Aggression - Treatment

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Disclosures

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

Aggression algorithm

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

Aggression algorithm

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

Aggression algorithm

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

Aggression algorithm

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 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 (Match-ATDC 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

Aggression algorithm

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.

5a) Aggression and comorbidity

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.

5a) Aggression and comorbidity

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.

5a) Aggression and comorbidity

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.

5a) Aggression and comorbidity

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.

Aggression algorithm

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 Psychiatry*. 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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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) 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, Jl Child Adolescent Psychopharmacology 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.

T-MAY, 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