

## DISRUPTIVE & AGGRESSIVE BEHAVIOR DISORDERS —IN BRIEF:

### Assessment and Diagnosis

#### Assessment Recommendations:

- **Recommendation I:** Evaluate any patient at high risk (i.e., with risk factors such as family history, irritability, inattentiveness, defiance of adults, poor social skills, aggression towards others, lack of school readiness, etc.) for the possibility of an disruptive behavior disorder.
  - Disruptive behavior disorders include oppositional defiant disorder and conduct disorder.
- **Recommendation II:** When evaluating a teen with possible disruptive behavior disorder, conduct separate Interviews with the teen and guardian using DSM 5 criteria.
- **Recommendation III:** Use DSM-5 criteria for ODD and conduct disorder to evaluate children and youth with a possible disruptive behavior disorder.

#### DSM-5 Diagnostic Criteria

##### Oppositional Defiant Disorder:

- Loses temper
- Angry
- Arguing with adults
- Disobedience
- Easily annoyed
- Spiteful
- Blames others for mistakes
- Deliberately annoys others

**Note:** The principal subdivision to be made in ODD is between the variety that appears to progress to CD and the variety that does not. Greater *severity and early onset* of oppositional behavior, frequent physical fighting, parental substance abuse and low socio-economic status appear to increase the risk of progression to more severe antisocial behaviors observed in CD (Dulcan & Loeber, 1995)

##### Conduct Disorder:

- Exhibits a pattern of behavior that violates the rights of others or disregards age-specific social norms
  - Deliberately break rules
  - Aggressive toward people or animals
  - Destructive of property
  - Lying and theft
  - Violation of rules, e.g., skipping school and substance use
- **Recommendation IV:** Assess with validated disruptive or aggressive rating scales to help guide the diagnosis and increase diagnostic precision of a disruptive behavior disorder
    - The Modified Overt Aggression Scale (clinician or parent version) is a useful tool for tracking disruptive behavior disorder problems.
    - For children with accompanying ADHD, the Vanderbilt Rating Scale can be a useful tool to track oppositional and aggressive/conduct problems.
    - Both scales can be downloaded at no cost, <https://www.cappcny.org/home/clinical-rating-scales/>

Differential Diagnosis:

Possible Trajectory	Oppositional Defiant Disorder →	Conduct Disorder →	Anti-Social Personalit
Major Symptoms	Angry, argues, easily annoyed, disobedient, spiteful, loses temper, blames	Violates others' rights, physical harm, property damage, deceitful, serious violations of rules	
Prognosis		Guarded with onset before age 10 or if more serious symptoms are present	Guarded
Risk Factors	As an infant was fussy, reactive or excessive motor activity	Male, parental rejection, harsh parenting, peer rejection, trauma	Family History

- **Recommendation V:** Obtain an evidence-based psychotherapy.
  - Therapies that teach the parent how to use appropriate rewards and consequences can be helpful and are indicated in the presence of a disruptive behavior disorder. These should always be considered as essential initial components of the treatment plan. These therapies include:
  - Parent-Child Interaction Therapy (PCIT) (training for AR therapists available at UAMS/PRI)
  - Parent Management Training (PMT)
  - Collaborative Problem-solving therapy (CPS, R. Greene et al.)

Pharmacotherapy

- **No pharmacotherapy is currently FDA approved for the use in children and adolescents with disruptive behavior disorders, except in the presence of autism, for which both aripiprazole and risperidone have been approved.**
- If a child with severe disruptive behavior has primary psychiatric disorder (e.g., ADHD, depression, anxiety, psychosis, bipolar disorder, etc.), psychotherapy and pharmacotherapy for the primary clinical diagnosis (or the “underlying condition”) is warranted and may significantly diminish the behavioral difficulties as well as the aggression.
- If treatment of the primary disorder fails to relieve severe symptoms of aggression, medication interventions with atypical antipsychotic agents, mood stabilizers, and antiepileptic medications have been shown to decrease aggression. Multiple double blind clinical trials have shown that the atypicals antipsychotic agents (especially risperidone) have beneficial effects on aggression.

- When mood or anxiety disorders are present, treating the disorder with antidepressant medication may decrease irritability and impact aggression.
- When ADHD is present, the use of medications to improve attention and impulsivity (e.g., stimulants) may also improve a child's oppositional and irritability problems, as well as enable the child to benefit from the psychotherapeutic interventions noted above.
- See Dosing Chart for atypicals below.

## Recommendation - Collaborative Care

- Primary Care clinicians should actively support children and adolescents who are referred to mental health for disruptive or aggressive symptoms. Consider sharing care with mental health professionals if possible.
- **The free Psych TLC** service is available for:
  - Consultation on psychiatric medication related issues including:
    - Advice on diagnosis and initial management for your patient
    - Titration of psychiatric medications
    - Side effects of psychiatric medications
    - Combination of psychiatric medications with other medications
    - Referral and services consultation regarding children with mental health issues
  - A licensed mental health professional (MHP) and a child and adolescent psychiatrist (CAP) are available via telephone to provide consultation and support to PCPs from 8am-5pm, M-F. Simply call **(844) 547-5688** or **(501) 320-7270** to contact the Psych TLC Call Center. One of our expert MHPs will obtain basic information from you about the child and then set up a convenient time for Peter S. Jensen, MD, or another child & adolescent psychiatrist to call you back, usually within 30 minutes to 2 hours.

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

Atypical Antipsychotics	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
Clozapine ***	6.25-25 mg	1-2x starting dose (18-30 days)	150-300 mg	200-600 mg	150-300 mg	200-600 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
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
Ziprasidone	20 mg	20 mg for children 20-40 for adolescents (18-30 days)	NDA	NDA	NDA	NDA; (In adults, 160-180 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.

\*\*\*Please Note: Clozapine should NOT be prescribed by primary care clinicians without psychiatrist input and oversight.