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FAMILIES THRIVE WITH GOOD MENTAL HEALTH

Aggression: Treatment

Zoya Popivker, DO
Child and Adolescent Psychiatrist
Northwell Health

Presenter:

Zoya Popivker, D.O.

Northwell Health
zpopivker@northwell.edu
516-927-1630

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Disclosures

"Neither we nor our spouses/partners has a relevant financial relationship with a commercial interest to disclose.

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

Poll:

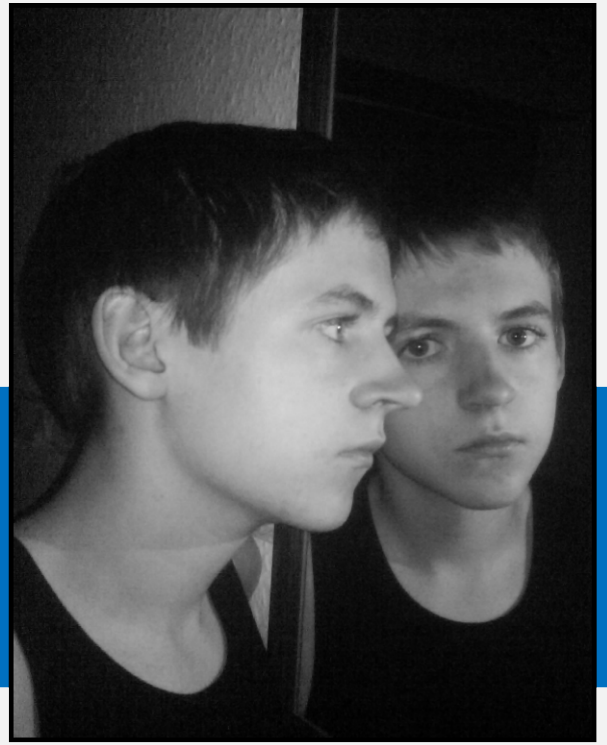
- How common it is in your practice for families to come to you specifically with concerns about a child's aggressive behaviors?
  - Very Common
  - Once in a While
  - Rare

Poll:

- When a patient has presented with concerns about aggression, which of these strategies have you typically used?

  (Select all that apply)

  - Referred to a mental health or another specialist.
  - Prescribed or adjusted medication.
  - Monitored the situation with planned follow-up.
  - Felt unable to adequately address the issue.
  - Called Project TEACH.



TREATMENT OF MALADAPTIVE AGGRESSION IN YOUTH

T-MAY

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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The REACH Institute

California Department of Mental Health

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TMAY - Treatment of Maladaptive Aggression in Youth

- Published in Pediatrics 2012
- Expert panel guidelines

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

Note: The order of these recommendations may be tailored to each patient's specific condition and needs.

Assessment & Diagnosis

Treatment Planning

Treatment

Ongoing Management

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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

-CHADD

-Parent To Parent of NYS www.ptopnys.org

-NY State Parent Network parentnetworkwny.org

-Families Together in New York State www.ftnys.org
- Advocacy Group –Parent support

-HealthyChildren.org

-Understood www.understood.org – high quality information about schools. ADHD, learning

-National Alliance for the Mentally Ill: www.nami.org

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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 the ongoing safety and ACES in the home
- Address educational issues
  - Assess school support: IEP, 504, need for behaviorist consult, FBA
- Refer for afterschool/summer activities
  - Structured community activities
- Counsel your families on parenting approaches
- Refer for evidence-based psychosocial interventions

Psychosocial therapies for aggression and comorbidity targets

Individual child therapies

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

Parent-child therapies for behavior

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

School related supports and therapies

1. Data gathering and positive behavioral supports

Systemic therapies for older patients

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

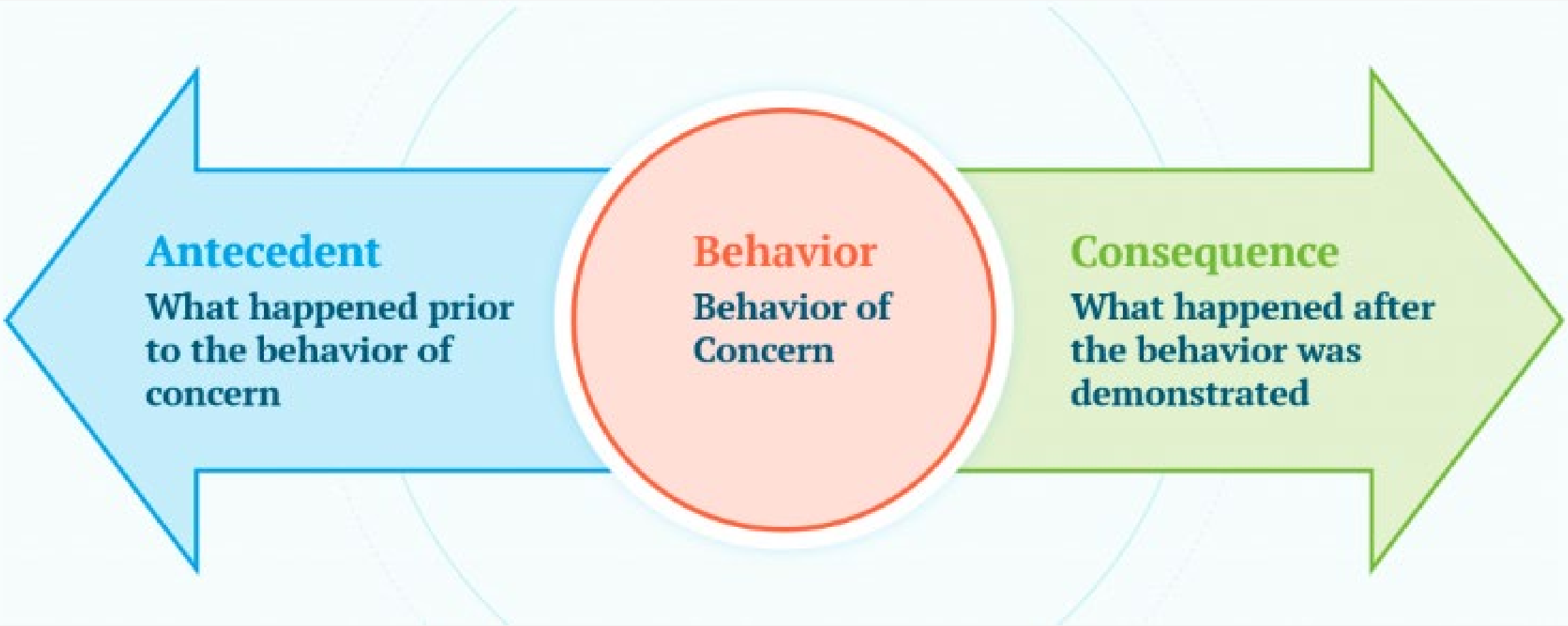
Child Only Psychotherapies

- 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

Back to the ABC's



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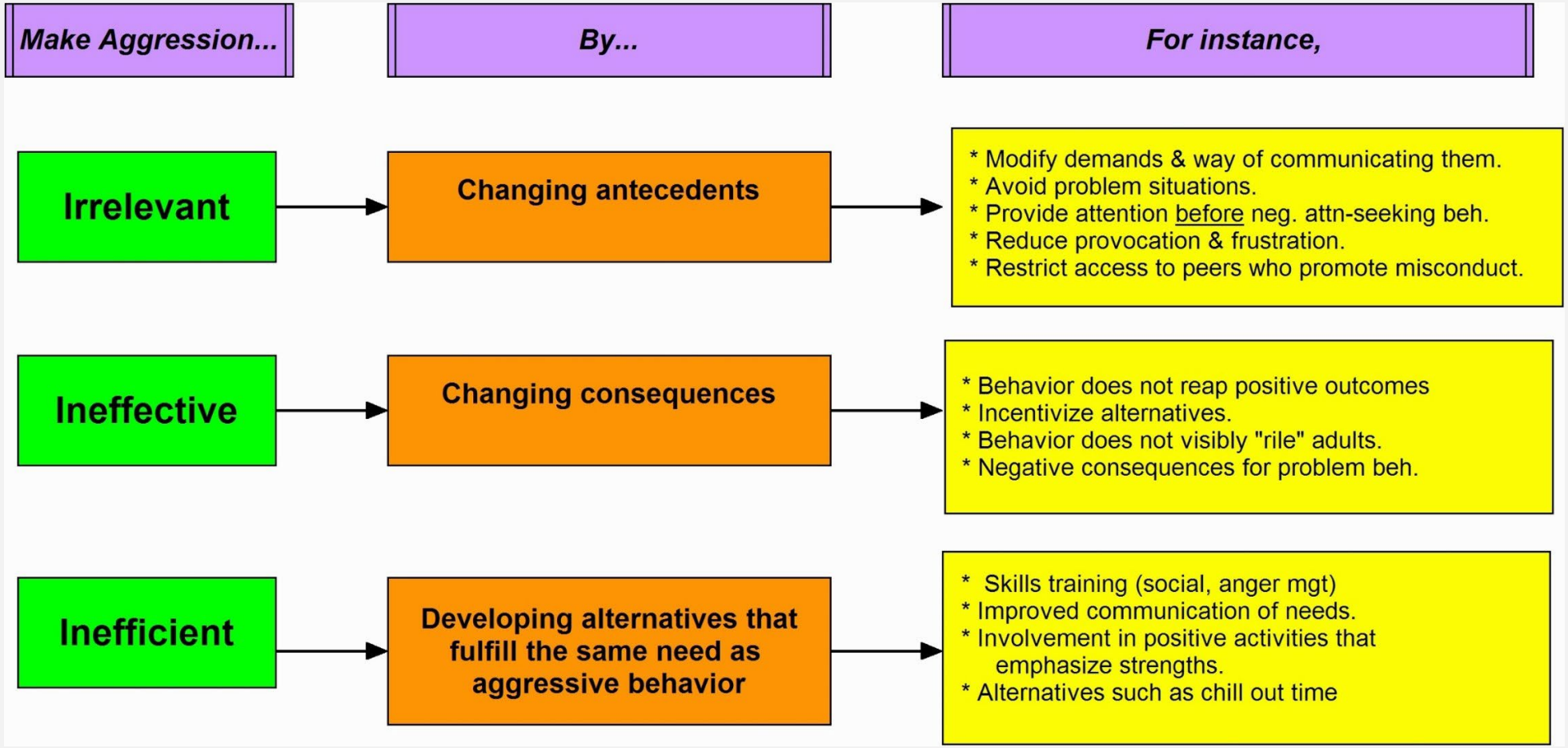
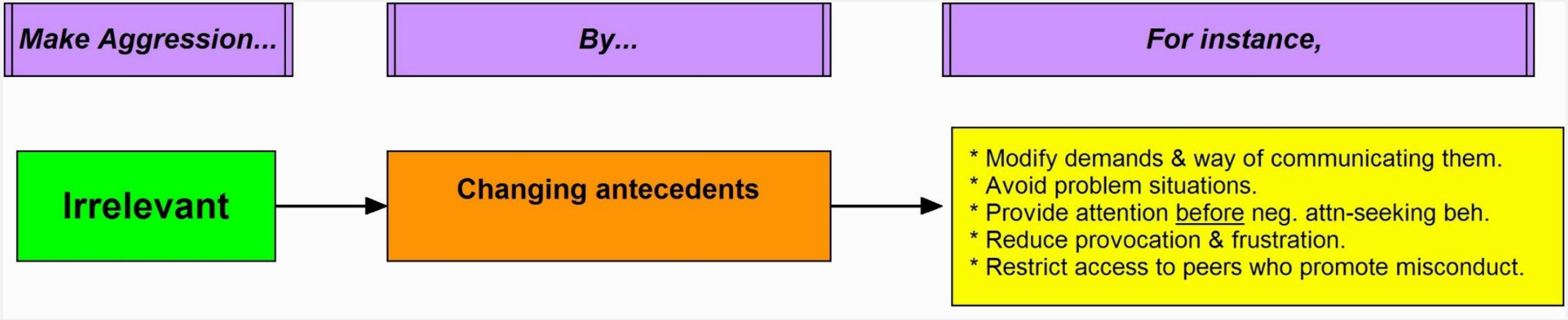
Psychosocial Treatments



Blader & Jensen, 2007; Blader & Connor, 2017. Based on O'Neill et al, 1997

Psychosocial Treatments: Antecedents



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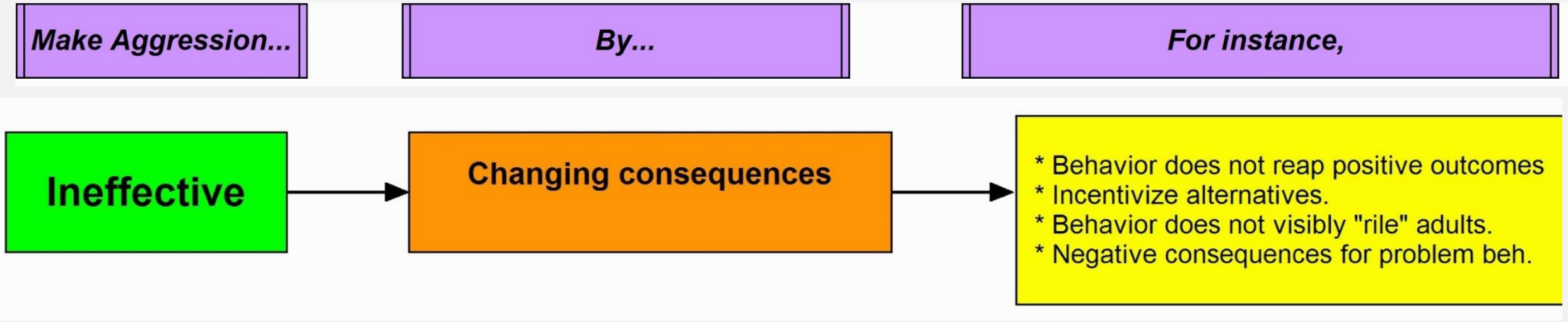

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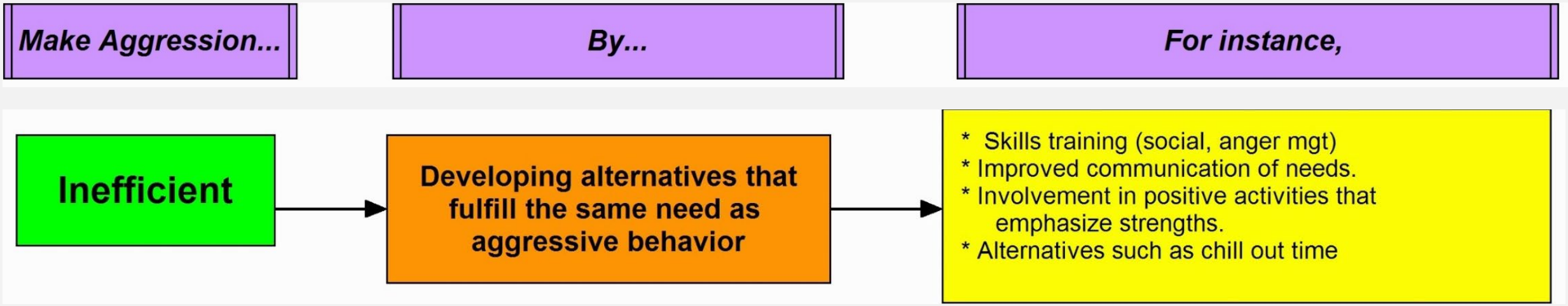

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Behavioral Principles

- 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 the positive (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 to be **clear** about which problem behaviors targeted and be clear about when occurrence is a problem.
  - **Ignore** 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**”.
  - **Consistency**: All parental figures work together and follow through.

Incredible Years Parenting Pyramid

"Connect before you Correct"

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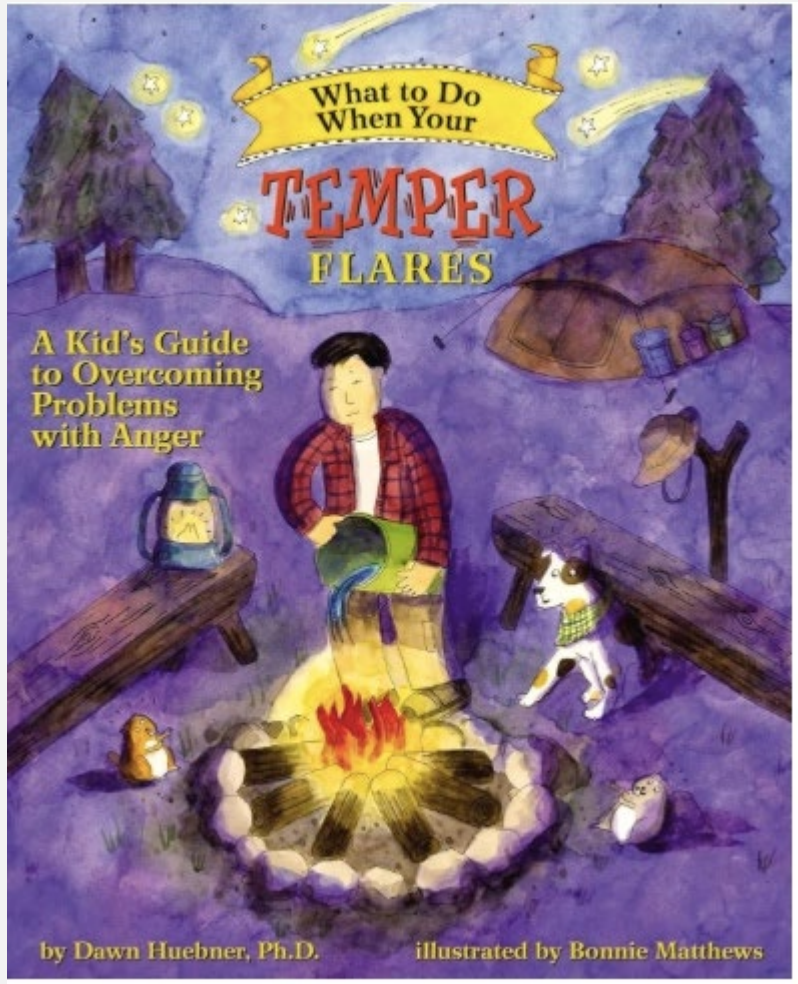
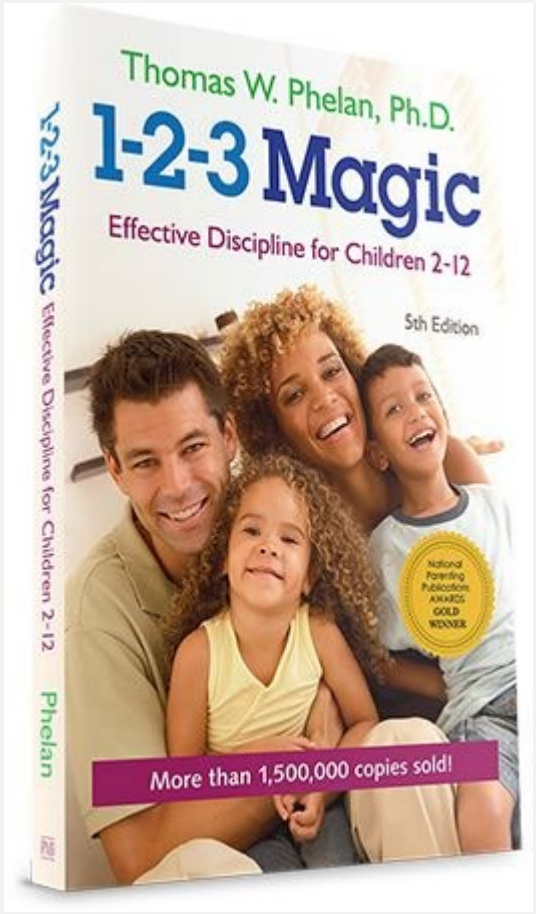
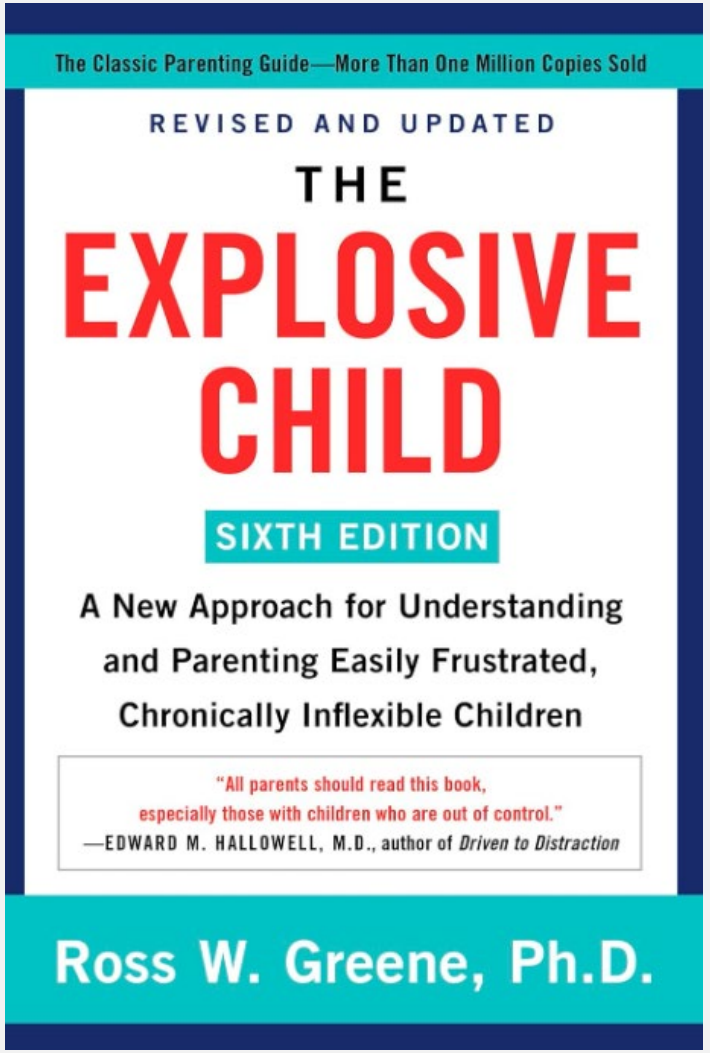
RESOURCE SLIDE: Parenting Books you can read to help the parents of your Patients







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T-MAY Recommendations

Medication Treatments:

- Treat the 1º Disorder (underlying condition) first, using recognized guidelines for that disorder.
- **ONLY IF** severe aggression persists after adequate psychosocial & medication treatments for the 1º 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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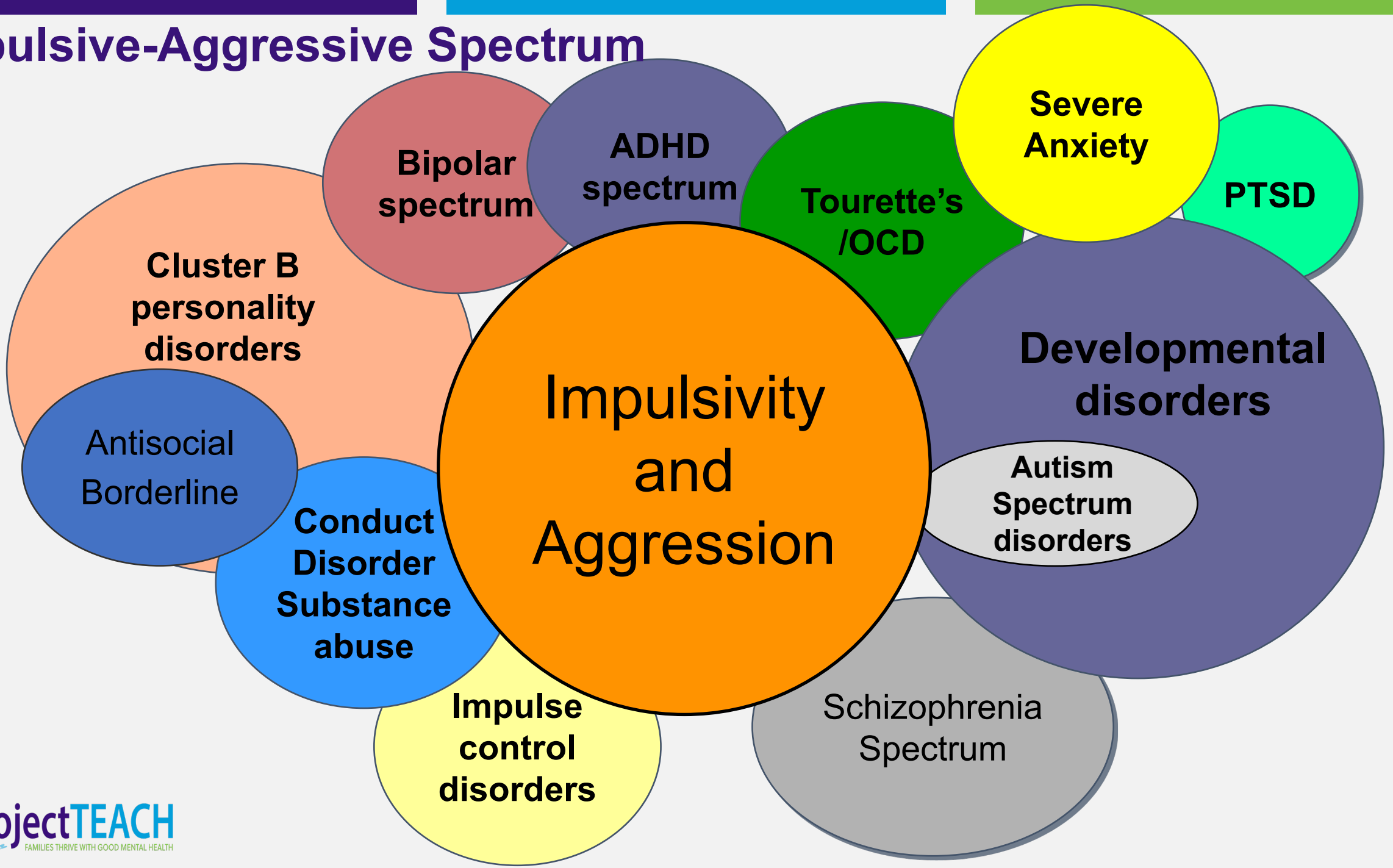
Identify and Treat the Primary Issue First

- Don’t start a referral, medication, or therapy for “aggression” until we have implemented treatment for the primary problem

Impulsive-Aggressive Spectrum



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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

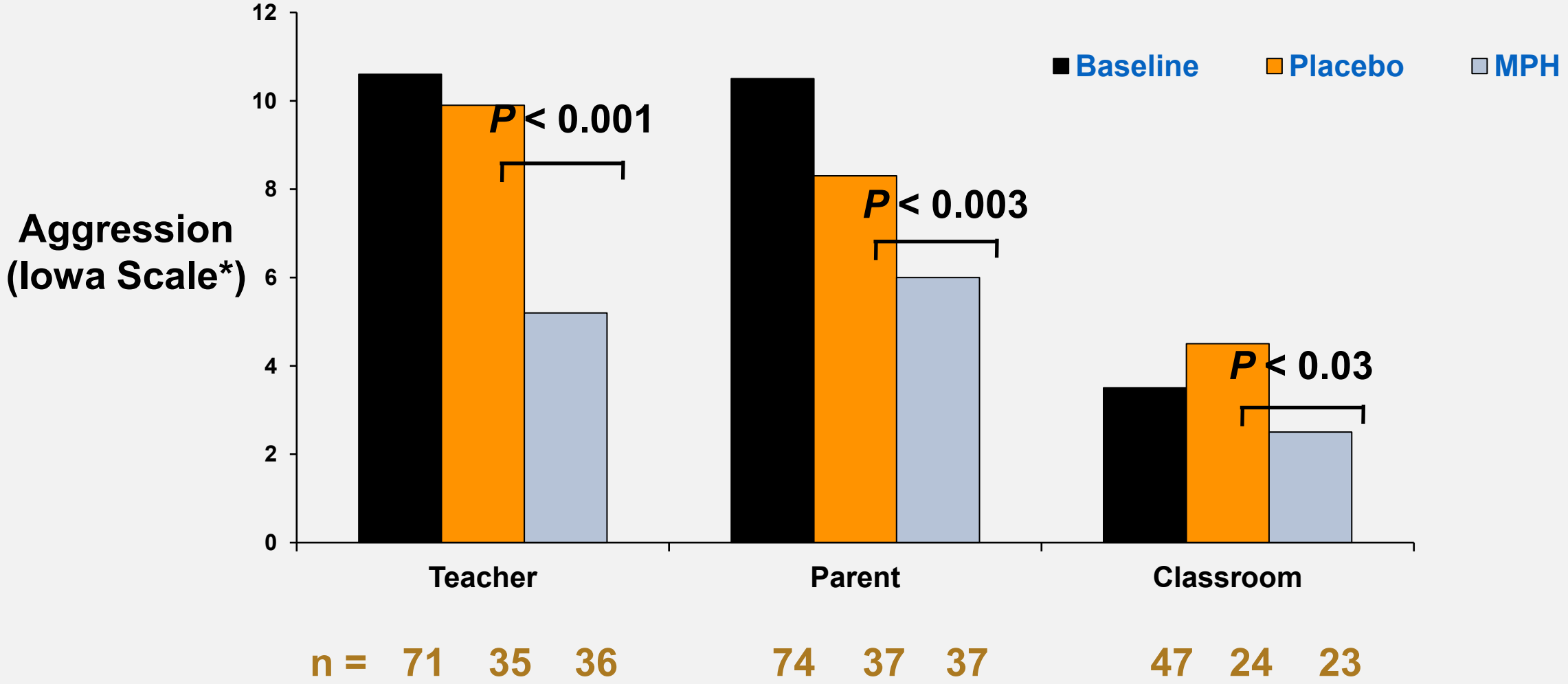
What is the Place of Medication in the Management of Aggression?

- 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

Klein RG et al. *Arch Gen Psychiatry.* 1997;54:1073-1080

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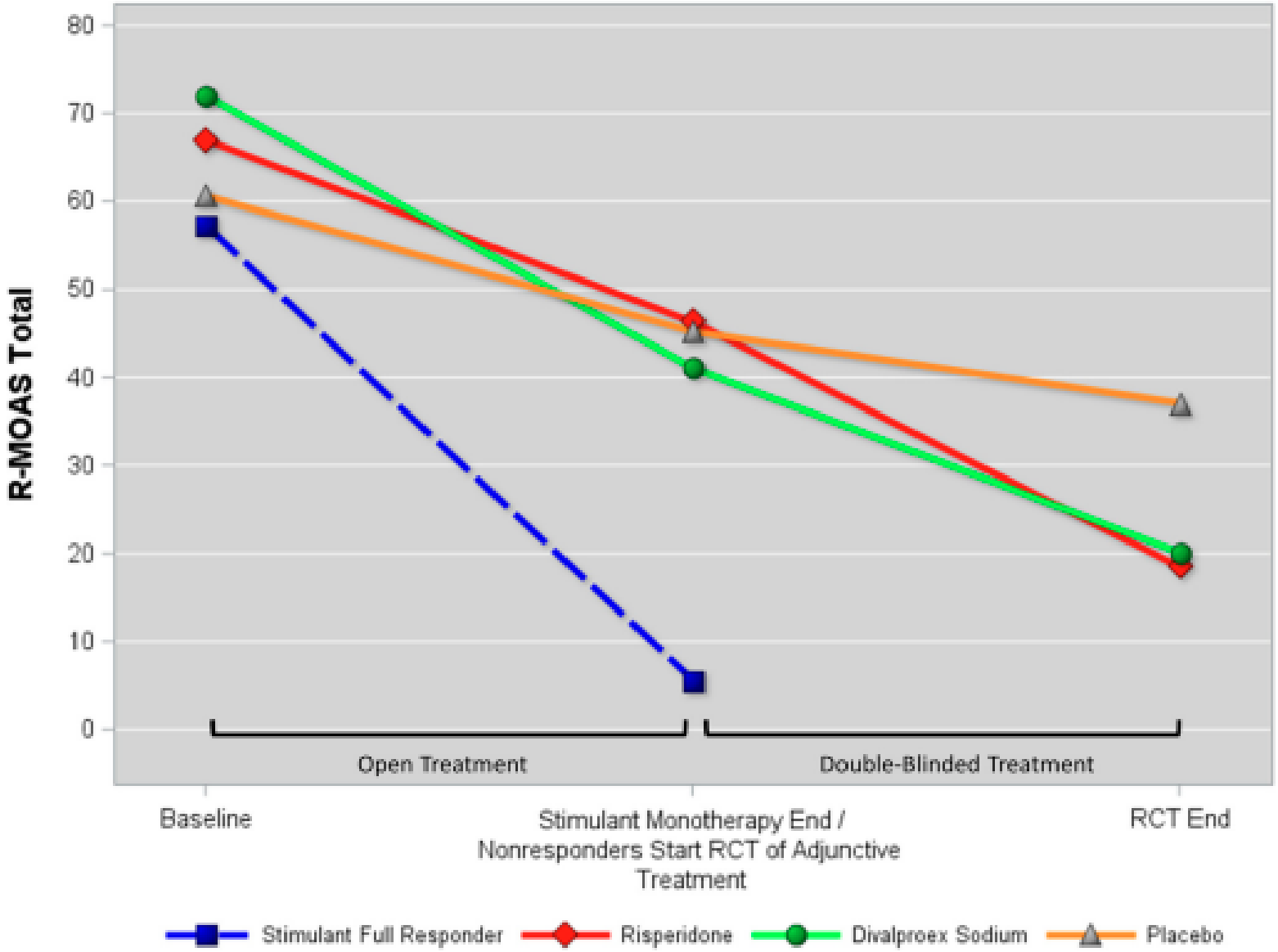
Before adding medications for aggression, make sure the medications for the primary disorder have been maximized

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.
  - If stimulant has been optimized, then consider alpha-2 agonist if sx persist, before adding atypical.

- 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



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

Joseph Blader et al
JAACAP 2021

Stepped Treatment for ADHD and Aggression

IF severe aggression persists despite,

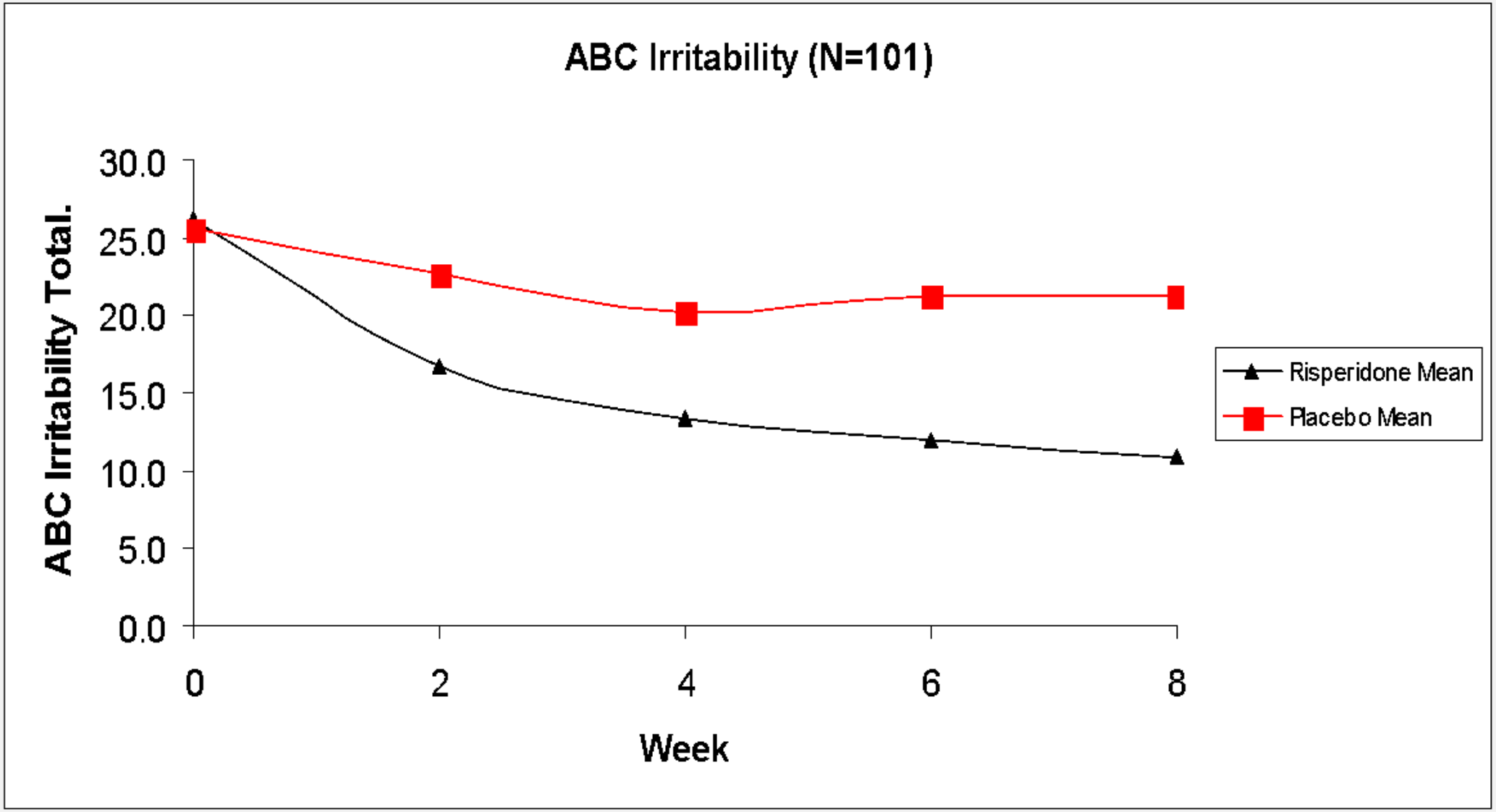
- treatment of the underlying condition has been optimized
- psychosocial treatments are not successful
- control of the initial level of aggression is **urgent**
- Consider: second generation antipsychotic medication trial

Dopamine-Serotonin Antagonists in Pediatric Primary Care

Medication	Brand Name	FDA approval	Dosing forms	Starting dose children	Starting dose adolescents	Target dosing aggression	Target dosing psychosis/ Bipolar
Risperidone	Risperdal	5-17 ASD +irritable 10-17 Bipolar Disorder (BD) manic/mixed; 13-17 Schizophrenia 6+ Tourettes	Tab: 0.25, 0.5, 1, 2, 3, 4 mg ODT: 0.25, 0.5,1,2,3,4 SOL: 1 mg/ml	0.25 mg HS	0.25-0.5 mg HS	1-2 mg/d	2-4 mg
Aripiprazole	Abilify	6-17 ASD + irritable; 10-17 BD (manic/mixed); 6-18 Tourettes	2,5,10,15, 20,30 tab ODT 10, 15 mg SOL 1mg/ml	2 mg QD	2-5 mg/day	2-10 mg /day	10-30 mg
Lurasidone	Latuda	10-17 BD (Dep) 13-17 Schizophrenia	20, 40, 60, 80 mg tab	--	20 mg QD (w/ food)	20-40 mg	40-80 mg
Quetiapine	Seroquel	10-17 BD (Manic); 13-17 Schizophrenia	Tab: 25,50,100, 200, 300, 400 mg; ER tab: 50,150,200, 300, 400	--	12.5-25 mg BID; ER 25-50 mg	50-200 mg Divided doses	400-800 mg Divided doses
Olanzapine	Zyprexa	10-17 BD (acute depression) 13-17 BDI acute mania 13-17 Schizophrenia	Tab: 2.5, 5, 7.5, 10, 15, 20 mg ODT (Zydis): 5, 10, 15, 20 mg	2.5 mg QD	2.5-5 mg QD	2.5-10 mg Note: **generally only used in ED for acute agitation or some cases of Eating disorders**	10-20 mg QD

03/24

Resource: Risperidone in Autism: Irritability Scale



RUPP Autism Group, NEJM, 2002

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

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.

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Atypical Antipsychotics: Side Effects

- Sedation
- Weight gain
- Metabolic Syndrome, Diabetes
- Gynecomastia/Galactorrhea/Amenorrhea
- Cardiac (ziprasidone), orthostatic hypotension
- 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

Comparison of Common Side Effects of Second Generation Atypical Antipsychotics

Atypical Anti-psychotic	Brand Name	Weight Gain	Constipation	Hyper-prolactinemia	Nausea/ Vomiting	Orthostasis	Dizziness	Akathisia	EPS	Somnolence	Tachycardia	↑ BG	↑ Lipids
Aripiprazole	Abilify	●●●	●●	—	●●	●●●	●	●●	●●	●●	●	●	—
Lurasidone	Latuda	—	—	—	●	—	●	●●	●●●●	●●●	●	—	—
Quetiapine	Seroquel	●●●	●	—	●	●	●●	●	●●	●●●●	●	●	●
Risperidone	Risperdal	●●●●	●●	●●●●	●●●	●	●●	●	●●●	●●●●	●	●	—

https://projectteachny.org/child-rating-scales. Under “Aggression”

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Monitoring Strategies in Children and Adolescents Treated With Antipsychotic Agents

Initial 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 AIMS, Barnes Akathisia scale	During titration, then every 3 months
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

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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

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- Guidelines recommend maintaining an atypical for about 6 months. IMPORTANT TO EDUCATE AT THE OUTSET

- 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 (25% dose reduction every 2-4 weeks)
- Routinely assess for side effects and drug interactions, including clinically relevant metabolic studies
- Provide info to children & parents re: side effects
- Collaborate with medical, educational, and/or MH specialists as needed

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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!

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We are here to help!

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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*