Intensive Training in Key Mental Health Issues: AGGRESSION IN CHILDREN AND ADOLESCENTS

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Sponsored by NYS OMH
Disclosures

• Cartesian Solutions-owner of integrated care consulting company

• Health NOW-committee for local BCBS
What causes kids to develop persistent aggression?
Like Fever, aggression is a final common pathway symptom and not a diagnosis!
Anatomy of Aggression

• We all want what we want
• Aggression occurs as an attempt to impact the world when we feel *powerless*
  • No internal resources available to get what want or calm self
  • No external resources available to divert or calm
  • All other strategies have failed to get what we want; we see no other better alternative
  • Overwhelmed by affect (anxiety, fear, shame, vulnerability) and tension
• Aggression makes us feel “strong” not helpless, powerless...but is aversive to others=we get LESS of what we want *and* we feel bad about ourselves
In short, aggression = an unhealthy solution to life’s problems when the demands of the world outstrip our resources (internal and external) to meet those demands successfully.
Clinical Types: Hot vs Cold Aggression

- **Cold**
  - Calculating, instrumental, predatory

- **Hot**
  - Impulsive: ADHD, TBI
  - Affective storm: Bipolar, DMDD, ASD, SUD
  - Anxious/hyperaroused: OCD, ASD, PTSD
  - Cognitive/disorganized: ID, TBI, Psychosis
TREATMENT OF MALADAPTIVE AGGRESSION IN YOUTH

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

Treatment Planning

1. Engage
Mindset of “anatomy of aggression”
Assume kids feel guilty and ashamed
Parents do too
Take a “no fault” spirit
  • Kids do well if they can
  • Parents do the best they know how
Aggression is a result of a confluence of factors (not one thing)
Involve the parent: “I can’t do it without you. Pills alone won’t give your child the skills he/she needs.”

Involve child/youth in tively recognizing “red zone”, monitoring and controlling aggressive outbursts
Treatment Planning

1. Engage
2. Assess
Assessment

- How severe/dangerous is the aggression?
- What is underpinning the aggression?
- What tipped the apple cart over?
How Severe/Dangerous is the Aggression

- What kind of aggression? Verbal? Physical?
- Who/what is target? Self? Others? Property?
- How severe is the aggression?
- How frequent is the aggression?
- How dangerous is the aggression?
  - Weapons?
  - Actual Injuries?
  - Injuries avoided because of adult intervention?
  - Escalating pattern?
Retrospective Modified Overt Aggression Scale (R-MOAS)

Instructions: These questions focus on difficulties with emotions and behavior. Please indicate how many times each of these behaviors occurred in the PAST WEEK.

### Verbal Incidents:

<table>
<thead>
<tr>
<th></th>
<th></th>
<th>0 - 1 times</th>
<th>2 - 4 times</th>
<th>5 or more times</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>How many times did your child shout angrily, curse, or insult people but then stopped quickly?</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>2</td>
<td>How many times did your child shout angrily, curse, or insult people in a repetitive, out-of-control way during episodes that lasted less than five minutes?</td>
<td>0</td>
<td>2</td>
<td>4</td>
</tr>
<tr>
<td>3</td>
<td>How many times did your child shout angrily, curse, or insult people in a repetitive, out-of-control way during episodes that lasted more than five minutes?</td>
<td>0</td>
<td>3</td>
<td>6</td>
</tr>
<tr>
<td>4</td>
<td>How many times did your child threaten to hurt someone?</td>
<td>0</td>
<td>4</td>
<td>8</td>
</tr>
</tbody>
</table>

5. Other verbal incidents (Please describe):

### Incidents Toward Other People:

<table>
<thead>
<tr>
<th></th>
<th></th>
<th>None</th>
<th>1 - 2 times</th>
<th>3 - 4 times</th>
<th>5 or more times</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>How many times did your child act like he/she was about to hit somebody or took a swing at someone without actually hitting another person?</td>
<td>0</td>
<td>4</td>
<td>8</td>
<td>12</td>
</tr>
<tr>
<td>2</td>
<td>How many times did your child hit someone with hands or an object, kick, push, scratch or pull hair, without causing real injury?</td>
<td>0</td>
<td>8</td>
<td>16</td>
<td>24</td>
</tr>
<tr>
<td>3</td>
<td>How many times did your child do any of the things in Item 2 and caused some mild injury (bruises, sprains, welts, etc.)?</td>
<td>0</td>
<td>12</td>
<td>24</td>
<td>36</td>
</tr>
<tr>
<td>4</td>
<td>How many times did your child do any of the things in Item 2 and caused serious injury (fracture, lost tooth, loss of consciousness, etc.)?</td>
<td>0</td>
<td>16</td>
<td>32</td>
<td>48</td>
</tr>
</tbody>
</table>

5. Other incidents toward other people (Please describe):
What is Underpinning the Aggression?

- PTSD
- Impulse control disorders
- Bipolar spectrum
- ADHD spectrum
- Tourette’s/OCD
- Conduct Disorder
- Substance abuse
- Cluster B personality disorders
- Antisocial Borderline
- Impulsivity and Aggression
- Developmental disorders
- Severe Anxiety
- Autism Spectrum disorders
- Schizophrenia Spectrum
- Substance abuse
- Schizophrenia Spectrum
Clinical pearl: In typically developing children, most aggression underpinned by:

(Rule out trauma)
ADHD
Anxiety
Depression
What Tipped the Apple Cart Over?

When did this start?

Did the **demands** of life (family, peers, academic, emotional, behavioral) change? COVID??

Did the **internal resources** change?

Did the **external circumstances** or resources change? (home, school, family, peers, neighborhood)
Steps in Initial Evaluation: Take a deep breath!

- Give yourself time to understand the problem
- Resist the need to prescribe on the first visit
- Interview patient and parent/guardian
- Input from school (Vanderbilt screen or phone call)
- Use standardized rating scales
- Physical examination (targeted)
- Appropriate laboratory studies (typically none)
Use Standardized Measures to Assess

Underlying condition
- Vanderbilt, SCARED, PHQ, etc

Aggression
- Modified Overt Aggression Scale (MOAS)-Retrospective
- Outburst Monitoring Scale
- Nisonger Child Behavior Rating Form (N-CBRF)
1. Engage
2. Assess
3. Partner and develop Tx plan
Next Step T-MAY Recommendations: Initial Treatment Planning

- **Triage safety risk** assessment - referral to a MH specialist or ER
- **Assure no maltreatment/trauma**
- **Partner** with family and child in developing an acceptable treatment plan
  - What has been tried?
  - Family and patient preference
1. Engage
2. Assess
3. Partner
4. Psychoeducation
5. Support
Present your understanding of "anatomy of aggression" in this child:

- What underpinning the aggression,
- what tipped the apple cart

The child’s "system is on overload"

Behavior often escalates to a "red zone": encourage observing the precipitants, evolution, places of detouring when "yellow"

Positive approach
- Positive reinforcement
- “Catch the child being good”
- Don’t reward negative behaviors

Importance of teaming and follow through
Psychoeducation: Helpful Books for Parents

- Phelan TW (2016). 3-Step Discipline for Calm, Effective, and Happy Parenting
Psychoeducation:
Helpful Books for Kids

Herman S (2018). Train Your Angry Dragon: Teach Your Dragon To Be Patient. A Cute Children Story To Teach Kids About Emotions and Anger Management. (Dragon Books for Kids)


Parent Support Local Groups

Family Help Center 716-892-2172 (24 hour hotline; programs for families at risk for maltreatment

Families Together in New York State: www.ftnys.org; 888-326-8644 (toll-free) Advocacy group

Families CAN 716-884-2599. Peer support, information, individual advocacy


Parent Support Websites

ADHD Family Support Center: www.adhd.com

Behavior Charts
http://freeprintablebehaviorcharts.com/behaviorcharts3-10.htm

Children and Adults with ADHD: www.CHADD.org

Child and Adolescent Bipolar Foundation: www.bpkids.org ; 847-256-8525.

Depression and Bipolar Support Alliance: www.dbsalliance.org ; 800-826-3632 (toll-free)

National Alliance for the Mentally III: www.nami.org; 800-950-NAMI (toll-free)

CAP PC www.cappcny.org , under Resources Links
1. Engage
2. Assess
3. Partner
4. Psychoeducation
5. Support
6. Psychosocial treatment
T-MAY Recommendations:  
Psychosocial Treatment First Line

- Evidence based parent and child skills training during all phases of care (*first line*).

- Generally referred to as
  - parent management training
  - Parent guidance
  - behavior management
  - Coping skills for child

- For severe situations consider more intensive or wraparound services or crisis or emergency services
Common Denominators of PMT

First focus on engagement and positives ("catching them being good", play, read)

Attention to how limits set/structure provided

- Proactive better than reactive
- What problem behaviors targeted
- When occurrence "counts" as a problem
- \textit{Realistic} rewards and consequences
- Apply fairly and nonjudgmentally/ "emotionally neutral"

Adults work together and follow through
Incredible Years Parenting Pyramid

- Use Selectively
  - Time out
  - Loss of Privilege
  - Natural & Logical consequences

- Use Liberally

Benefits for Child:
- Problem Solving
- Cooperation
- Self Esteem
- Attachment

Parent Skills & Strategies:
- Empathy
- Attention and Involvement
- Play
- Problem Solving
- Listening
- Talking

- Praise
- Encouragement

- Rewards
- Celebrations

- Ignore
- Distract
- Redirect

- Clear Limits
- Household Rules
- Consistent Follow-Through

- Responsibility
- Predictability
- Obedience

- Social Skills
- Thinking Skills
- Motivation

- Annoying Behaviors
- Aggression
1. Engage
2. Assess
3. Partner
4. Psychoeducation
5. Support
6. Psychosocial treatment
7. Medications
Medication Management Principle 1: Treat the Underlying Condition

• Initial medication treatment should target the underlying disorder(s)
• Follow evidence based guidelines and optimize treatment for the primary disorder

• *For ADHD this may include using an alpha agonist as augmenting agent*
Medication Management Principle 2: Consider an atypical antipsychotic if……..

1. psychosocial treatment insufficient
2. optimizing medication for underlying condition insufficient
3. Aggression is severe=dangerous to self/others, or major life consequence close (hospitalization, disrupted home, arrest)
## Atypical Toolbox

*Note: Risperidone and aripiprazole most experience in youth and FDA approved for irritability in ASD*

<table>
<thead>
<tr>
<th>Atypical Antipsychotic</th>
<th>Start at (mg/day)</th>
<th>Target Dose (mg/day)</th>
<th>Monitor</th>
<th>Watch Out For</th>
</tr>
</thead>
<tbody>
<tr>
<td>Risperidone</td>
<td>0.25-0.50</td>
<td>1-3</td>
<td>Weight/Height/BMI</td>
<td>EPS/TD</td>
</tr>
<tr>
<td>Aripiprazole</td>
<td>2.5-5</td>
<td>5-20</td>
<td>Weight/Height/BMI</td>
<td>EPS</td>
</tr>
<tr>
<td>Quetiapine</td>
<td>50-100</td>
<td>300-600</td>
<td>Weight/Height/BMI</td>
<td></td>
</tr>
<tr>
<td>Ziprasidone</td>
<td>20-40</td>
<td>80-160</td>
<td>Weight/Height/BMI ECG</td>
<td>Take with food, Assess cardiac risk factors</td>
</tr>
<tr>
<td>Olanzapine</td>
<td>5</td>
<td>5-20</td>
<td>Weight/Height/BMI</td>
<td>Choles/FAs</td>
</tr>
</tbody>
</table>
Dosing for Atypicals

Use recommended titrations schedules for this indication and deliver an adequate medication trial before changing or adding meds.
Adverse Effects

**Rare, serious:** Neuroleptic malignant syndrome, agranulocytosis (clozapine), increased LFTs, tardive dyskinesia (long term)

**Common, serious:** weight gain, hyperlipidemia, diabetes

Cognitive: sedation, slowed, memory

Neurologic: dystonia, akathisia, akinesia, rigidity, tremor, lowered seizure threshold

Endocrine: elevated prolactin, gynecomastia, galactorrhea

Cardiovascular: increased QT (ziprasidone), orthostatic hypotension
## Safety and Tolerability of Atypical Antipsychotics

<table>
<thead>
<tr>
<th></th>
<th>Anticholinergic</th>
<th>Elevated prolactin</th>
<th>EPS</th>
<th>Orthostasis</th>
<th>QTc Increase</th>
<th>Sedation</th>
<th>Weight Gain</th>
</tr>
</thead>
<tbody>
<tr>
<td>Aripiprazole</td>
<td>0/+</td>
<td>0/+</td>
<td>+</td>
<td>+</td>
<td>0</td>
<td>+</td>
<td>++</td>
</tr>
<tr>
<td>Risperidone</td>
<td>+</td>
<td>++++</td>
<td>++</td>
<td>++</td>
<td>+</td>
<td>+</td>
<td>+++</td>
</tr>
<tr>
<td>Olanzapine</td>
<td>++</td>
<td>++</td>
<td>+</td>
<td>++</td>
<td>+</td>
<td>+++</td>
<td>++++</td>
</tr>
<tr>
<td>Quetiapine</td>
<td>+</td>
<td>0/+</td>
<td>0/+</td>
<td>++</td>
<td>+</td>
<td>++</td>
<td>++</td>
</tr>
<tr>
<td>Ziprasidone</td>
<td>+</td>
<td>+</td>
<td>+</td>
<td>+</td>
<td>++</td>
<td>+</td>
<td>0/+</td>
</tr>
<tr>
<td>Clozapine</td>
<td>++++</td>
<td>0/+</td>
<td>0/+</td>
<td>+++</td>
<td>+</td>
<td>+++</td>
<td>++++</td>
</tr>
</tbody>
</table>


SEE T-MAY Reference Guide
## Monitoring for Children and Adolescents on APs

<table>
<thead>
<tr>
<th>Assessments</th>
<th>Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>Height, weight, BMI percentile</td>
<td>Baseline, every visit</td>
</tr>
<tr>
<td>Blood pressure, pulse</td>
<td>Baseline, 3 months and 6-monthly</td>
</tr>
<tr>
<td>Fasting glucose, lipids</td>
<td>Baseline, 3 months and q6-12m</td>
</tr>
<tr>
<td>Liver function tests</td>
<td>Baseline, 3 months and q6-12m</td>
</tr>
<tr>
<td>Electrolytes, blood count, renal function</td>
<td>Baseline and annually (unless on CLOZ)</td>
</tr>
<tr>
<td>Prolactin</td>
<td>Only when symptomatic</td>
</tr>
<tr>
<td>Dyskinesia/TD</td>
<td>AIMS Baseline, 3 months and annually</td>
</tr>
</tbody>
</table>

Correll, JAACAP, 2008
Medication Management Principle 3: If the first atypical doesn’t work or side effects emerge........

Try a different atypical antipsychotic
Medication Management Principle 4: And If a second atypical doesn’t work

For a partial response consider augmentation with a mood stabilizer

Lithium best evidence but moderate effect only with inpatients---

NOT A PRIMARY CARE INTERVENTION

CALL PROJECT TEACH!
Caveat 1:
Avoid using more than 2 psychotropic medications simultaneously if possible
Caveat 2: Don’t continue atypicals forever!

- Most children with aggression driven by ADHD, anxiety, depression or trauma can reach stability and stop atypicals (Autism spectrum, ID may need long term).
- Once aggression resolved, continue for 6-12 months and taper off by 25% Q2-4weeks until discontinued.
Aggression is a final common pathway symptom, not a diagnosis

Rule out trauma

Understand what tipped over apple cart

Use rating scale to
  - Assess aggression
  - Assess underlying condition

Engage the family and child: no fault spirit

Provide psychoeducation and support
Review: Treatment

First: triage safety (advise of emergency resources)

Second: psychosocial interventions first line

Third: If unresponsive to psychosocial interventions, consider medications

Fourth: first line medications target the underlying condition

Fifth: if treating underlying fails, aggression severe, consequences serious consider an atypical antipsychotic

Sixth: Risperidone and aripiprazole generally first line

Seventh: if first atypical fails then try 2\textsuperscript{nd}

Eighth: if still doing poorly, refer

ANYTIME call Project TEACH—1-855-227-7272