

Disruptive Behavior Disorders

Child with oppositional patterns and/or aggressive patterns interfering with functioning in home, school, or with peers

History:

- From parent and child
- review symptoms of ODD and CD, with attention to safety concerns
- Ask about parents' discipline practices
- ask about parental depression or mental health

Primary reference source: AACAP.
Practice parameter for the assessment and treatment of children and adolescents with oppositional defiant disorder. *J Amer Acad Child Adolescent Psychiatry.* 2007;46(1):126-141.

Safety assessment

- Confirm any firearms or other weapons in home are secured
- Adolescent substance abuse
- Rule out maltreatment and family violence
- Homicidal thoughts/plans

As needed:
Advise firearm safety
Substance abuse referral
OCS referral
ER emergency referral for safety

Differential Diagnosis (details below)

- Normal Development
- ADHD
- Adjustment disorder with disturbance of conduct
- Anxiety disorders
- Developmental delay
- Mood disorder
- Punitive parenting/consider maltreatment

Treat primary disorder first

Severe aggression, significant risk to others or risk of educational failure?

Yes

No

Refer for mental health evaluation , continue to follow at least q month until referral solid

Ongoing symptoms or worsening? No specialtv appt?

Yes

Consider psychopharmacological treatment as adjunct to behavioral rx (chart below)

Primary Care Interventions

- Explain rationale for safe consequences
- (Specific interventions described below)
- General Principles of interventions for disruptive behavior disorders
 - Reduce positive reinforcement of disruptive behavior
 - Increase reinforcement (praise, token economy) of prosocial and compliant behaviors
 - Ignore annoying or mildly oppositional/provocative behaviors (reduce attention)
 - Punishment for disruptive or unsafe behaviors usually consists of a form of time out, loss of tokens, and/or loss of privileges.
 - Make parental response predictable, contingent and immediate.
- Schedule frequent follow-ups
- Monitor with Vanderbilt or other scale q month

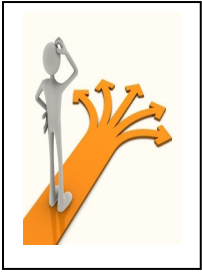
Ongoing symptoms or worsening?

Yes

Disruptive Behavior Disorders

Hallmark symptoms: Difficulty following rules, trouble with respecting adult authority, and/or aggressive and destructive behaviors.

Oppositional Defiant Disorder	Conduct Disorder	Disruptive Disorder NOS
A pattern of negativistic, hostile, and defiant behavior lasting at least 6 months	Repetitive and persistent pattern of behavior in which the basic rights of others or major age-appropriate societal norms or rules are violated	Signs of ODD and/or CD which do not meet full criteria but which cause significant functional impairment
6 month duration	12 month duration	
At least 4 symptoms	At least 3 of following symptoms	
(1) often loses temper (2) often argues with adults (3) often actively defies or refuses to comply with adults' requests or rules (4) often deliberately annoys people (5) often blames others for his or her mistakes or misbehavior (6) is often touchy or easily annoyed by others (7) is often angry and resentful (8) is often spiteful or vindictive	Aggression to people and animals (1) often bullies, threatens, or intimidates others (2) often initiates physical fights (3) has used a weapon that can cause serious physical harm to others (e.g., a bat, brick, broken bottle, knife, gun) (4) has been physically cruel to people (5) has been physically cruel to animals (6) has stolen while confronting a victim (e.g., mugging, purse snatching, extortion, armed robbery) (7) has forced someone into sexual activity	
	Destruction of property (8) has deliberately engaged in fire setting with the intention of causing serious damage (9) has deliberately destroyed others' property (other than by fire setting)	
	Deceitfulness or theft (10) has broken into someone else's house, building, or car (11) often lies to obtain goods or favors or to avoid obligations (i.e., "cons" others) (12) has stolen items of nontrivial value without confronting a victim (e.g., shoplifting, but without breaking and entering; forgery)	
	Serious violations of rules (13) often stays out at night despite parental prohibitions, beginning before age 13 years (14) has run away from home overnight at least twice while living in parental or parental surrogate home (or once without returning for a lengthy period) (15) is often truant from school, beginning before age 13 years	
Out of proportion to age and developmental level		
Must cause functional impairment	Must cause functional impairment	
Not only in the context of mood or psychotic disorder		



Differential Diagnosis of Disruptive Behavior Disorders

Diagnosis

Normal development

How the diagnosis can be differentiated from DBD

Behaviors are described as problematic but are typical for child's developmental level. Also consider low parental frustration threshold, and a wide range of causes of parental stress, or high parental anxiety.

ADHD

Impulsivity and inattention prominent, behaviors do not violate social norms the way CD behaviors do/are associated with remorse when caused by impulsivity

Adjustment disorder with disturbance of conduct

Changes in behavior in response to known (or not yet identified) stressor such as important changes in family structure from death, divorce, family conflict, in school setting including new teacher, emotionally unsafe educational or other environment, or changes in home setting. Adjustment disorder should be considered when changes in behavior are sudden or context-specific.

Anxiety Disorders

(Including generalized anxiety, separation anxiety, specific phobias, obsessive compulsive disorder)

Pervasive or context-specific anxiety can be identified by asking child about internal responses and asking parent about range of anxiety symptoms. Disruptive behaviors may present in young children or those with limited ability to express internal distress or around powerful triggers like driving to school for a child with school avoidance or a child with OCD who is directed not to follow a compulsion.

Frustration associated with **Developmental Delays**

Disruptive behaviors in the context of excessive developmental demands- being asked to/trying to do something that is beyond the child's capacity in academic setting, language, or physical development.

Mood Disorder

(Depressive disorder, bipolar disorder)

Prominent mood symptoms (depression, irritability, euphoria), behavioral difficulties decrease when mood normalizes, "neurovegetative" symptoms such as sleep, appetite, concentration, energy problems present, symptoms interfere with non-authority relationships like friends, siblings

Assessment Strategies

Universal screening- Pediatric Symptom Checklist or other broad-band screener. Attend to "2"s on items related to aggressive or oppositional behaviors.

Symptom-Specific Structured measures

- Vanderbilt ADHD Rating Scale (ages 6-12)
 - ODD: items 19-26 (require ≥ 4 for positive score)
 - CD: items 27-40 (require ≥ 3 for positive score)

History

- Include history from child and parent
- Rule out major changes in family or educational setting
- Ask about new violence exposure
- Explore parenting style, consequences for inappropriate behaviors
- Explore parental depression/other psychopathology, which may contribute to harsh, punitive parenting



- If history of chronic or severe medical problem, consider that parents may see child as vulnerable and that child has not experienced consistent limit setting

Physical Examination/observations

- Physical exam unlikely contributory
- Notice child compliance with parent and staff instructions (and any difference in these patterns)
- Attend to general mood in room (fearful? angry?)

Referrals to consider

- Cognitive testing or developmental testing (r/o specific learning disability, developmental delay)
- Hearing screen (if concerned about deafness)

Safety issues in DBDs

- Confirm any firearms or other weapons in home are secured
- Adolescent substance abuse
- Rule out maltreatment and family violence (parent-> child, parent-> parent, child -> parent)



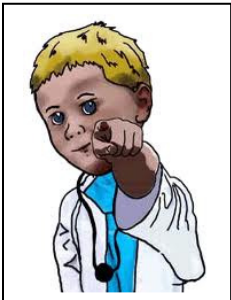
Primary Care Interventions for DBDs

Prevention

- Start discussing aggression at 1 year visit
- Emphasize the power of enjoying the baby!

Prevention and early intervention

- Acknowledge stresses of parenting
- Explain rationale for recommendations regarding safe consequences
- General Principles of interventions for disruptive behavior disorders
 - Reduce positive reinforcement of disruptive behavior
 - Increase reinforcement (praise, token economy) of prosocial and compliant behaviors
 - Ignore annoying or mildly oppositional/provocative behaviors (reduce attention)
 - Punishment for disruptive or unsafe behaviors usually consists of a form of time out, loss of tokens, and/or loss of privileges.
 - Apply consequences and/or punishment for disruptive behavior.
 - Make parental response predictable, contingent and immediate.
- Schedule frequent follow-ups



Specific intervention strategies: Preschool and School age children

- Consider behavior chart (handout included)
- Prescribe "Time in" (handout included)
- Review safe discipline strategies

Specific intervention strategies: Adolescents

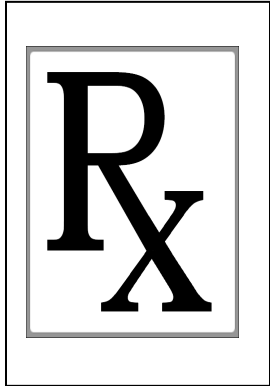
- Emphasize problem solving skills (handout included)
- Focus on identifying and managing emotional reactions
- Encourage constructive family communication
- Encourage balance of positive reinforcement (motivators) and contingent, safe consequences (punishments)

Indicators of need for specialty referral

- Extreme, unsafe behaviors (use of weapons, aggressive behaviors)
- Unresponsive to primary care interventions
- Extreme family distress/parental mental health problems



- Duty to protect: If a patient has a clear plan to harm someone else, clinician should take steps to protect that individual (referral to law enforcement, referral to ER/mental health for safety assessment, or other)



Evidence Based Treatments for ODD/CD and Parent Handouts

Program name	Age Range	Website/resources
Incredible Years Series	0-8	www.IncredibleYears.com
Triple P-Positive Parenting Program	0-13	http://www5.triplep.net
Parent Child Interaction Therapy	0-8	www.pcit.org
Center for Collaborative Problem Solving	0-18	www.explosivechild.com
Functional Family Therapy	10-18	http://www.fftinc.com
The Adolescent Transitions Program	11-13	http://cfc.uoregon.edu/atp.htm

Adapted from AACAP (2009) ODD: A guide for families from the American Academy of Child and Adolescent Psychiatry. Washington DC. www.aacap.org

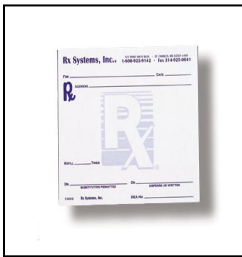
Specialty treatments used in ODD/CD

Preschoolers

- Parent management training- focuses on increasing positive interactions, shaping child behavior through positive reinforcement, increased attention to positive behaviors, less attention to negative behaviors, clear, safe consequences for unsafe behaviors)

Adolescents

- Individual therapy focused on problem solving
- Family therapy to address maladaptive communication and parenting styles
- Group therapy
- Multi-systemic therapy (MST)- addresses basic needs and provides intensive case management and home based therapy
- Functional Family Therapy (FFT)- addresses problematic family communication and interaction styles



Role of psychopharmacology in treatment of aggressive behaviors

Principles of psychopharmacology in treating DBDs

- Medications for youth with ODD are mostly considered to be adjunctive, palliative, and noncurative.
- Medication should not be the sole intervention in ODD and is not the first line treatment
- Medication trials are most effective after a strong treatment alliance has been established
- Nonresponsiveness to a specific compound should lead to a trial of another class of medication rather than the rapid addition of other medications.
- Treat primary underlying cause of aggression with disorder-specific medications (e.g. stimulants or alpha agonists for ADHD before atypical antipsychotic agent)
- *(Adapted from AACAP (2007) Practice Parameter for assessment and treatment of ODD and Pappadopulus (2003) Treatment recommendations for use of antipsychotics for aggressive youths. Full references below).*

Summary of Medications used in treatment of aggression

Medication (brand name)	Medication class	Usual starting dose	Usual titration plan	Maximum pediatric dose	Supported by RCTs?	FDA Approved for aggression	Common Adverse effects	Potentially dangerous adverse effects
Clonidine	Alpha Agonist	.025-.5 mg qhs	Increase by 0.05 mg/day q week	0.3 mg per day divided TID	Yes	Yes	Hypotension, drowsiness, sedation	Hypotension, bradycardiarebound hypertension
Guanfacine (Tenex; Intuniv)	Alpha Agonist	.25-.5 mg qhs	Increase by max 0.5 mg/day every 7 days	3 mg per day divided BID	No	No	Hypotension, drowsiness, sedation (less than clonidine)	Hypotension, rebound hypertension
Methylphenidate (immediate release or extended release formulations)	Stimulant	5-10 mg BID (am and noon) or equiv	Can increase quickly every 3-7 days to effect/adverse effects	60 mg per day	Yes	No (not for aggression)	Decreased appetite, sleep disturbance, emotional dysregulation,	? Association with sudden death, lower seizure threshold
Risperidone	Atypical antipsychotic	0.125-.25 mg q hs	.25-.5mg per 1-2 weeks (minimum 2 week trial)	< 45 kg: 2.5 mg; >45 kg: 3 mg	Yes	Yes (for children with PDD)	Sedation, weight gain, hyperglycemia and hyperlipidemia	Metabolic effects, Extrapyramidal side effects
Lithium	Salt				yes	Yes	Sedation, hypothyroidism,	Ventricular tachycardia, delirium
Valproate	AED				No	No		Teratogenicity, polycystic ovary

Resources for parents: See AACAP Parent Handout

References for DBD section

AACAP. Practice parameter for the assessment and treatment of children and adolescents with oppositional defiant disorder. *J Amer Acad Child Adolescent Psychiatry*. 2007;46(1):126-141.

- Chacko A, Wakschlag LS, Hill C, Danis B, Espy B. Viewing preschool disruptive behavior disorders and attention-deficit/hyperactivity disorder through a developmental lens: What we know and what we need to know. *Child and adolescent psychiatric clinics of North America*. 2009;18(3):627.
- Connor DF, Boone RT, Steingard RJ. Psychopharmacology and aggression: II. A meta-analysis of nonstimulant medication effects on overt aggression-related behaviors in youth with SED. *Journal of Emotional and Behavioral Disorders*. 2003;11(3):157-168.
- Connor DF, Glatt SJ, Lopez I. Psychopharmacology and aggression. I: A meta-analysis of stimulant effects on overt/covert aggression-related behaviors in ADHD. *J Amer Acad Child Adolescent Psychiatry*. 2002;41(3):253-261.
- Eyberg SM, Nelson MM, Boggs SR. Evidence-based psychosocial treatments for children and adolescents with disruptive behavior. *Journal of Clinical Child and Adolescent Psychology*. 2008;37(1):215.
- Pappadopulos E, MacIntyre JC, Crimson L, et al. Treatment recommendations for the use of antipsychotics for aggressive youth (TRAAY). Part II. 2003;42(2):145-161.