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

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Sponsored by NYS OMH

ProjectTEACH

TRAINING AND EDUCATION FOR THE ADVANCEMENT OF CHILDREN'S HEALTH

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

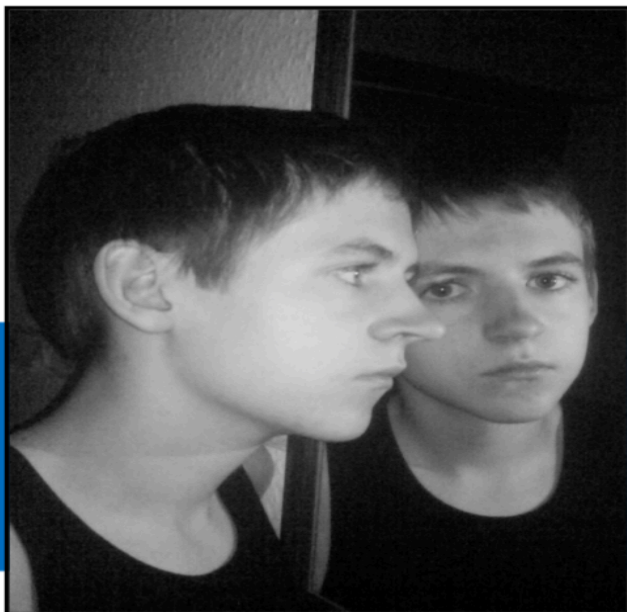
- We all want what we want
- Aggression occurs as an attempt to impact the world when we feel ***powerless***
  - No internal resources available to get what want or calm self
  - No external resources available to divert or calm
  - All other strategies have failed to get what we want; we see no other 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=
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

TMAY Pediatrics 2012



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

https://www.ahrq.gov/chain/practice-tools/behavioral-mental-health/treatment-of-maladaptive-aggression-in-youth-toolkit.html

Treatment Planning

1. Engage

Engagement Pearls

- 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*)

Capstone Comments

- 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?

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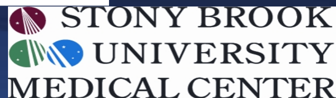


Project SPICY
Stepped Pharmacotherapy for Improved Self-Control among Youth

A. Child's First Name: | B. Child's Last Name:
C. Your First Name: | D. Your Last Name:

E. Your Relationship to Child: ◯ Mother ◯ Father ◯ Grandmother ◯ Grandfather ◯ Other

Staff Entries
Site: S B K | Project: 0 2 | Participant:
Visit Type | Visit #
Month / Day / Year

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:

Category weight = 1

	0 - 1 times	2 - 4 times	5 or more times
1. How many times did your child *shout angrily, curse*, or *insult people* but then stopped quickly?	◯ 0	◯ 1	◯ 2
2. 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?	◯ 0	◯ 2	◯ 4
3. 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?	◯ 0	◯ 3	◯ 6
4. How many times did your child *threaten to hurt someone*?	◯ 0	◯ 4	◯ 8

5. Other verbal incidents (Please describe):

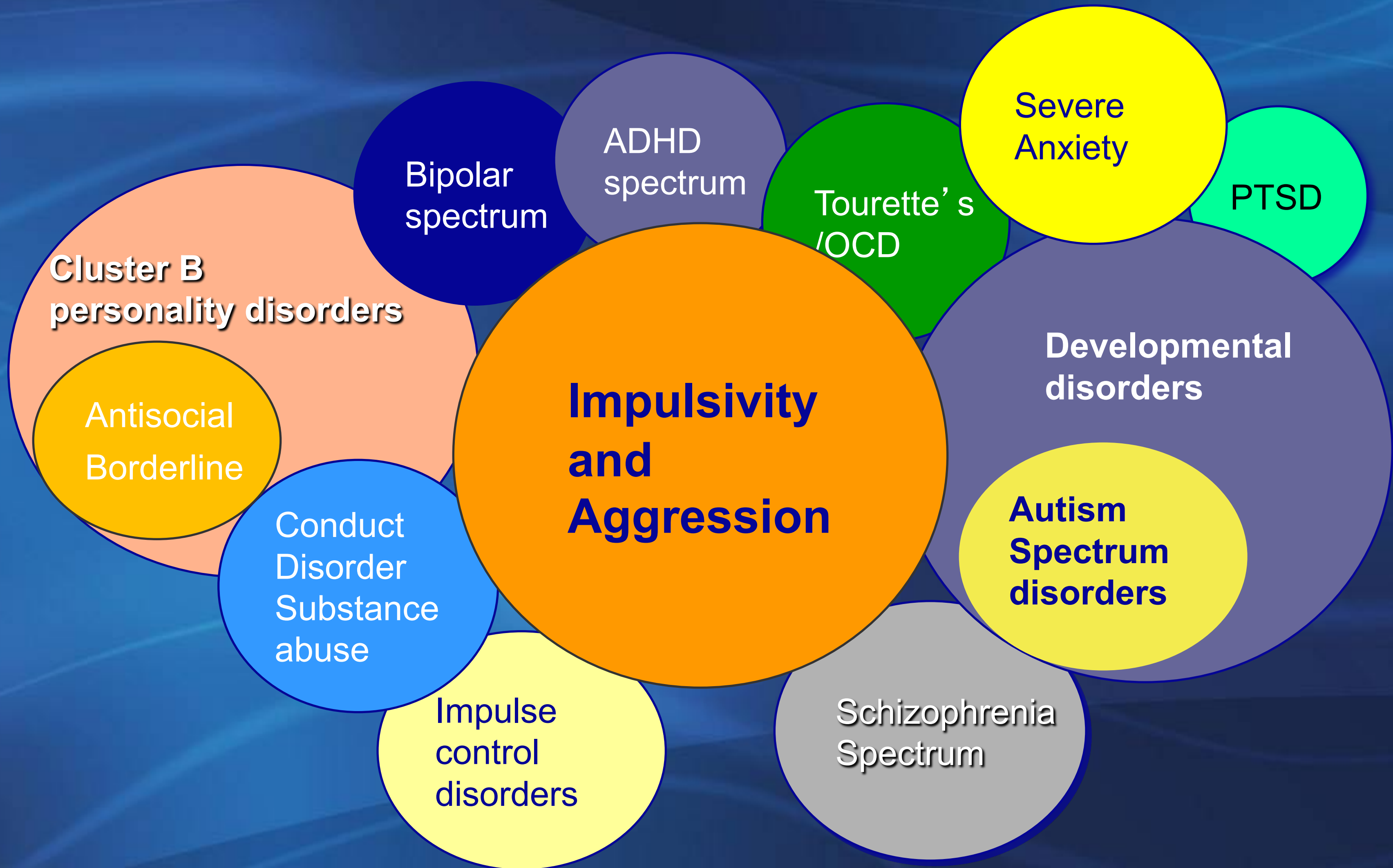
Incidents Toward Other People:

Category weight = 4

	None	1 - 2 times	3 - 4 times	5 or more times
1. 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?	◯ 0	◯ 4	◯ 8	◯ 12
2. How many times did your child *hit someone* with hands or an object, *kick, push, scratch* or *pull hair*, without causing real injury?	◯ 0	◯ 8	◯ 16	◯ 24
3. How many times did your child do any of the things in Item 2 and caused some mild injury (bruises, sprains, welts, etc.)?	◯ 0	◯ 12	◯ 24	◯ 36
4. 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.)?	◯ 0	◯ 16	◯ 32	◯ 48

5. Other incidents toward other people (Please describe):

What is Underpinning the Aggression?



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**

Psychoeducation Pearls

- 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

- Barkley R, Benton C (2013). Your Defiant Child: Eight Steps to Better Behavior
- Bernstein J (2015). 10 Days to a Less Defiant Child, second edition: The Breakthrough Program for Overcoming Your Child's Difficult Behavior
- Greene R (2014). The Explosive Child: A New Approach for Understanding and Parenting Easily Frustrated, Chronically Inflexible Children
- Kazdin A (2009). The Kazdin Method for Parenting the Defiant Child
- Phelan TW (2016). 3-Step Discipline for Calm, Effective, and Happy Parenting
- Phelan TW (2010). 1-2-3 Magic: Effective Discipline for Children 2-12

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)
- Huebner D, Matthews B (2007). What to Do When Your Temper Flares: A Kid's Guide to Overcoming Problems With Anger (What to Do Guides for Kids)
- Lite L (2015). Angry Octopus: An Anger Management Story introducing active progressive muscular relaxation and deep breathing
- Verdick E, Lisovskis M (2015). How to Take the Grrrr Out of Anger (Laugh & Learn®)

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
- Mental Health Association of Erie County: Child and Family Support Program http://www.eriemha.org 716-886-1242. Peer support for children and families
- Parent Network of WNY https://parentnetworkwny.org 716-332-4175. Broad family support, referral, education

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 Ill: 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**

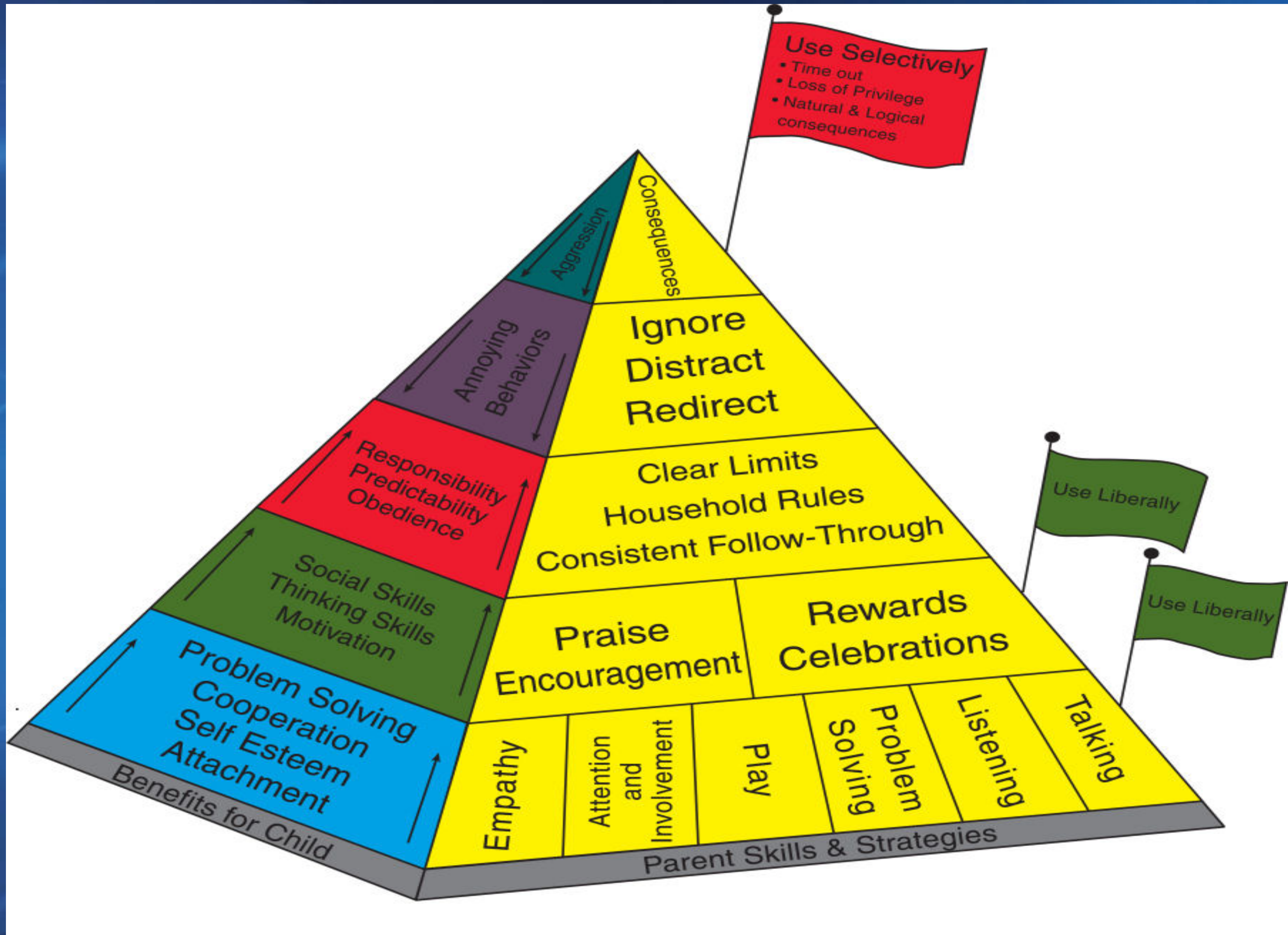
T-MAY Recommendations: Psychosocial Treatment First Line

- 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
  - *Realistic* rewards and consequences
  - Apply fairly and nonjudgmentally/ “emotionally neutral”
  - Adults work together and follow through

Incredible Years Parenting Pyramid



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

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

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

	Anticholinergic	Elevated prolactin	EPS	Orthostasis	QTc Increase	Sedation	Weight Gain
Aripiprazole	0/+	0/+	+	+	0	+	++
Risperidone	+	++++	++	++	+	+	+++
Olanzapine	++	++	+	++	+	+++	++++
Quetiapine	+	0/+	0/+	++	+	++	++
Ziprasidone	+	+	+	+	++	+	0/+
Clozapine	++++	0/+	0/+	+++	+	++++	++++

Adapted from: Pappadopulos EA et al. Schizophr Bull. 2002;28:111-121. Marder et al, 2003; Potkin et al, 2003.

SEE T-MAY Reference Guide

Monitoring for Children and Adolescents on APs

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

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

Review: Assessment and First Steps

- 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 2nd
- **Eighth**: if still doing poorly, refer
- ANYTIME call Project TEACH—1-855-227-7272