

Viewing Time

The program will take up to one hour to complete.

Target Audience

This program is designed for primary care physicians.

Other health care professionals working with patients and their families may also find this program of interest.

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Faculty Disclosure

Robert Karasov, MD, has disclosed no actual or potential conflict of interest in relation to this educational activity.

During this educational activity **Dr. Karasov** will not be discussing the use of any commercial or investigational product not approved for any purpose by the FDA.

Evaluation and Treatment of Aggression in Youth and Adolescents

Robert Karasov, MD
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Evaluation and Treatment of Aggression in Youth and Adolescents

A lecture discussing the differential diagnosis of aggression, the tailoring of appropriate medical treatments, as well as understanding behavioral techniques for managing aggression in youth and adolescents.

Program Objectives

Upon completion of this program, participants should be able to:

- Discuss the differential diagnosis of aggression.
- Tailor medication treatments for aggression.
- Understand behavioral techniques for managing aggression.
- Recognize when to use atypical antipsychotics.

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Receiving CME Credit

To receive CME credit you must view the entire program and complete the evaluation form at the end.

Evaluation and Treatment of Aggression in Youth and Adolescence

Robert S Karasov MD
Park Nicollet Clinic

Case study

- MD 17 y.o. male, GAT, athletic
- Victim of bullying in jr high, bully suicided, bully's former girlfriend is now patient's GF
- Irritable, problems with authority, parent conflict
- History of separation anxiety
- Yells at bosses, teachers, cheating, violent outbursts, punches holes in walls, broke chairs
- No FH of Bipolar or EtOH
- Impulsive, inattentive
- Won't touch handles on doorknobs

Aggression: a symptom not a diagnosis


- Approach to Diagnosis
- Risk Assessment
- Treatment
- TRAY guidelines



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Escalating Books

- The Difficult Child: temperament
- Your Defiant Child
- The Explosive Child
- The Bipolar Child




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Profile of Parent Characteristics what's the match?

(Your Defiant Child)

- Health Problems
- Physical Problems
- Emotional Problems
- Thinking Problems
- Problems with Attention
- Problems with Activity Level
- Problems with Impulse Control
- Problems with Moodiness
- Problems with Eating
- Problems with Sleeping.



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Oppositional Defiant Disorder

4 or more features for at least 6 months


- Loses temper
- Argues with adults
- Actively defies rules or won't comply
- Deliberately annoys people
- Blames others for mistakes or misbehavior
- Touchy, easily annoyed
- Often angry, resentful
- Often spiteful, vindictive
- B. significant impairment
- C. Not only during mood disorder
- D. Doesn't meet criteria for Conduct Disorder (or if over 18 y.o. antisocial personality disorder)



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The Explosive Child

- Trouble handling emotions, frustration, can't think through or remember outcomes of prior outbursts. ie. They get stuck.
- Low frustration threshold, everything bugs them
- Low frustration tolerance, everything is major
- Inflexible, not adaptable, can't shift gears
- Concrete, rigid, black and white
- Not affected by rewards and consequences
- Out of the blue quality
- ? Hypersensitive to certain issues, ex. Texture
- Co-morbidity (ADD, mood, anxiety, OCD, social issues)
- Fall apart when tired, hungry




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Conduct Disorder

3 or more features in the last 12 months

- Bullies, threatens, intimidates
- Initiates fights
- Used a weapon
- Physically cruel to people
- ...to animals
- Steals while confronting the victim
- Forced sexual activity
- Fire setting to harm
- Destroys property
- Broken into house car or buildings
- Lies to obtain goods, cons
- Shoplifting
- Stays out at night
- Run away at least twice
- Often truant



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Disruptive Behavior Disorder NOS

- Features of Conduct Disorder or ODD
- Doesn't meet full criteria



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Intermittent Explosive Disorder 312.34

- A. Several discreet episodes of failure to resist aggressive impulses that result in serious assaultive acts or destruction of property
- B. The degree of aggressiveness expressed during the episode is grossly out of proportion to any precipitating psychosocial stressor
- C. The episodes are not better accounted for by another disorder and not due to physiologic effects of a substance or general medical condition



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Severe Mood Dysregulation a.k.a. "Rages"

Leibenluft NIMH

- Dis-inhibition of ADHD combined with
- Irritability of Oppositional Defiant Disorder
- Rages: explosive outbursts out of proportion in intensity and duration to the trigger
- At risk for Conduct Dis. and substance abuse
- No increased risk of adult Bipolar Disorder
- Affective impulsive aggression (different term)



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Aggression: clinical questions

- Temper problems?
- What provokes temper and what are the objects?
- How does the child express anger? Verbal, physical
- Does child meet criteria for conduct disorder?
- Does the child show remorse?
- History of being abused?
- Gang association



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Risk Assessment:

resource analysis

- Demographic factors: late teen, disadvantaged ethnic group
- Violence threat: expressed threat, provocative relationship, a plan, access to weapons
- Past History: of violent threats or actions, history of abuse, neuro impairment, drug use
- Psychological factors: persecutory delusions, command hallucinations, deals with anxiety by externalizing
- Social Environment: parents able and willing to control patient, family neglect, abuse, violence
- Therapeutic alliance: terminated? Motivated?



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So what's causing the aggression?

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ADHD and Executive Function

- Shifting cognitive set (changing your mindset)
ie. coming in from recess
- Organization and planning
- Impulse Control and disorganization leads to frustration
- Working memory: need to hold past, present and future simultaneously to problem solve
- Separation of Affect: emotion overwhelms thought. Approaching the cliff.
- Demanding, self centered, lack empathy, tact



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Nonverbal Learning Disability

- Poorer nonverbal than verbal skills
- Poor Math
- Trouble comprehending reading material despite good skills at reading words
- Poor nonverbal memory and visual perception
- Trouble with tasks requiring problem-solving, flexibility and adaptability
- Difficulties with social perception, social judgment and social interaction skills.
- Good at rote learning, rigid, black and white



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Language Processing

Verbal Comprehension: connotation, intonation

Categorize and label emotions: feeling words

Expressive: finding the right words

code switching (talk differently to diff people)

topic selection and maintenance

humor regulation, conversational technique

requesting skills

perspective taking

affective matching

lingo fluency

complimenting



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Mood

- Depression: may present as irritable, agitated, volatile:
often don't meet criteria for major depression or bipolar
- Anxiety:
internalize: cry, ruminate
- externalize: lash out
- OCD rituals
-



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Social Skills Deficits

- Reading social cues
- At the extreme, PDD, Aspergers



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Other Disabilities

Learning Disabilities

Math

Reading

Writing

Language Processing

Tics

Physical Disabilities

Short Stature

Autism Spectrum



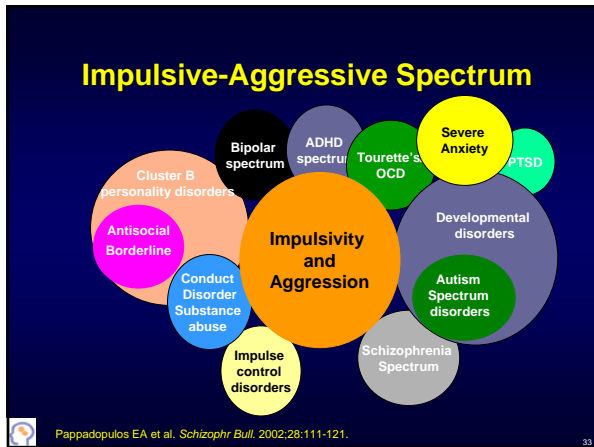
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Sensory Integration Dysfunction

- Integrating touch, movement, coordination, body position and awareness, sight and sound
- If under reactive: fluctuate between over and under responsiveness
- If over reactive: sensitive to textures, sounds, react poorly to routine movements
- Trouble with motor activities, handwriting, labels on clothing, food textures, smells, temp.
- "...a child with this profile is likely to begin to show increased activity level; less organized, focused and goal oriented behavior; and the appearance of being overwhelmed with less ability to listen to and/or respond to verbal input in busy, noisy environments. He may become distressed and be more likely to lash out at others or himself."

Other Diagnoses to consider

- Mental retardation
- Bipolar Disorder 1 and 2
- PTSD: hyper-vigilant, traumatized
- Migraines: acute confusional state, before, during or after a headache
- Seizures
- Frontal lobe tumor



TRAAAY

Treatment Recommendations for the Use of Antipsychotics for Aggressive Youth

Robert S Karasov M.D.
 Park Nicollet Clinic
 Slides courtesy of Peter Jensen M.D.

TRAAAY

Treatment Recommendations for the Use of Antipsychotics for Aggressive Youth

New York State Office of Mental Health and Center for the Advancement of Children's Mental Health at Columbia University, Dept of Child and Adolescent Psychiatry

Goals and Principles (TRAAAY)

- Complete a diagnostic assessment before using medications
- Treat co-existing or primary psychiatric disorders before treating aggression
- Use psychosocial treatment interventions with the child and family before using medications
- Use a conservative dosing strategy with medications
- Carefully monitor side effects and effectiveness of medication
- Minimize use of STAT or PRN medications for managing acute aggression.

Aggression in Children & Adolescents: Critical Treatment Issues

- Most common reason for psychiatric referral
- Complicates treatment/leads to poorer outcomes
- Frequent use of atypical antipsychotics and multiple medications
- Lack of controlled trials to inform physicians' prescribing practices

Pappadopulos EA et al. Schizophr Bull. 2002;28:111-121.

Antipsychotic Use Is Increasing in Children and Adolescents

Age-specific prevalence rates of total antipsychotic use (1996-2000) based on analysis of Texas Medicaid claims

Patel NC, et al. J Child Adolesc Psychopharmacol. 2002;12:221-229.

Types of Medications Used to Treat Inpatient Youths

From a Sample of 100 Inpatient Charts, New York State Office of Mental Health (NYS-OMH). Pappadopulos EA et al. Schizophr Bull. 2002;28:111-121.

Diagnoses of Youths Treated With Antipsychotics

204 diagnoses from a sample of 100 inpatient charts (NYS-OMH). Pappadopulos EA et al. Schizophr Bull. 2002;28:111-121.

Antipsychotic Use by Indication in Child and Adolescent Patients*

N = 967.
 *Child and adolescent defined as 0-17 years of age.
 Source: IMS Health, NDTI, MAT ending 2Q02.

Initial Evaluation Prior to Pharmacologic Treatment

- Comprehensive diagnostic interview with patient and parent/guardian
 - Contact prior treating physician
 - Review treatment records
 - Contact teachers
 - Identify other medications being taken
- Physical examination
- Appropriate laboratory studies

Assess Treatment Effects and Outcomes

- Use standardized symptom/behavior rating scales to measure severity and frequency of target symptoms (eg, Modified Overt Aggression Scale)
 - Prior to treatment
 - At regular intervals throughout treatment
 - During acute episodes
 - When treatments are changed or discontinued



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THE MODIFIED OVERT AGGRESSION SCALE (MOAS)*

Patient _____ Date _____
 Rater _____

INSTRUCTIONS
 Rate the patient's aggressive behavior over the past week. Select as many items as are appropriate. Refer to the pocket guide for the full measure.

SCORING
 1) Add items in each category. 2) In scoring summary, multiply sum by weight and add weighted sums for total weighted score. Use this score to track changes in level of aggression over time.

Verbal Aggression
 0 No verbal aggression
 1 Shouts angrily, curses mildly, or makes personal insults
 2 Curses, swears, or is severely insulting, hits temple or cheeks
 3 Impulsively threatens violence toward others or self
 4 Threatens violence toward others or self repeatedly or deliberately
SUM VERBAL AGGRESSION SCORE

Aggression Against Property
 0 No aggression against property
 1 Throws floor angrily, rips clothing, urinates on floor
 2 Throws objects down, kicks furniture, defaces walls
 3 Breaks objects, smashes windows
 4 Pulls fire. Throws objects dangerously
SUM PROPERTY AGGRESSION SCORE

Autoaggression
 0 No autoaggression
 1 Hits or scratches skin, pulls hair out, hits self (without injury)
 2 Burns hand, hits teeth into walls, throws self on floor
 3 Burns hand with cigarettes, burns, or wounds self
 4 Inflicts major injury on self or makes a suicide attempt
SUM AUTOAGGRESSION SCORE

Physical Aggression
 0 No physical aggression
 1 Makes menacing gestures, swings at people, grabs at clothing
 2 Strikes, pushes, scratches, pulls hair of others (without injury)
 3 Attacks others, causing mild injury (bruises, sprains, welts, etc.)
 4 Attacks others, causing serious injury
SUM PHYSICAL AGGRESSION SCORE

CATEGORY	SUM SCORE	WEIGHTS	WEIGHTED SUM
Verbal Aggression		X1	
Aggression Against Property		X3	
Autoaggression		X3	
Physical Aggression		X5	
Total Weighted Score			

* Modified from Kay SR, Wenzel F, Marder LR (1988). Profile of aggression among psychiatric patients. I. nature and prevalence. *Journal of Nervous and Mental Disease* 77:323-340



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YOUNG MANIA RATING SCALE*

Patient _____ Date _____
 Rater _____

INSTRUCTIONS
 Rate the severity of the patient's manic symptoms over the last week. Item scores range from 0 to 8, with higher scores indicating a greater severity of symptoms. Items marked with a † are doubled due to their clinical importance. Refer to the pocket guide for the full measure.

Elevated Mood	0	1	2	3	4
Increased Motor Activity/Energy	0	1	2	3	4
Sexual Interest	0	1	2	3	4
Sleep	0	1	2	3	4
Irritability †	0	2	4	6	8
Speech (Rate and Amount) †	0	2	4	6	8
Language/Thought Disorder	0	1	2	3	4
Content †	0	2	4	6	8
Disruptive/Aggressive Behavior †	0	2	4	6	8
Appearance	0	1	2	3	4
Insight	0	1	2	3	4

TOTAL SCORE: _____
 (0-13 = minimal severity; 14-20 = mild; 21-26 = moderate; 27-38 = severe)

* Reprinted from Young RC, Biggs JT, Zugmaier VE et al. (1978). A rating scale for mania: reliability, validity, and sensitivity. *British Journal of Psychiatry* 133:429-435



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Nonpharmacologic Treatment of Primary Disorder

- Initiate psychosocial/behavioral treatment
- Exact therapeutic approach will depend on diagnosis and individual circumstances
- Provide evidence-based (EB) psychosocial treatment or close to it
- Assess patient response
- Continue psychosocial and/or educational therapy even if medication is initiated later to manage aggression



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Overview of Treatment Strategies for Chronic Agitation/Aggression

- First treat primary condition using adequate trials of:
 - Non-pharmacologic/educational treatments
 - Pharmacologic treatments
- If successful, continue as needed
- If unsuccessful, consider using atypical antipsychotics



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Behavioral Programs Can Lead to Reductions in Restraint and PRNs*

- Behavioral program implemented on coeducational residential unit for six months (program phase)
 - Token economy
 - Exclusionary timeout (i.e., a timeout room)
 - Response cost or fining
- Emergency mechanical restraints decreased by 79% during program phase and 81% during maintenance phase
- PRNs reduced by 79% during program phase and 75% during maintenance phase

Foxx, RM (1998). A comprehensive treatment program for inpatient adolescents. *Behav Interventions* 13:67-77



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Agitation Treatment for Pediatric Emergency Patients

JAACAP Feb. 2008

Non pharmacologic interventions

- Clearly introduce yourself, explain what will happen
- Use simplified language, soft voice, slow movements
- Reduce environmental stim (noise, light, fewer people)
- Remove breakable objects
- Allow room for pacing, offer food and drink,
- Reassure, listen, empathize
- Tell them you will honor reasonable requests

Non-pharmacologic interventions-continued

- Clarify their goals and try to link their cooperation to that goal
- Find things for the child to control, like choice of drinks
- Engage available consultants: security, SS, psychiatry
- Offer distracting toys/sensory modalities
- Remain engaged; perceived ignoring may encourage escalations
- Remember not to take their anger personally

Emergency Psychopharmacology

JAACAP Feb 08

- PO preferred over IM: usual scheduled dose or addl .25-.5 of total daily dose as single dose (check max dose range for benzos and antipsychotics)
- Anxiety: lorazepam, diazepam, Benadry
- Psychotic thoughts or mania: atypical antipsych
- Impulsive aggression: risperidone, olanzapine
- Delirium: treat the cause, risperidone, Haldol
- Add benzo to atypical after 30 min if needed
- IM drugs: lorazepam, diazepam, benadryl, ziprasidone, haldol, olanzapine
- PO Risperadone: same onset as IM Haldol 30 min.

TABLE 2
Emergency Psychopharmacology

The following recommendations should be reviewed with regional experts.

If patient is already taking psychiatric medications:

1. Give usual PO medications on schedule, unless toxicity suspected.
2. If not at usual dose time, consider one fourth to one half of total daily amount as a single dose if taking benzodiazepine or antipsychotic (check maximum dose range, avoid antipsychotic dose in potential for agitation).

Symptom-specific treatments (PO preferred over IM):

- Anxiety: lorazepam, diazepam, or possibly diphenhydramine
- Psychotic thoughts or mania: risperidone, olanzapine, IM ziprasidone, or IM haloperidol
- Impulsive, maladaptive aggression: risperidone or olanzapine
- Delirium: treat underlying medical cause, consider risperidone or haloperidol

May add on benzodiazepine to an antipsychotic after 30 minutes as needed.

General agitation treatments (PO preferred over IM):

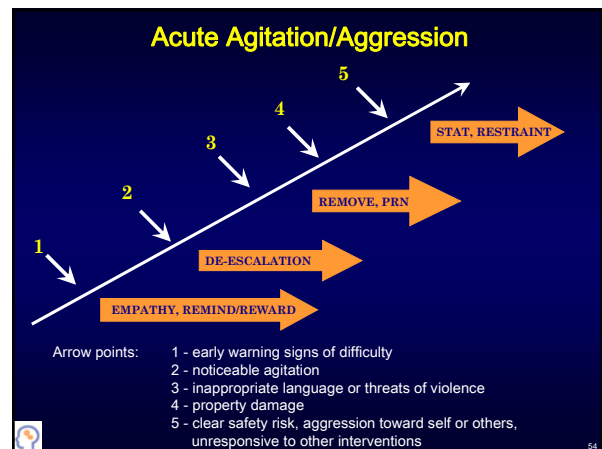
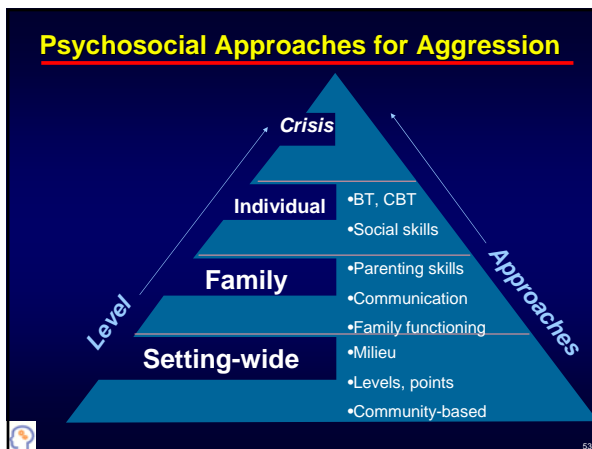
- PO risperidone
- PO olanzapine
- PO/IM/IV diazepam
- PO/IM/IV lorazepam
- IM ziprasidone
- IM haloperidol plus IM lorazepam (can be in same syringe)

May add on benzodiazepine to an antipsychotic after 30 minutes as needed.

Suggested dose ranges:

- Diazepam, 0.04-0.2 mg/kg/dose PO/IM/IV (max 10 mg/dose)
- Diphenhydramine, 1 mg/kg/dose to max 50 mg PO/IM/IV
- Haloperidol, 0.025-0.075 mg/kg/dose IM (max 5 mg/dose)
- Lorazepam, 0.05 mg/kg/dose PO/IM/IV (max 2 mg/dose)
- Olanzapine, 2.5 mg (school age) to 10 mg (late adolescence) PO
- Risperidone, 0.25 mg (school age) to 2 mg (late adolescence) PO
- Ziprasidone, 10-20 mg IM if >16 y, 10 mg IM if 12-16 y

Diphenhydramine or benzodiazepines may cause disinhibition. If muscle stiffness or movement problems develop after use of an antipsychotic, give diphenhydramine 1 mg/kg/dose to max 50 mg PO/IM/IV.



Atypical Antipsychotic Agents*

- Aggressive symptoms often require simultaneous use of antipsychotics with first-line treatments for primary conditions
- Evidence that atypical antipsychotics are effective for treating aggression
- First-line treatment for psychotic disorders in youth
 - Childhood-onset schizophrenia
 - First-episode schizophrenia

*Connor, D. In: *Aggression and Antisocial Behavior in Children and Adolescents: Research and Treatment*. New York, NY: Guilford Press; 2002.

Currently Available Atypical Antipsychotics

- Clozapine (Clozaril®)
- Risperidone (Risperdal®)
- Olanzapine (Zyprexa®)
- Quetiapine (Seroquel®)
- Ziprasidone (Geodon®)
- Aripiprazole (Abilify®)

Short-term Randomized Trials for Aggression

Study	Subjects Diagnosis	Duration & Dose range	Results
Aman et al., 2002	n=118, 5-12 years • DBD • Subaverage intelligence	• 6 weeks • oral risperidone 0.02-0.06 mg/kg/day	• Risperidone more effective than placebo. • Most common adverse events: headache and somnolence.
Snyder et al., 2002	n=110, 5-12 years, IQ 36-84 • DBD, NCBRF score ≥ 24 • 80% w/ comorbid ADHD	• 1 week (SB) then 6 weeks (DB) • risperidone 0.02-0.06 mg/kg/day	• Risperidone superior to placebo • Most common adverse events: somnolence, headache, appetite ↓, dyspepsia.
Van Bellinghen et al., 2001	n=13, 6-14 years, IQ 66-85 • behavioral disturbance	• 4 weeks • risperidone ≤ .01 mg/kg/day	• Risperidone superior to placebo
Findling et al., 2000	n=20, 5-15 years • CD • Moderate severity (CGI)	• 10 weeks, • risperidone <50 kg, ≤ 1.5 mg/kg/day; >50 kg, ≤ 3 mg/kg/day	• Risperidone superior to placebo • No noted EPS

Nonrandomized Long-term Pharmacological Interventions

Study	Subjects Diagnosis	Duration & Dose range	Results
Findling et al., 2004	n=107, 5-12 years, IQ 36-84 • Severe DBD • Subaverage intelligence	• 48 weeks • oral risperidone 0.02-0.06 mg/kg/day	• Rapid, significant improvement • AE: somnolence, headache, rhinitis, weight gain.
Turgay et al., 2002	n=77, 5-12 years • DBD • Low intellectual functioning • Completed 2 weeks of DB therapy	• 48 weeks • risperidone 0.02-0.06 mg/kg/day	• Risperidone reduced CD • Most common adverse events: somnolence, headache, weight gain. • Efficacy of risperidone was constant.

Atypical Antipsychotic Dosing Strategies

- Be conservative
 - "Start low, go slow, taper slowly"
- Minimize use of prns or stats
- Assess response and side effects on routine and systematic basis
- Use atypical antipsychotic agent at adequate dose for appropriate period before making changes

AP SIDE-EFFECTS CHECKLIST

Patient _____ Date _____
 Rater _____

INSTRUCTIONS
 Rate the severity of the following side effects from 0 (not present) to 3 (severe). Side effects marked with a † should be scored using only 0 (not present) or 1 (present). Refer to the pocket guide for BMI scores and age percentiles.

ANCHORS
 0 = None
 1 = Mild
 2 = Moderate
 3 = Severe
 N/A = Not Assessed

Life-Threatening		Weight and Diabetes	
NMS †	_____	Height	_____ inches
Decreased ANC	_____	Baseline Weight	_____ lbs.
Agranulocytosis †	_____	Current Weight	_____ lbs.
Marked increase in LFTs	_____	Weight Gain	_____ lbs.
		BMI	_____
		BMI Percentile	_____
EPS		Elevated Glucose	_____
Akathisia	_____	Elevated Cholesterol	_____
Akinesia	_____	Elevated Triglycerides	_____
Tremor	_____		
Muscle Rigidity	_____	Endocrine	
Dystonia †	_____	Amenorrhea †	_____
Tardive Dyskinesia	_____	Galactorrhea †	_____
		Gynecomastia †	_____
Cognitive Effects			
Confusion	_____	Anticholinergic	
Memory Problems	_____	Dry Mouth	_____
Sedation	_____	Blurred Vision	_____
Hypersomnia	_____	Constipation	_____
Irritability	_____		
Headache	_____	Other	
		Insomnia	_____
Cardiac		Nausea/Vomiting	_____
QTc Prolongation	_____	Sexual Dysfunction	_____
Tachycardia	_____	Decreased Libido	_____
Hypotension	_____	Dermatological	_____
		Hypersalivation	_____
		Enuresis	_____

Avoiding Polypharmacy

- Avoid using multiple medications simultaneously whenever possible
- Re-evaluate regimen of patient who does not experience decreased aggression while receiving multiple medications
- Consider tapering/discontinuing one or more medications if patient is on 4 medications without clear benefit



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Evaluating Antipsychotic Therapy

- When using atypical antipsychotic for the treatment for aggression
 - If no response, try a second atypical agent
 - If a partial response, consider adding a mood stabilizer



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Tapering/Discontinuing Medications

- Consider tapering atypical antipsychotic medications in patients showing remission of aggressive symptoms for 6 months or longer
- If tapering of dose is well tolerated, discontinue the medication



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Case study

- MD 17 y.o. male, GAT, athletic
- Victim of bullying in jr high, bullied suicided, bullie's former girlfriend is now patient's GF
- Irritable, problems with authority, parent conflict
- History of separation anxiety
- Yells at bosses, teachers, cheating, violent outbursts, punches holes in walls, broke chairs
- No FH of Bipolar or EtOH
- Impulsive, inattentive
- Won't touch handles on doorknobs



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Case study con't

- ADD, OCD, Anxiety, ODD, BPD
- Severe family disruption
- Legal problems, college dropout
- Chemical dependency
- Multiple meds tried including stimulants, SSRIs mood stabilizers, atypicals, clonazepam
- Help parents set boundaries and protect themselves



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Case study #2 JE

- 18 y.o. Hx Depression, cutting, suicidal ideation
- ADHD-stimulants cause irritability
- Hx. Pick up table, throw plates, grabbed knife, almost punched hockey coach
- Zyprexa, Wellbutrin
- 30 lb. Weight gain: D/C Zyprexa
- PE: lots of anger, unaware of it. Very irritable
- Started Abilify: less irritable
- Jr. college, loves to hunt, fish, hang out



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Case study #3

- 11 y.o. male 5th degree assault of bus driver
- Rigid rule follower, anxiety
- Poor social skills, gets picked on
- Refused to move from his seat
- Adult attempted to forcibly remove him
- Started SSRI, wrote letter to the school



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Comments and Questions

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