



Aggression - Treatment

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Project TEACH



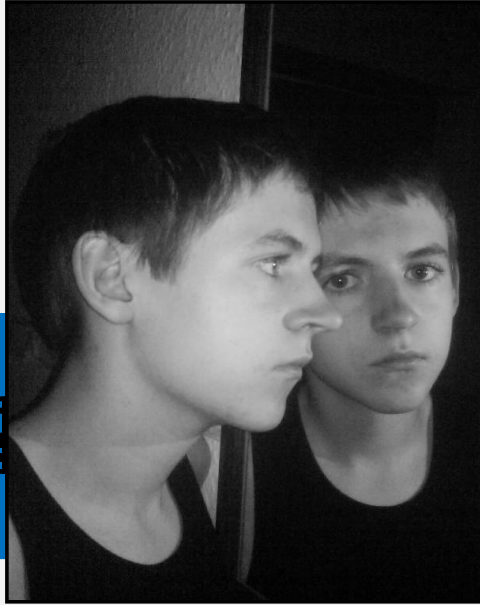


Learning Objectives

1. Learn about a resource to help guide assessment and treatment of aggression
2. Identify the components of an effective treatment team including family members and professionals
3. Understand the psychopharmacologic approach to clinical aggression
 - Selecting medications
 - Initiating and Tapering dosages
 - Monitoring Improvement
 - Identifying and minimizing medication side effects



TREATMENT OF
MALADAPTIVE
AGGRESSION
IN YOUTH



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CALIFORNIA DEPARTMENT OF
Mental Health

The Rutgers CERTS Pocket Reference Guide

For Primary Care Clinicians and Mental Health Specialists

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Center for Education and Research on Mental Health Therapeutics (CERTS), Rutgers University, New Brunswick, NJ*

The REACH Institute (Resource for Advancing Children's Health), New York, NY*

The University of Texas at Austin College of Pharmacy*

New York State Office of Mental Health

California Department of Mental Health

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T MAY- Treatment of Maladaptive Aggression in Youth

- Published in Pediatrics 2012
- Expert panel guidelines
- The Fundamental Assessment Task is to determine the **main driver** of aggression
- Then treatment is that of the **underlying condition**- same as treatment of the fever is the treatment of the cause of the fever.





T-MAY Algorithm:

T-MAY RECOMMENDATIONS

ASSESSMENT + DIAGNOSIS

Engage patients and parents (emphasize need for their on-going participation)
 Conduct a thorough initial evaluation and diagnostic work-up before initiating treatment
 Define target symptoms and behaviors in partnership with parents and child
 Assess target symptoms, treatment effects and outcomes with standardized measures

INITIAL TREATMENT + MANAGEMENT PLANNING

Conduct a risk assessment and if needed, consider referral to mental health specialist or ER
 Partner with family in developing an acceptable treatment plan
 Provide psychoeducation and help families form realistic expectations about treatment
 Help the family to establish community and social supports

PSYCHOSOCIAL INTERVENTIONS

Provide or assist the family in obtaining evidence-based parent and child skills training
 Identify, assess and address the child's social, educational and family needs, and set objectives and outcomes with the family
 Engage child and family in maintaining consistent psychological/behavioral strategies

MEDICATION TREATMENTS

Select initial medication treatment to target the underlying disorder(s); follow guidelines for primary disorder (when available)
 If severe aggression persists following adequate trials of appropriate psychosocial and medication treatments for underlying disorder, add an AP, try a different AP, or augment with a mood stabilizer (MS)
 Avoid using more than two psychotropic medications simultaneously
 Use the recommended titration schedule and deliver an adequate medication trial before adjusting medication

SIDE-EFFECT MANAGEMENT

Assess side-effects, and do clinically-relevant metabolic studies and laboratory tests based on established guidelines and schedule
 Provide accessible information to children and parents about identifying and managing side-effects
 Use evidence-based strategies to prevent or reduce side-effects
 Collaborate with medical, educational and/or mental health specialists if needed

MEDICATION MAINTENANCE + DISCONTINUATION

If response is favorable, continue treatment for six months.
 Taper or discontinue medications in patients who show a remission in aggressive symptoms ≥ 6 months

Assessment & Diagnosis

Treatment Planning

Treatment

Ongoing Management

4-MAY RECOMMENDATIONS



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MEDICATION MAINTENANCE & DISCONTINUATION

If response is favorable, continue treatment for six months
Taper or discontinue medications in patients who show a remission in aggressive symptoms 6 months





T-MAY Recommendations

Treatment Planning

- Conduct a **risk assessment** & if needed, consider referral to a MH specialist or ER, Urgent Care, CPEP, Mobile Crisis service
- Partner with family in developing an acceptable treatment plan
- Provide psycho-education to help families form reasonable expectations
- Help the family establish community & social supports





T-MAY Recommendations

Psychosocial Interventions:

- ▶ Provide or assist family in obtaining evidence-based parent- and child- skills training
- ▶ Identify, assess, and address the child's social, educational, & family needs, and set objectives & outcomes with the family
- ▶ Enlist & engage the child and family in maintaining consistent psychological & behavioral strategies





Psychosocial Interventions

- Address educational issues
- Refer for afterschool/summer activities
- Address the ongoing safety and ACES in the home
- Counsel your families on parenting approaches
- Refer for evidence-based psychosocial interventions





Psychosocial therapies for aggression and comorbidity targets

1. Individual child therapies

1. CBT (cognitive behavioral) therapies for self management
2. Treatments for trauma or other comorbidity

2. Parent-child therapies for behavior

1. Parent education
2. PCIT
3. Triple P/PPP
4. Behavioral therapies focusing on managing antecedents and consequences

3. School related supports and therapies

1. Data gathering and positive behavioral supports

4. Systemic therapies for older patients

1. Individual/parental/marital/family therapies
2. Multisystemic therapy



Child only psychotherapies

- Coping skills for child: learning how to calm self, what puts them in the aggressive “red zone”, what to do to prevent, when best time to intervene
- An individualized recipe such as “modular” therapies for comorbidity of anxiety, trauma, depression, ADHD, conduct
- **But BEST in concert with parent-child work**





Parent-child therapies for aggression

- Cycles of coercive aggression within a family can be intergenerational and trauma based (Gerald Patterson, 1980s)
 - Child observes modeled “successful” aggression in family
 - Escalation of violence by child to have family submit to child’s wants (appeasement)
 - Pattern of aggression is reinforced in all family members
- Antecedents and consequences of aggression are important to consider in all cases. **Assess disciplining styles of parents.** Getting dads involved can turn the case around.
- **THINK ABOUT A-B-C’s**



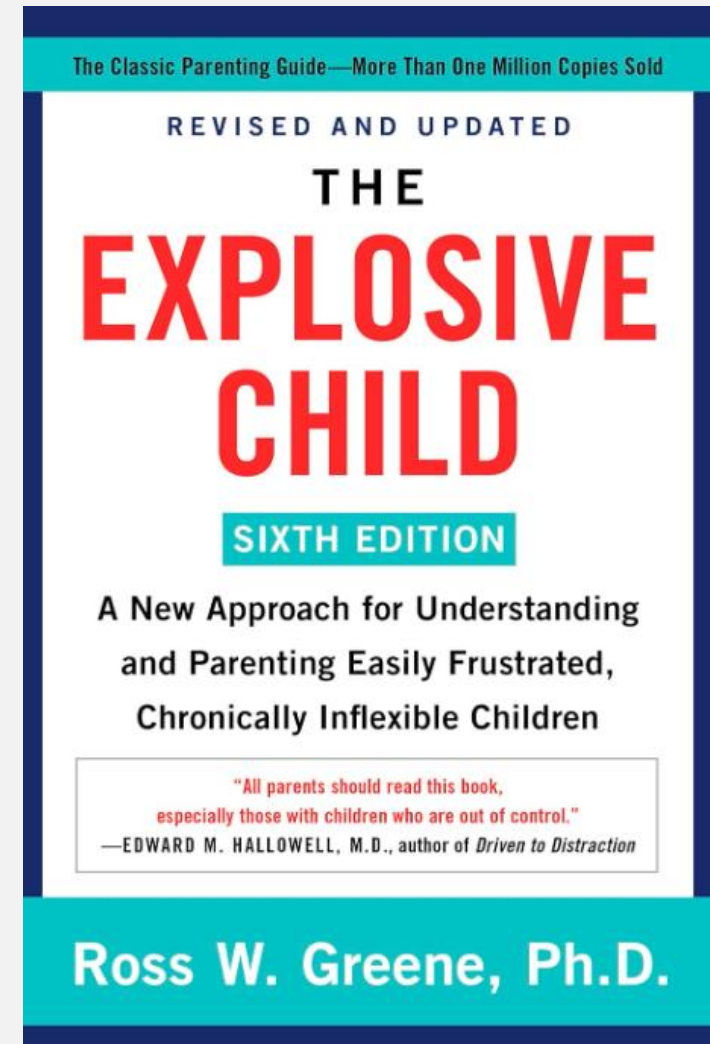
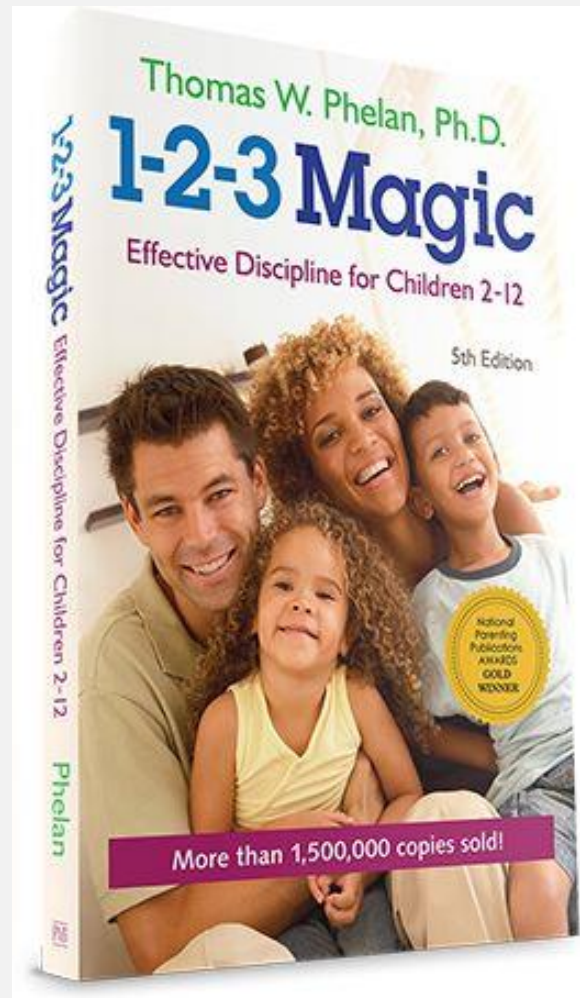


Behavioral Principles

- Involve the parent: “I can’t do it without you. Pills alone won’t give your child the skills he/she needs.”
- First focus on engagement and positives (e.g. play, read, “catching them being good”)
- Attention to how limits set and structure provided at home
 - Proactive parents better than reactive. Pre-decided **realistic** positive rewards and consequences are most useful.
 - Parents need to be clear about which problem behaviors targeted and be clear about when occurrence is a problem.
 - **Ignoring** behaviors. Parents should track relative positive and negative comments. Under stress we all tend to be negative in tone.
 - Apply fairly and nonjudgmentally/ “emotionally neutral”.
 - All parental figures work together and follow through.



RESOURCE SLIDE: Parenting Books you can read to help the parents of your Patients



4-MAY RECOMMENDATIONS



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INITIAL TREATMENT & MANAGEMENT PLANNING

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PSYCHOSOCIAL INTERVENTIONS

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Engage child and family in maintaining consistent psychological/behavioral strategies



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SIDE-EFFECT MANAGEMENT

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MEDICATION MAINTENANCE & DISCONTINUATION

If response is favorable, continue treatment for six months
Taper or discontinue medications in patients who show a remission in aggressive symptoms 2-6 months





T-MAY Recommendations

Medication Treatments:

- Treat the 1^o Disorder (underlying condition) first, using recognized guidelines for that disorder.
- **ONLY IF** severe aggression persists after adequate psychosocial & medication treatments for the 1^o Disorder, **add an AP**
 - If first AP fails, try another, or consider mood stabilizer
- If possible, avoid using more than two psychiatric medications simultaneously
- Use recommended titration schedule and deliver adequate doses before adjusting or changing medications

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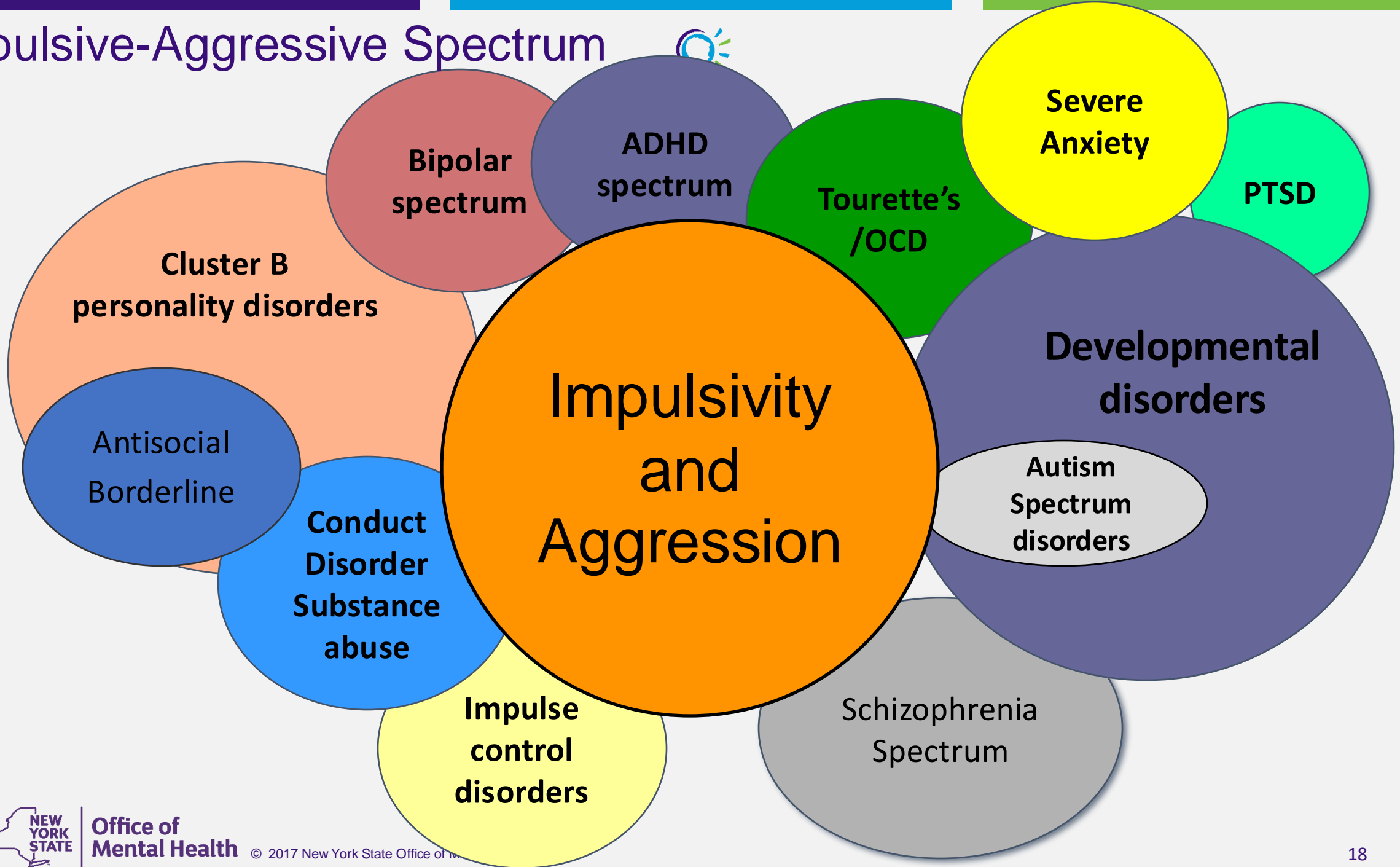


Identify and Treat the Primary Issue First

Don't start a referral, medication, or therapy for "aggression" until we have implemented treatment for the primary problem



Impulsive-Aggressive Spectrum





DSM Diagnoses with Aggression

- Anxiety
- Autism Spectrum Disorders
- ADHD
- PTSD
- Impulse Control Disorders
- Bipolar Disorder
- Disruptive Mood Dysregulation Disorder (DMDD)
- Conduct Disorder
- Substance Use Disorders
- Schizophrenia/ Psychotic Disorders
- Personality Disorders/ Cluster B/ Antisocial Personality Disorder





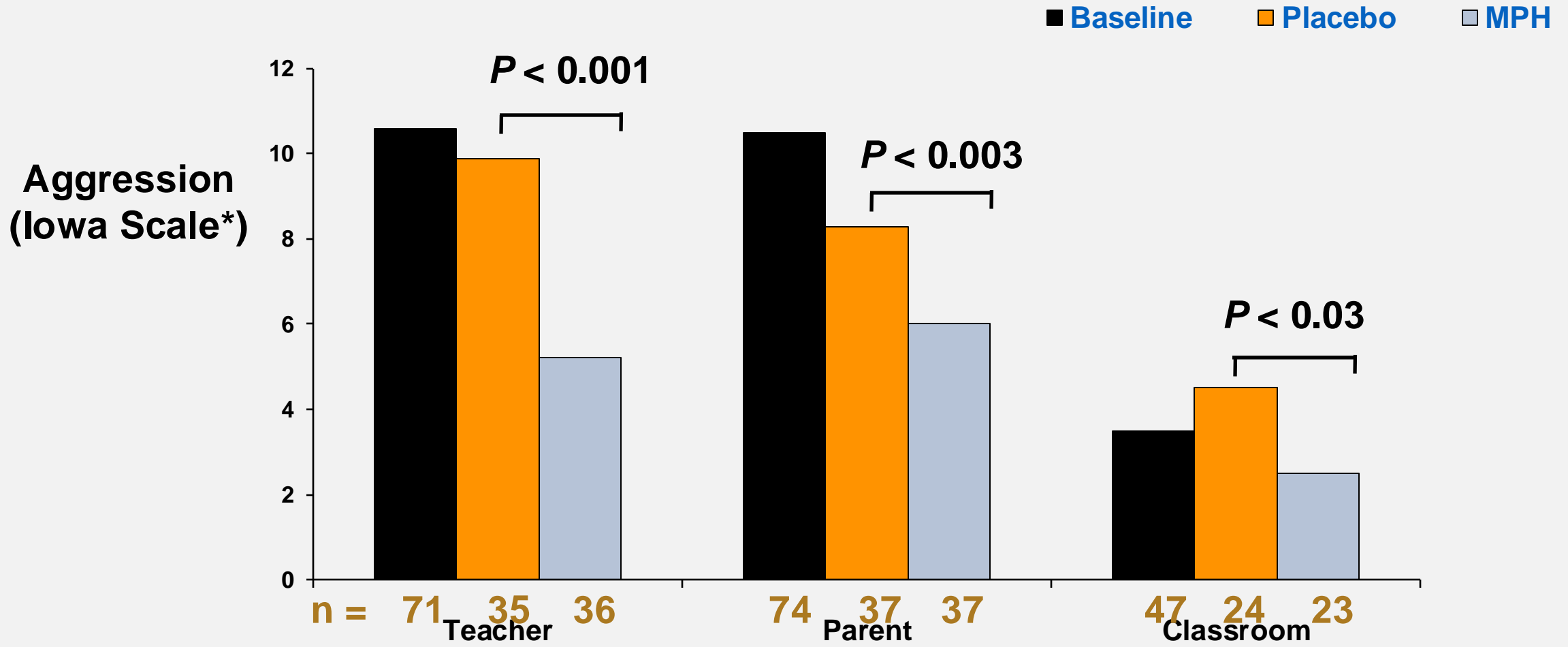
What is the Place of Medication in the Management of Aggression?

- Treatment of the underlying condition- e.g. ADHD – stimulant, non stimulant such as alpha-2 agonist
- Anxiety/Depression – SSRIs- etc.

View aggression
as a symptom,
not a diagnosis!



Methylphenidate in ADHD/CD: Impulsive Aggression



*Sum of 5 items, range 0-15





Before adding medications for aggression, make sure the primary medications for the disorder have been maximized

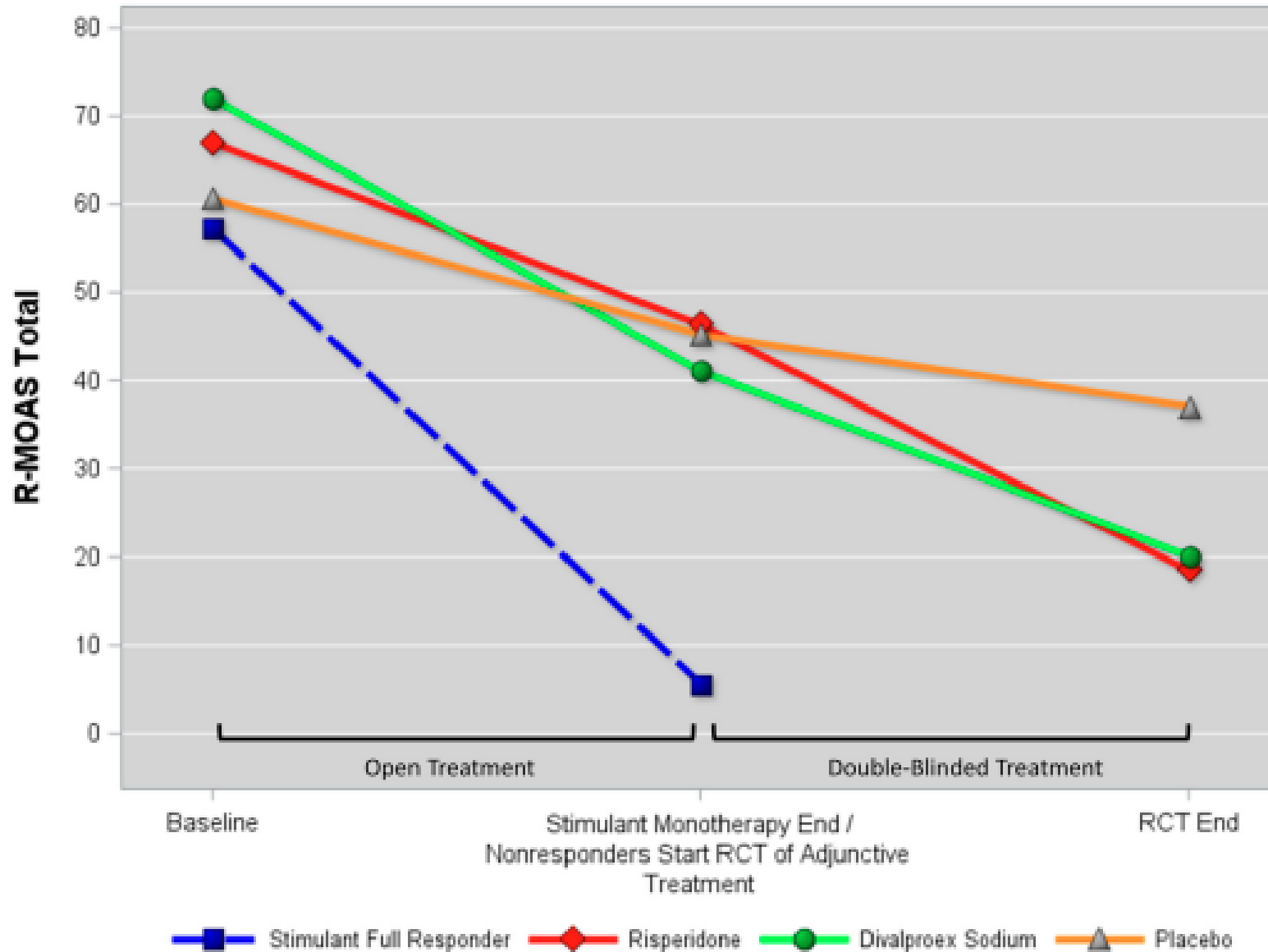




Optimize meds for the primary disorder first

- Don't add an alpha agonist or an atypical antipsychotic to combat aggression in an ADHD child until we have maximized stimulants.
- Don't add an antipsychotic for an aggressive anxious child until SSRI trials have truly failed

FIGURE 3 Retrospective Modified Overt Aggression Scale Scores of Treatment Groups



Joseph Blader et al JAACAP 20

Stepped Treatment for ADHD and Aggression

Note: RCT = randomized controlled trial; R-MOAS = Retrospective Modified Overt Aggression Scale.



IF severe aggression persists despite,

- treatment of the underlying condition has been optimized
- psychosocial treatments are not successful
- control of the initial level of aggression is **urgent**
- Consider: second generation antipsychotic medication trial



Atypical Antipsychotics: Optimal Dosing/Titration Strategies for Children and Adolescents

Atypical Anti- psychotics	Starting Daily Dose	Titration Dose, q3-4 day (~Min. days to antipsychotic dose)	Usual Daily Dose Range in Aggression*		Usual Daily Dose Range in Psychosis	
			Child	Adolescent	Child	Adolescent
Aripiprazole	2.5-5 mg	2.5-5 mg (7-10 days)	2.5-15 mg	5-15 mg	5-15 mg	5-30 mg
Risperidone	0.25 mg for children 0.50 mg for adolescents	0.5-1 mg (10-15 days)	1.5-2 mg	2-4 mg	3-4 mg	3-6 mg
Olanzapine	2.5 mg for children 2.5-5 mg for adolescents	2.5 mg (10-15 days)	NDA	NDA	7.5-12.5 mg	12.5-20 mg
Quetiapine	12.5 mg for children 25 mg for adolescents	25-50 mg to 150 mg then 50-100 mg (18-30 days)	NDA	NDA	NDA	300-600 mg
Ziprasidone	0.25 mg for children 0.50 mg for adolescents	20 mg for children 20-40mg for adolescents (18-30 days)	NDA	NDA	NDA	NDA; (in adults, 160-180mg)
Clozapine	6.25-25 mg	1-2x starting dose (18-30 days)	150-300 mg	200-600 mg	150-300 mg	200-600 mg**

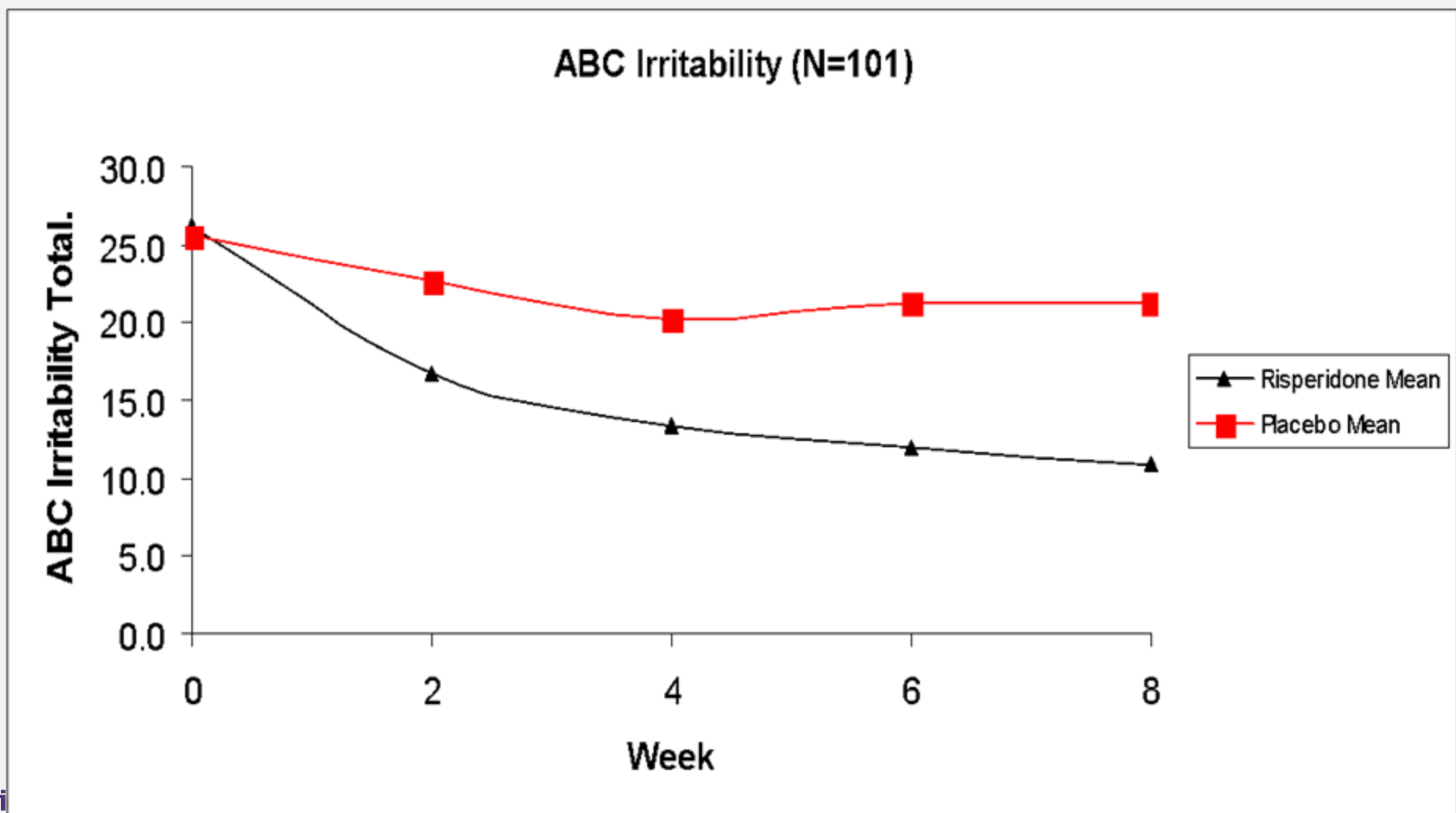
NDA = no data available.

*There is little information to guide dosing strategies for aggression. However, for aggressive children treated with risperidone, doses are about half that of the usual antipsychotic dose.

**In treatment resistant schizophrenic adults, a serum clozapine level (of the parent compound) greater than 350mg/dl is generally required for efficacy.



Resource: Risperidone in Autism: Irritability Scale





Atypical Antipsychotics in Disruptive Behavior Disorders With Aggression: Levels of Evidence

Atypical Antipsychotics	Short-Term Efficacy
Risperidone	A
Aripiprazole	B*
Olanzapine	C
Ziprasidone	C
Clozapine	C
Quetiapine	D

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A = >2 randomized, controlled studies; B = 1 randomized, controlled study; C = clinical experience, eg, open studies, case reports, etc., D = no data or negative outcome.

- Studies done with aggression/irritability in autism: Based on all available RCTs thru 8/2013. Adapted from Jobson KO, Potter WZ. *Psychopharmacol Bull.* 1995;31:457-459.





Baseline Labs for Atypicals

- Glucose
- **Lipid panel**
- CMP
- CBC





Monitoring

- Height
- Weight
- Pulse
- Blood pressure

RESOURCE SLIDE - ADA/APA

Recommended Monitoring Protocol for Patients on AP's

	Baseline	4 Weeks	8 Weeks	12 Weeks	Quarterly	Annually	5 Years
Personal/Family History	X						
Weight/BMI	X	X	X	X	X		
Waist Circumference	X					X	
Blood Pressure	X			X		X	
Fasting Plasma Glucose	X			X		X	
Fasting Lipid Profile	X			X			X

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MEDICATION MAINTENANCE & DISCONTINUATION

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Taper or discontinue medications in patients who show a remission in aggressive symptoms 6 months





Atypical Antipsychotics: Side Effects

- Sedation
- Weight gain
- Metabolic Syndrome
- Gynecomastia/Galactorrhea/Amenorrhea
- Cardiac (ziprasidone)
- Motor
 - Akathisia (Barnes Akathisia Rating Scale)
 - inner restlessness and externally observable restlessness
 - Extrapyramidal side effects (Simpson Angus Scale)-Parkinsonism
 - Shuffling, gait, rigidity, tremor, salivation, head rotation, eye rolling
 - Tardive Dyskinesia (**A**bnormal **I**nvoluntary **M**ovement **S**cale) AIMS
 - Special focus on the jaw, tongue, perioral area





- Guidelines recommend maintaining an atypical for about 6 months.
- The intent is to build self regulation skills that will allow the gradual withdrawal and cessation of meds after 6 months





T-MAY Recommendations

Ongoing Management

- Start low, go slow, taper slow
- Routinely assess for side effects and drug interactions, including clinically relevant metabolic studies
- Provide info to children & parents re: side effects
- Use E-B strategies to prevent-reduce side effects
- Collaborate with medical, educational, and/or MH specialists as needed





**Reassess
Reassess
Reassess**

Medications needed for aggression at one time may no longer be needed.

Don't blindly refill prescriptions or accept another provider's refills without a reassessment





Aggression Treatment Pearls

- Form a team – Enlist the family in reading (Ross Greene, etc.) and problem-solving
- Diagnose and aggressively treat any underlying disorder, especially ADHD/ODD
- Encourage use of behavioral strategies, building new skills
- If/when all of the above aren't enough, consider atypical or other agents!



We are here to help!

- www.projectteachny.org
- 1-855-227-7272





Resource: Atypical Toolbox

Atypical Antipsychotic	Start at (mg / day)	Target Dose (mg/day)	Monitor	Watch Out For
Risperidone	0.25-0.50	1-3	Weight/Height/BMI	EPS/TD
Aripiprazole	2.5-5	5-20	Weight/Height/BMI	EPS
Quetiapine	50-100	300-600	Weight/Height/BMI	
Ziprasidone	20-40	80-160	Weight/Height/BMI ECG	Take with food, assess cardiac risk factors
Olanzapine	5	5-20	Weight/Height/BMI	Choles/FAs



Resource: T-MAY Resources

- Complete 38-page Toolkit: go to website to download pdf: www.TheReachInstitute.org (see Footer– “Resources”)
- Knapp P, et al., & the T-MAY Steering Group. Treatment of Maladaptive Aggression in Youth (T-MAY) Guidelines I. Family Engagement, Assessment & Diagnosis, and Initial Management. *Pediatrics*, 129:e1562-1576, 2012
- Scotto Rosato N, et al., & the T-MAY Steering Group. Treatment of Maladaptive Aggression in Youth (T-MAY) Guidelines II. Psychosocial Interventions, Medication Treatments, and Side Effects Management. *Pediatrics*, 129:e1577-1586, 2012
- Pappadopulos E, et al. Treatment of Maladaptive Aggression in Youth (T-MAY). Results from a Consensus Survey of Experts-recommended Best Practices. *J Child Adol Psychopharm*, 21:505-515, 2011

