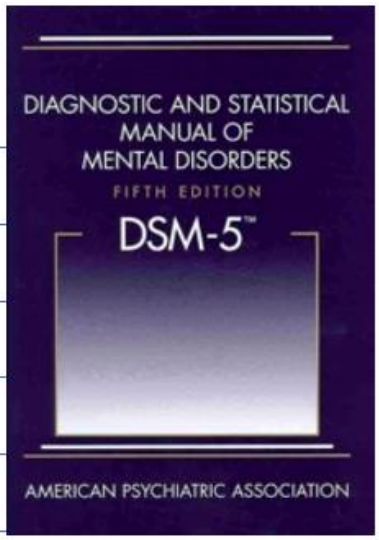
DISRUPTIVE BEHAVIORS

• Disruptive Behaviors •

Disruptive, Impulse-control, and Conduct Disorders involve problems in the self-control of emotions and behaviors which result in the violation of another one's rights and/or cause significant conflict with societal norms or authority figures.

DSM 5: Disruptive, Impulse Control, and Conduct Disorders
Oppositional defiant disorder
Intermittent explosive disorder
Conduct disorder
Antisocial personality disorder
Pyromania
Kleptomania
Other specified disruptive, impulse-control, and conduct disorders
Unspecified disruptive, impulse-control, and conduct disorders



Epidemiology[1]

Recent data collected as part of the National Survey of Children's Health (survey years: 2016 – 2019) reported an 8.9% prevalence rate of children and adolescents aged 3–17 years with a diagnosis of behavior problems, with a 7.0% point prevalence rate at the time of the survey. Children aged 6–11 years had higher rates of behavior problems than children who were less than 6 years or older than11 years. Similar to rates of ADHD, boys had more than twice the estimated prevalence of behavior problems compared with girls. When considering factors related to race, Black children had the highest estimated prevalence of behavior problems, followed by White and Hispanic children, with the lowest estimates among Asian children.

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Socioeconomic factors determined that the highest prevalence of behavior problems was among children in homes affected by poverty and among children with public health insurance; the prevalence of behavior problems was also higher among children of parents with a high school education (or less) as compared to those families with parents attaining more than a high school education. Additionally, it was found that the prevalence of behavior problems was higher among children living in rural areas than among those in urban or suburban areas.

Diagnostic Criteria

The revision of DSM-IV to DSM-5 added a chapter specifically categorizing disruptive, impulse-control, and conduct disorders. This revision brought together disorders that were previously included in the chapter "Disorders Usually First Diagnosed in Infancy, Childhood, or Adolescence" (i.e., oppositional defiant disorder; conduct disorder; and disruptive behavior disorder not otherwise specified, now categorized as other specified and unspecified disruptive, impulse-control, and conduct disorders) and the chapter "Impulse-Control Disorders Not Otherwise Specified" (i.e., intermittent explosive disorder, pyromania, and kleptomania). Evidenced based research supported the underpinnings of these disorders to all be characterized as problems in emotional and behavioral self-control.

Of note, ADHD is frequently comorbid with the disorders in this chapter but is now listed in DSM 5 within the chapter categorizing Neurodevelopmental Disorders. It had previously (DSM-IV TR) been considered within the Disruptive Behavior Disorders. Please review the ADHD Colorado Care Guide for further information on the assessment, diagnosis, and treatment of ADHD.

Click the links below to review diagnostic criteria for each of the DSM-5 categorized disruptive, Impulse control, and conduct disorders:

- Oppositional Defiant Disorder
- Intermittent Explosive Disorder
- Conduct Disorder
- Antisocial Personality Disorder
- Pyromania
- Kleptomania
- Other specified disruptive, impulse control, and conduct disorders
- Unspecified disruptive, impulse control, and conduct disorders

Etiology

Several biological and environmental risk factors have been associated with the development of disruptive behaviors. Parents or caregivers should be supported in receiving their own forms of psychotherapy as needed.

Biological Risk Factors

- Parent with a diagnosis of:
  - o Alcohol Dependence
  - o Antisocial Personality Disorder
  - o Attention Deficit/Hyperactivity Disorder
  - o Conduct Disorder
  - o Schizophrenia
- Sibling with a Disruptive Behavior Disorder
- ODD: Familial Pattern ODD is more common in families in which at least one parent has a history of Mood Disorder, ODD, CD, ADHD, ASPD, or a Substance Related Disorder. Some studies suggest a link between maternal depression and ODD; however, the direction of causality is suspect. ODD is more common in the families where there is serious marital discord
- CD: Familial Pattern Twin and adoption studies show genetic and environmental factors
- Maternal smoking during pregnancy
- Maternal and paternal depression/ postpartum mood disorders

Environmental Risk Factors

- Parental rejection/neglect
- Harsh discipline
- Inconsistent parenting/multiple caregivers
- Lack of Supervision
- Large family size
- Single parent status
- Marital discord
- Abuse and neglect – emotional, physical or sexual
- Poverty
- Parental criminality & psychopathology
- Drug and alcohol use by parents/caregivers
- Exposure to violence

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Screening

CoPPCAP recommends pediatric providers initially use an age-appropriate broadband screening measures to better understand the symptom profile. When clinically indicated, narrowband screening measures, especially ones that collect information from multiple reports and within multiple environments may be utilized to further detect symptoms of a disruptive behavior disorder. Consider the use of the following screening measures that include several open-source options that are free for use:

Screener. DxCategory	Screener.Name	Screener.Acronynm	Screener.Description
Social-Emotional Development	The Survey of Well-being of Young Children 2-60 months Caregiver Report	SWYC ⇒ English ⇒ Spanish	The Survey of Well-being of Young Children (SWYC)™ is a freely-available, comprehensive screening instrument for children under 5 years of age. The SWYC was written to be simple to answer, short, and easy to read. The entire instrument requires 15 minutes or less to complete and is straightforward to score and interpret. The SWYC is approved by MassHealth for compliance with the Children's Behavioral Health Initiative screening guidelines. The SWYC is copyright © 2010 Tufts Medical Center. Every SWYC form includes sections on developmental milestones, behavioral/emotional development, and family risk factors. At certain ages, a section for Autism-specific screening is also included. Age-specific SWYC forms are available for each age on the pediatric periodicity schedule from 2 to 60 months.
Social-Emotional Development	Preschool Pediatric Symptom Checklist 18-60 months Caregiver Report	PPSC ⇒ English ⇒ Spanish	The Preschool Pediatric Symptom Checklist (PPSC) is a social/emotional screening instrument for children 18–60 months of age. The PPSC was created as one part of a comprehensive screening instrument designed for pediatric primary care and is modeled after the Pediatric Symptom Checklist.
Social-Emotional Development	Brief Early Childhood Screening Assessment 18-60 months Caregiver Report	Brief ECSA* ⇒ English	The Brief ECSA screens children 18-60 months for signs of emotional and behavioral problems.

Social-Emotional Development	Pediatric Symptom Checklist – 17 item 4-18 years Caregiver Report	PSC-17 ⇒ English ⇒ Spanish	The Pediatric Symptom Checklist is a 17-item screening questionnaire listing a broad range of children's emotional and behavioral problems that reflects parents' impressions of their child's psychosocial functioning. The screen is intended to facilitate the recognition of emotional and behavioral problems so that appropriate interventions can be initiated as early as possible. The PSC-17 is used to screen for childhood emotional and behavioral problems including those of attention, externalizing, and internalizing.
Social-Emotional Development	Pediatric Symptom Checklist – Youth – 17 item 11-18 years Self-Report	PSC-Y-17 ⇒ English ⇒ Spanish	The Pediatric Symptom Checklist - Youth - 17 is a 17 item screening questionnaire listing a broad range of behavioral and psychosocial problems in youth. The screen is intended to facilitate the recognition of emotional and behavioral problems so that appropriate interventions can be initiated as early as possible. The PSC-Y-17 is used to screen for emotional and behavioral problems including those of attention, externalizing, internalizing, and suicidal ideation.
Social-Emotional Development	Ages & Stages Questionnaire: Social Emotional 1-72 months Caregiver Report	ASQ-SE $$$	SQ:SE- 2 is a set of questionnaires about behavior and social- emotional development in young children. There are nine questionnaires for different ages to screen children from 1 month to 6 years old.

Screener.Dx Category	Screener.Name	Screener.Acronynm	Screener.Description
Irritability Outbursts	The Emotional Outburst Inventory 6-12 years Caregiver Report Teacher Report	EMO-I ⇒ English	The Emotional Outburst Inventory (EMO-I) is a brief screening tool for irritability and severe emotional outbursts in youth
Irritability Outbursts	The Modified Overt Aggression Scale 13+ years Caregiver Report	MOAS ⇒ English	Scale of severity of aggressive behavior on a weekly basis; has been used as an outcome measure for aggression treatment studies

Options for Treatment: Psychotherapy

Without intervention, it is likely that Disruptive Behavior Disorders may progress. There are several promising treatments that are available and if completed have enduring benefits. Early intervention during preschool years have been linked with the most lasting benefits. A thorough review from Kaminski & Claussen (2017) demonstrated multiple modes of therapy have been effective in reducing/treating disruptive behaviors but finding the right mode of therapy for families impacts adherence and outcomes. Note that effective treatment for disruptive behaviors involves parents/caregivers in the therapy.

Evidence based forms of psychotherapy for treating disruptive behaviors include:

- **Parent Management Training** (PMT) is directed toward parents and teaches them to identify antecedents, resulting behaviors and the associated consequences for their children as well as themselves. Ultimately, the training focuses on reinforcing desired behaviors. PMT has been shown to be effective for children ranging in ages from 3 – 13. Learn more at: www.blueprintsprograms.org/parent-management-training-pmt/

- **Parent-Child Interaction Therapy** (PCIT) emphasizes improvements in the relationship between the parent and child and offers tools to help manage behaviors that are disruptive. PCIT has been shown to be effective for children ranging in ages from 2 – 12. Learn more at: www.pcit.org

- **Incredible Years®** is a set of interlocking, comprehensive, and developmentally based programs targeting parents, teachers, and children. The training programs that compose Incredible Years® Series are guided by developmental theory on the role of multiple interacting risk and protective factors in the development of conduct problems. The programs are designed to work jointly to promote emotional, social, and academic competence and to prevent, reduce, and treat behavioral and emotional problems in young children. Incredible Years has been shown to be effective for children ranging in ages from 0 – 12. Learn more at: https://incredibleyears.com/

- **Positive Parenting Program** ® (Triple P) is a parenting and family support system designed to prevent – as well as treat – behavioral and emotional problems in children and teenagers. It aims to prevent problems in the family, school, and community before they arise and to create family environments that encourage children to realize their potential. Triple P has been shown to

be effective for children ranging in ages from 0 – 16. Learn more at: https://www.triplep.net/glo-en/home/

- **Multisystemic Therapy** (MST) is a family- and community-based intervention originally developed for juvenile offenders. It has since been adapted and evaluated for a range of serious externalizing problems, including violent offending and substance abuse. MST employs a home-based model, delivering services where problems occur (i.e., homes, schools, and neighborhoods).5 MST has been shown to be effective for children ranging in ages from 12 – 17 but can be utilized outside that range as clinically appropriate. Learn more at: www.blueprintsprograms.org/programs/32999999/multisystemic-therapy-mst/

- **Function Family Therapy** (FFT) is a family-based prevention and intervention program for high-risk youth that addresses complex and multidimensional problems through clinical practice that is flexibly structured and culturally sensitive. PMT has been shown to be effective for children ranging in ages from 11 – 18. Learn more at: www.fftllc.com/

Options for Treatment: Pharmacotherapy

- An important first step for treatment is a comprehensive assessment of underlying causes, as reviewed above.
- **Medication should be used as an adjunctive to a psychosocial, community and educational interventions (see therapies listed above).**
- Medications seem to be more helpful for impulsive, reactive types of aggression, rather than proactive (planned, predatory).
- Given that there are few FDA approved options for any specific disruptive behavior disorders or aggression, we are often treating the symptoms of an underlying diagnosis.
    - Generally, this is palliative not curative, but can help while other skills are learned in therapy and practiced in the family setting.
    - First treat any underlying disorder, then target specific symptoms if not improving.
- First treat underlying ADHD, Anxiety or Mood disorder, such as DMDD.
    - Colorado Care Guide – ADHD
    - Colorado Care Guide – Anxiety
    - Colorado Care Guide - Depression
- Optimize treatment of mood or anxiety with SSRI.
- Optimize treatment of ADHD with stimulant +/- alpha-agonist

- TOSCA study of Severe Childhood Aggression in kids with ADHD and Oppositional Defiant Disorder (ODD) or Conduct Disorder (CD) found that maximizing stimulant treatment or adding risperidone led to improvement in aggression, conduct and ODD symptoms, and ADHD.
- Risperidone is the most studied atypical antipsychotic for aggression
  - specifically in conduct disorder, lower IQ and autism.
- Pediatric patients are at increased risk for side effects from Atypical Antipsychotics. Young age and male sex increase risk for dystonic reactions. See additional considerations for metabolic monitoring below the table.

Medications

Medications that may be used to treat comorbid disorders in children and adolescents with disruptive behaviors

Class	Medication (Brand name)	Common dose range (mg/day)	Tablet size (mg)	Common side effects	Serious or Rare side effects	FDA Indications
SSRI	Escitalopram (Lexapro™)	5 – 20	5, 10, 20	• Headache • Insomnia • Diarrhea • Decreased appetite • Hyperactivity/restlessness • Vomiting • Increased anger/irritability • Sexual dysfunction • Muscle pain • Weight loss/gain	• Boxed warning—suicidal thinking and behavior in children, adolescents, and young adults • Potential for abnormal heart rhythm • Mania • Serotonin syndrome Bleeding problems	Fluoxetine - 8 years and up for depression. Escitalopram – 12 years and up for depression Sertraline – pediatric OCD Duloxetine (SNRI)- generalized anxiety disorder ages 7 and up.
	Sertraline (Zoloft™)	25 – 200	25, 50, 100			
	Fluoxetine (Prozac™, Sarafem™)	10 – 60	10, 20, 40, 60			
Atypical Antipsychotics	Aripiprazole (Abilify™)	1-15	2, 5, 15, 20, 30	• Restlessness • Dizziness • Orthostasis • increased appetite • Weight gain, • Fatigue, drowsiness, • Nausea, • Heartburn, • Metabolic changes (elevated cholesterol) • Hyperprolactinemia • constipation • sedation • sialorrhea • sexual dysfunction • Extrapyramidal symptoms- tremor or muscle stiffness	• Neuroleptic Malignant Syndrome • Lower seizure threshold QTc prolongation	• 10 and older for bipolar disorder, manic or mixed episodes. • 13 to 17 for schizophrenia and bipolar. • **5 to 17 for irritability associated with autism**
	Risperidone (Risperdal™)	0.25 – 4	0.25, 0.5, 1, 2, 3, 4 Solution: 1mg/mL			• 13 and older for schizophrenia • 10 and older for bipolar mania and mixed episodes • **5 to 16 for irritability associated with autism**
	Quetiapine (Seroquel™)	25 – 400	25, 50, 100, 200, 300, 400			• 13 and older for schizophrenia • 18 and older for bipolar disorder. • 10 17 for treatment of manic and mixed episodes of bipolar disorder.
	Olanzapine (Zyprexa™)	2.5 – 15	2.5, 5, 7.5, 10, 15, 20			• ages 13 17 as second line treatment for manic or mixed episodes of bipolar disorder • and schizophrenia (13 17).
Antihistamine	Diphenhydramine (Benadryl™, Banophen™, Diphenhist™)	12.5 – 50	25, 50	• Sleepiness • Dry mouth • Decreased sweating	• symptoms. • Abnormal heart rhythms • Agitation	

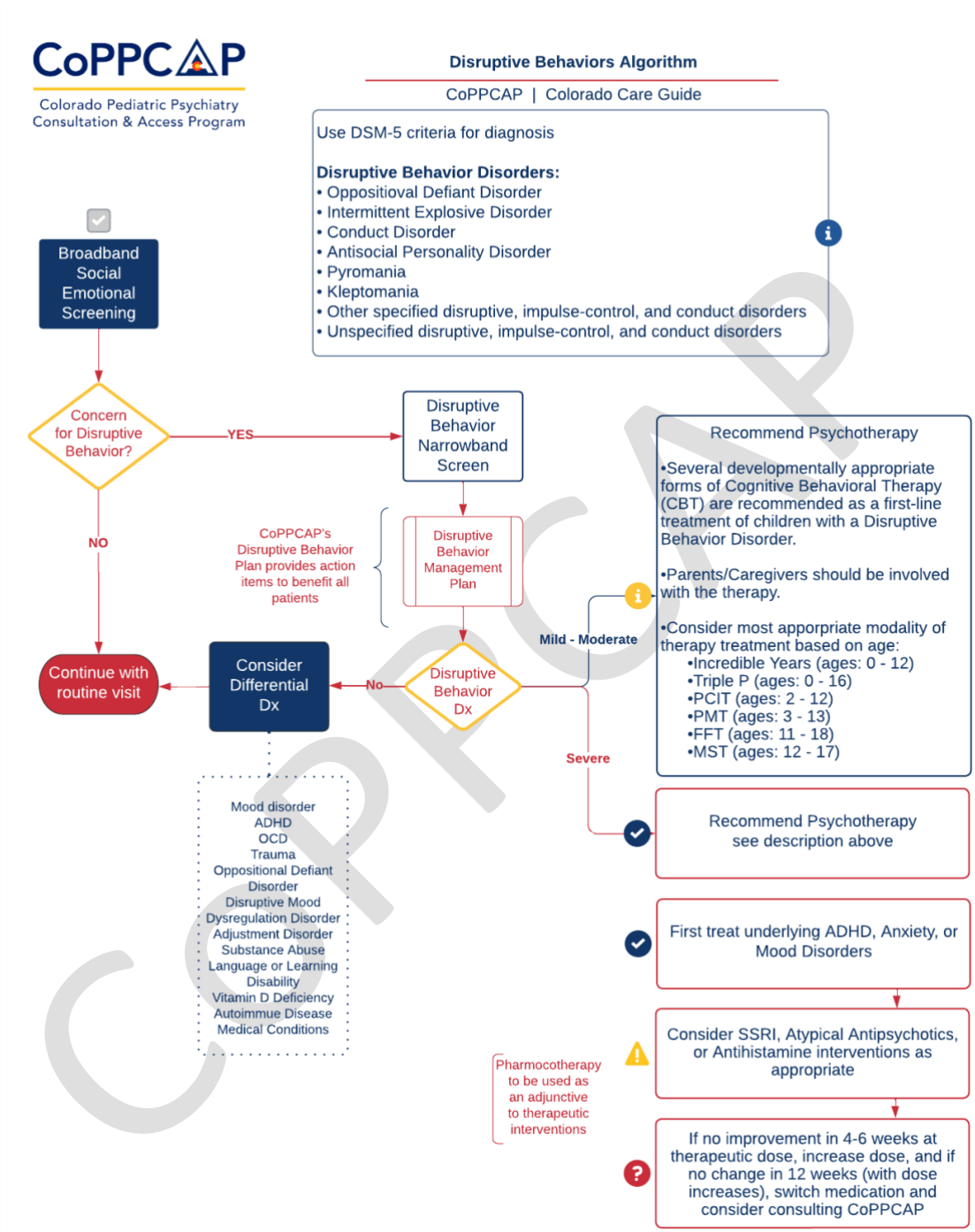
	Hydroxyzine (Atarax™)	25 – 50	10, 25, 50		• Difficulty completely emptying the bladder • Harm to certain types of blood cells • Seizures	

Antipsychotic metabolic monitoring

	Baseline	4 Weeks	8 Weeks	12 Weeks	24 Weeks	Annually
Weight (BMI)	x	x	x	x	x	x
Waist Circumference	x			x	x	x
Blood Pressure	x	x	x	x	x	x
Fasting Glucose/HgbA1c	x			x	x	x
Fasting Lipid Panel	x			x	x	x

Consider: ECG: baseline, 24 weeks, annually

Reference: Psychotropic Medication Utilization Parameters for Children and Youth in Texas Public Behavioral Health (6thVersion) March 2019.



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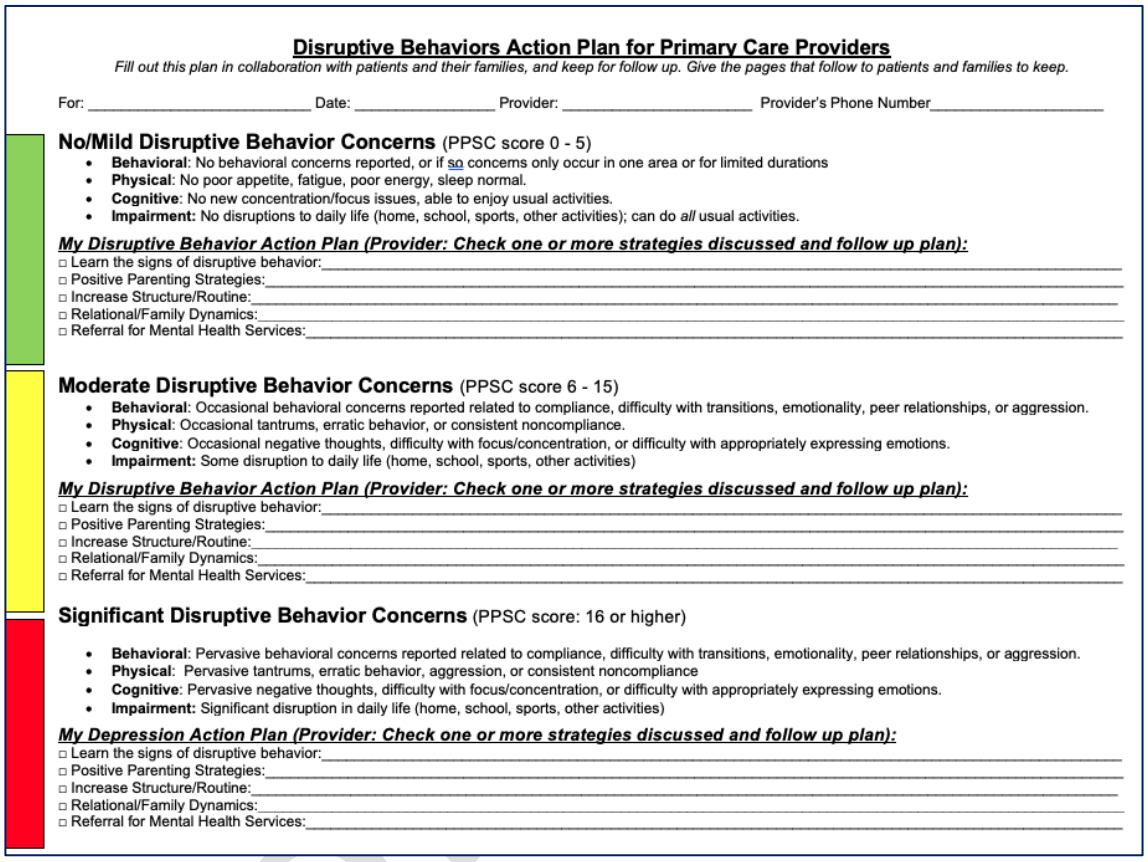
Disruptive Behaviors Management Plan

CoPPCAP offers a Disruptive Behaviors Management Plan for use in Primary Care settings to help provide psychoeducation & actionable items providers, caregivers, and patients can take after depression screening.



Disruptive Behaviors Action Plan for Primary Care Providers

Fill out this plan in collaboration with patients and their families, and keep for follow up. Give the pages that follow to patients and families to keep.

For: _____ Date: _____ Provider: _____ Provider's Phone Number_____

No/Mild Disruptive Behavior Concerns (PPSC score 0 - 5)

- **Behavioral**: No behavioral concerns reported, or if so concerns only occur in one area or for limited durations
- **Physical**: No poor appetite, fatigue, poor energy, sleep normal.
- **Cognitive**: No new concentration/focus issues, able to enjoy usual activities.
- **Impairment:** No disruptions to daily life (home, school, sports, other activities); can do *all* usual activities.

My Disruptive Behavior Action Plan (Provider: Check one or more strategies discussed and follow up plan):

□ Learn the signs of disruptive behavior:_____
□ Positive Parenting Strategies:_____
□ Increase Structure/Routine:_____
□ Relational/Family Dynamics:_____
□ Referral for Mental Health Services:_____

Moderate Disruptive Behavior Concerns (PPSC score 6 - 15)

- **Behavioral**: Occasional behavioral concerns reported related to compliance, difficulty with transitions, emotionality, peer relationships, or aggression.
- **Physical**: Occasional tantrums, erratic behavior, or consistent noncompliance.
- **Cognitive**: Occasional negative thoughts, difficulty with focus/concentration, or difficulty with appropriately expressing emotions.
- **Impairment:** Some disruption to daily life (home, school, sports, other activities)

My Disruptive Behavior Action Plan (Provider: Check one or more strategies discussed and follow up plan):

□ Learn the signs of disruptive behavior:_____
□ Positive Parenting Strategies:_____
□ Increase Structure/Routine:_____
□ Relational/Family Dynamics:_____
□ Referral for Mental Health Services:_____

Significant Disruptive Behavior Concerns (PPSC score: 16 or higher)

- **Behavioral**: Pervasive behavioral concerns reported related to compliance, difficulty with transitions, emotionality, peer relationships, or aggression.
- **Physical**: Pervasive tantrums, erratic behavior, aggression, or consistent noncompliance
- **Cognitive**: Pervasive negative thoughts, difficulty with focus/concentration, or difficulty with appropriately expressing emotions.
- **Impairment:** Significant disruption in daily life (home, school, sports, other activities)

My Depression Action Plan (Provider: Check one or more strategies discussed and follow up plan):

□ Learn the signs of disruptive behavior:_____
□ Positive Parenting Strategies:_____
□ Increase Structure/Routine:_____
□ Relational/Family Dynamics:_____
□ Referral for Mental Health Services:_____

click the image above to access the full Disruptive Behaviors Management Plan

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Resources:

- American Academy of Child & Adolescent Psychiatry – Facts For Families
    - ADHD
    - Conduct Disorder
    - Oppositional Defiant Disorder

Crisis Hotlines:

- National Suicide Prevention Lifeline - 1-800-273-8255
- National Suicide Hotline – 1-800-784-2433
- Colorado Crisis Services – 1-844-493-8255 (or text "Talk" to 38255)

Books for Parents

- *The Incredible Years: A Troubleshooting Guide for Parents of Children Aged 2-8*
- *The Difficult Child*
- *1-2-3 Magic: Effective Discipline for Children*
- *How to Raise an Emotionally Intelligent Child*
- *SOS Help for Parents*
- *No More Meltdowns*
- *Parenting Your Out-of-Control Teenager: 7 Steps to Reestablish Authority and Reclaim Love*
- *Taking Charge of ADHD*
- *Your Defiant Teen: 10 Steps to Resolve Conflict and Rebuild Your Relationship*
- *Your Defiant Child: 8 Steps to Better Behavior*

Mental Health App reviews

One Mind PsyberGuide is a non-profit project run by a team of experts in mental health, technology, and technology delivered care based out of the University of California, Irvine and Northwestern University. One Mind PsyberGuide is not an industry website; its goal is to provide accurate and reliable information free of preference, bias, or endorsement.

American Academy of Child & Adolescent Psychiatry
WWW.AACAP.ORG

NAMI
National Alliance on Mental Illness

NIH National Institutes of Health

CDC
Centers for Disease Control and Prevention

The REACH Institute

Triple P
Positive Parenting Program

The Incredible Years®

Primary References

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