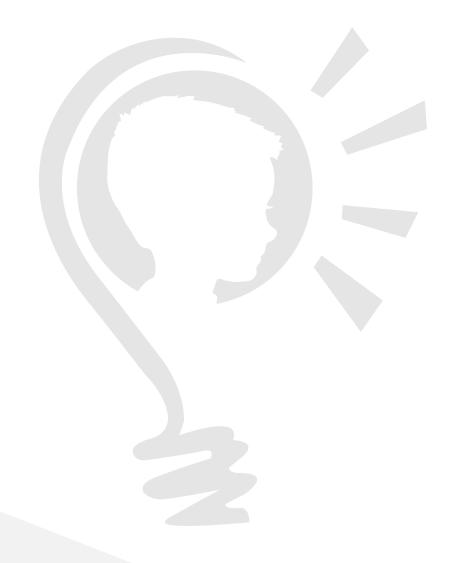
Department of Psychiatry and Behavioral Sciences

Department of Pediatrics

Montefiore Medical Center/ The Albert Einstein School of Medicine







#### Speaker:

#### **Breck Borcherding MD**

Department of Psychiatry and Behavioral Sciences

Department of Pediatrics

Montefiore Medical Center/

The Albert Einstein School of Medicine

Contact:

718-839-7308

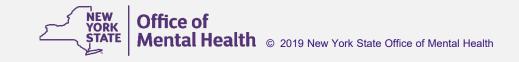
bborcher@montefiore.org





# Disclosures

Neither I nor my spouse/partner has a relevant financial relationship with a commercial interest to disclose.





1. Do a thorough psychosocial and comorbidity assessment. Set targets for treatment. Use MOAS for aggression, other scales for comorbidity.



- 1. Do a thorough psychosocial and comorbidity assessment. Set targets.
- 2. Psychoeducation for family and stakeholders.



- 1. Do a thorough psychosocial and comorbidity assessment. Set targets.
- 2. Psychoeducation family and stakeholders.
- 3. Assess safety as it impacts treatment choice.



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- 3. Assess safety as it impacts treatment choice.
- 4. Begin to refer for psychosocial therapies (always) and school/community supports as needed.



## 4a) Psychosocial therapies

#### 1. Individual therapies

- 1. CBT (cognitive behavioral)
- 2. Modular treatments for comorbidity

#### 2. Parent or parent-child therapies

- 1. PCIT
- 2. Triple P/PPP
- 3. Etc.

#### 3. Systemic therapies

- 1. Multisystemic therapy
- 2. Parental/marital/family therapies



#### 4b) Child therapies

- Coping skills for child: learning how to calm self, what puts them in the "red zone", what to do to prevent, when best time to intervene
- An individualized recipe such as "modular" therapies (<u>Match-ATDC</u> Bruce Chorpita and John Weisz) for comorbidity of anxiety, trauma, depression, conduct
- Typically in concert with parent-child work



### 4c) Parent-child therapies

- First focus on engagement and positives (e.g. play, read, "catching them being good"
- Attention to how limits set/structure provided
  - Proactive better than reactive
  - Parents need to be clear about what problem behaviors targeted
  - Clear about when occurrence is a problem
  - Pre-decided (collaboratively?), realistic rewards and consequences
  - Apply fairly and nonjudgmentally/ "emotionally neutral"
  - Both parents work together and follow through



- 1. Do a thorough psychosocial and comorbidity assessment. Set targets.
- 2. Psychoeducation family and stakeholders.
- 3. Assess safety as it impacts treatment choice.
- 4. Begin to consider psychosocial therapies (almost always) and school/community supports as needed.
- 5. Treat complex comorbidity intensely.



- 1. ADHD and aggression
- 2. Anxiety/depression/bipolar/DMDD and aggression
- 3. Conduct (undersocialized and callous traits) and aggression
- 4. Others and aggression
  - 1. Trauma
  - 2. Intermittent explosive disorder
  - 3. Academic and developmental problems including autism
  - 4. Traumatic brain injury
  - 5. Etc.





### 5b) Aggression and ADHD

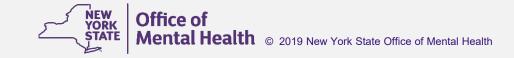
• Blader et al study- JAACP (2021) 60: 236-251.

In children with ADHD and aggression, optimizing the stimulant dose in 63% of pre-study children (ADHD-treated with stimulant before the study) negated the need to move to the study additional treatments of valproate or risperidone

 May need to add alpha-adrenergic meds clonidine or guanfacine in addition to a stimulant.

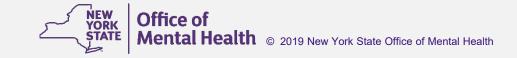


- 1. ADHD and aggression
- 2. Anxiety/depression/bipolar/DMDD and aggression
- 3. Conduct (undersocialized and callous traits) and aggression
- 4. Others and aggression
  - 1. Trauma
  - 2. Intermittent explosive disorder
  - 3. Academic and developmental problems including autism
  - 4. Traumatic brain injury
  - 5. Etc.



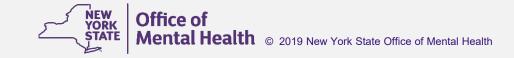


- 1. ADHD and aggression
- 2. Anxiety/mood and aggression
- 3. Conduct (undersocialized and callous traits) with predatory aggression- a special case for intense systemic treatments
- 4. Others and aggression
  - 1. Trauma
  - 2. Intermittent explosive disorder
  - 3. Academic and developmental problems including autism
  - 4. Traumatic brain injury
  - 5. Etc.



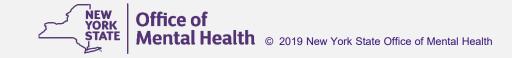


- 1. ADHD and aggression
- 2. Anxiety/depression/bipolar/DMDD and aggression
- 3. Conduct (undersocialized and callous traits) and aggression
- 4. Other problems and aggression
  - 1. Trauma
  - 2. Intermittent explosive disorder (unpremeditated and impulsive)
  - 3. Academic and developmental problems including autism
  - 4. Traumatic brain injury
  - 5. Etc.





- 1. Do a thorough psychosocial and comorbidity assessment. Set targets.
- 2. Psychoeducation family and stakeholders.
- 3. Assess safety as it impacts treatment choice.
- 4. Begin to consider psychosocial therapies (almost always) and school/community supports as needed.
- 5. Treat complex comorbidity intensely.
- 6. Consider carefully antipsychotics (SGA's) or other meds for acute use.





#### SUAY panel 2021 Safer Use of Antipsychotics in Youth

- The consensus panel focused on developing an approach to reducing potentially inappropriate prescribing of antipsychotic medications to children and adolescents. The overall process involves:
  - Identifying the target symptoms
  - Ruling out potential diagnoses
  - Reviewing current and past treatments (e.g., medications and psychotherapies)
  - Considering treatment alternatives (e.g., dose or medication changes, lower risk medications, psychotherapy).

# 6a) Antipsychotics in aggression

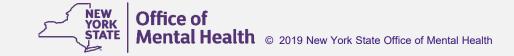
- · Liberally refer or seek consultation at this point.
- Use SGA's when the situation is unsafe acutely (i.e., in ER). Of course, hospitalize/refer if warranted.
- If you accept a patient from a hospital, make sure you discuss with the attending a plan if patient backslides.
- Use if psychosocial and comorbid treatments are exhausted and there is significant severity/dangerousness.
  - CMS Measures Inventory Tool 2800 (metabolic monitoring) and 2801 (first line psychosocial treatments)
  - SWAY- setting targets and durations for antipsychotic treatment
- Educate the family about risks and short term duration as goal. These
  meds are powerfully effective and families may argue about
  discontinuation when they work. Discontinue slowly after 6 months or
  so.

# 6b) Antipsychotics in aggression

- Choose risperidone or aripiprazole as trial.
   These are only FDA approved for irritability in autism.
- Dosing
  - Initiation
  - Maximizing
  - Discontinuation
- Side effects monitoring

## 6c) Antipsychotics in aggression

- Risperidone
  - Starting dose 0.5-1.0 mg/day
  - Dose range 1.5-4.0 mg
  - Titrate 0.5-1.0 mg about every 5 days according to side effect/symptom change
- Aripiprazole
  - Starting dose 2-5 mg
  - Dose range 2.5-20 mg
  - Titrate 2-5 mg biweekly according to side effect/symptom change
- Taper no faster than up titration. Slow down if necessary.
- Be aware of p450 enzyme interactions if polypharmacy.





## 6d) Antipsychotic side effects

- Common, serious: weight gain, hyperlipidemia, diabetes
- Rare, serious: Neuroleptic malignant syndrome, agranulocytosis (mostly clozapine), increased LFTs, tardive dyskinesia (long term)
- Cognitive: sedation, slowed, memory
- Neurologic: dystonia, akathisia, akinesia, rigidity, tremor, lowered seizure threshold, withdrawal dyskinesia
- Endocrine: elevated prolactin, gynecomastia, galactorrhea (risperidone, NOT aripiprazole)
- · Cardiovascular: increased QT (ziprasidone), orthostatic hypotension



#### Monitoring Strategies in Children and Adolescents **Treated With Antipsychotic Agents**

Assessment	Routine Follow-up
Personal and family medical history	Annually
Lifestyle behaviors	Each visit
Sedation/somnolence	Each visit
Sexual/reproductive dysfunction	During titration, then every 3 months
Parkinsonism, akathisia	During titration, at 3 months, then annually
Height, weight, BMI	Each visit
Blood pressure and pulse	At 3 months and annually
Electrolytes, blood count, renal and liver function	Annually
Fasting blood glucose and lipids	At 3 months, then every 6 months
Liver function tests	At 3 months, then annually
Prolactin	Only if symptomatic
ECG	Only if taking ziprasidone

Correll CU. J Am Acad Child Adolesc Pscyhiatry. 2008;47:9.



## 6b) Other meds in aggression

- Valproate
- Carbamazepine
- Neurontin
- Lamotrigine
- Lithium
- Propranolol

Although often used, and sometimes effective in individual cases, there is not good data on their general effectiveness before using previous parts of the algorithm. Seek consultation.



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- 3. Assess safety as it impacts treatment choice.
- Begin to consider psychosocial therapies (almost always) and school/community supports as needed.
- 5. Treat complex comorbidity intensely.
- 6. Consider carefully antipsychotics (SGA's) for acute use.
- 7. Follow-up with all stakeholders and team members, assess target responses, monitor changes in comorbidity, SEEK CONSULTATION AS NEEDED.



# Aggression readings

Daniel Connor et al, <u>JI Child Adolescent Psychopharmacology</u> 2019 29:576-591. Monograph on subtyping aggression and responses to treatment.

"Psychosocial and Pharmacologic Interventions for Disruptive Behavior in Children and Adolescents." AHRQ publication No. 15, October 2015. An evidence-based review.

<u>T-MAY</u>, Treatment of Maladaptive Aggression in Youth Reference Guide. Rutgers CERTs, 2010,

https://www.ahrq.gov/sites/default/files/wysiwyg/chain/practice-tools/tmay-final.pdf