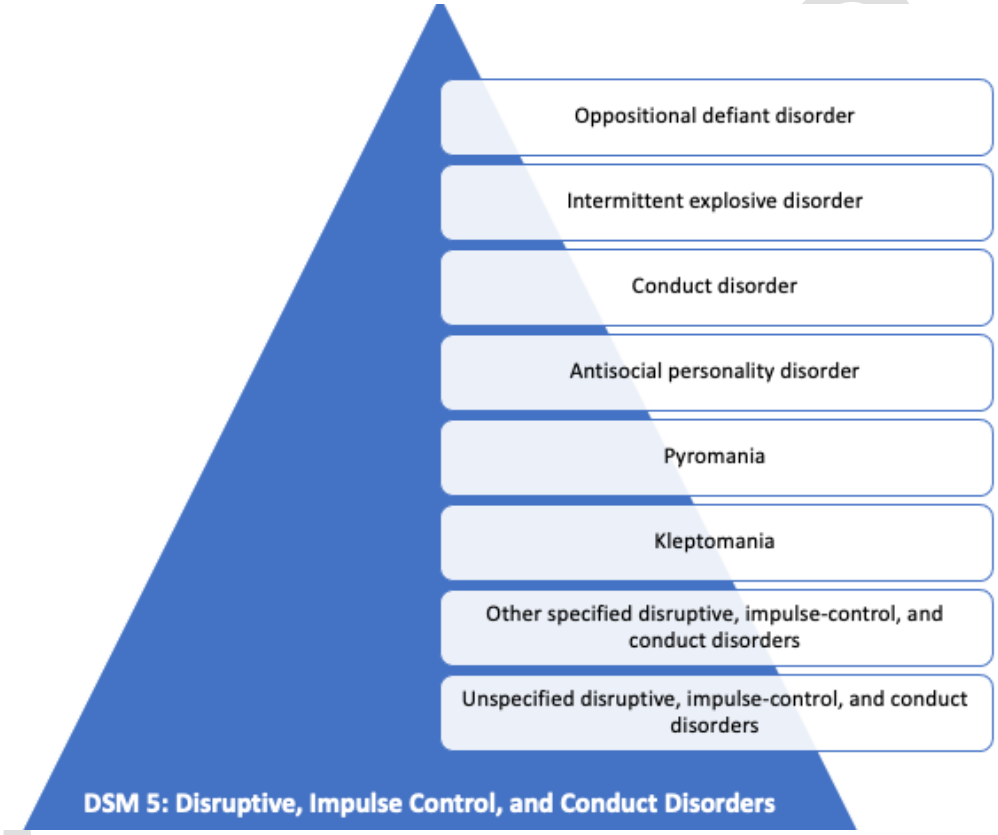
DISRUPTIVE BEHAVIORS

• 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.



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

AUTHORS:
Ryan Asherin, PhD, & Sandra Fritsch, MD

White and Hispanic children, with the lowest estimates among Asian children. 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.

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

Environmental Risk Factors

- Parental rejection/neglect
- Harsh discipline
- Inconsistent parenting/multiple caregivers
- Lack of Supervision
- Large family size
- Single parent status
- Marital discord
- Abuse – emotional, physical or sexual
- Poverty
- Abuse and Neglect
- Parental criminality & psychopathology

- Drug and alcohol use by parents/caregivers
- Exposure to violence

Screening

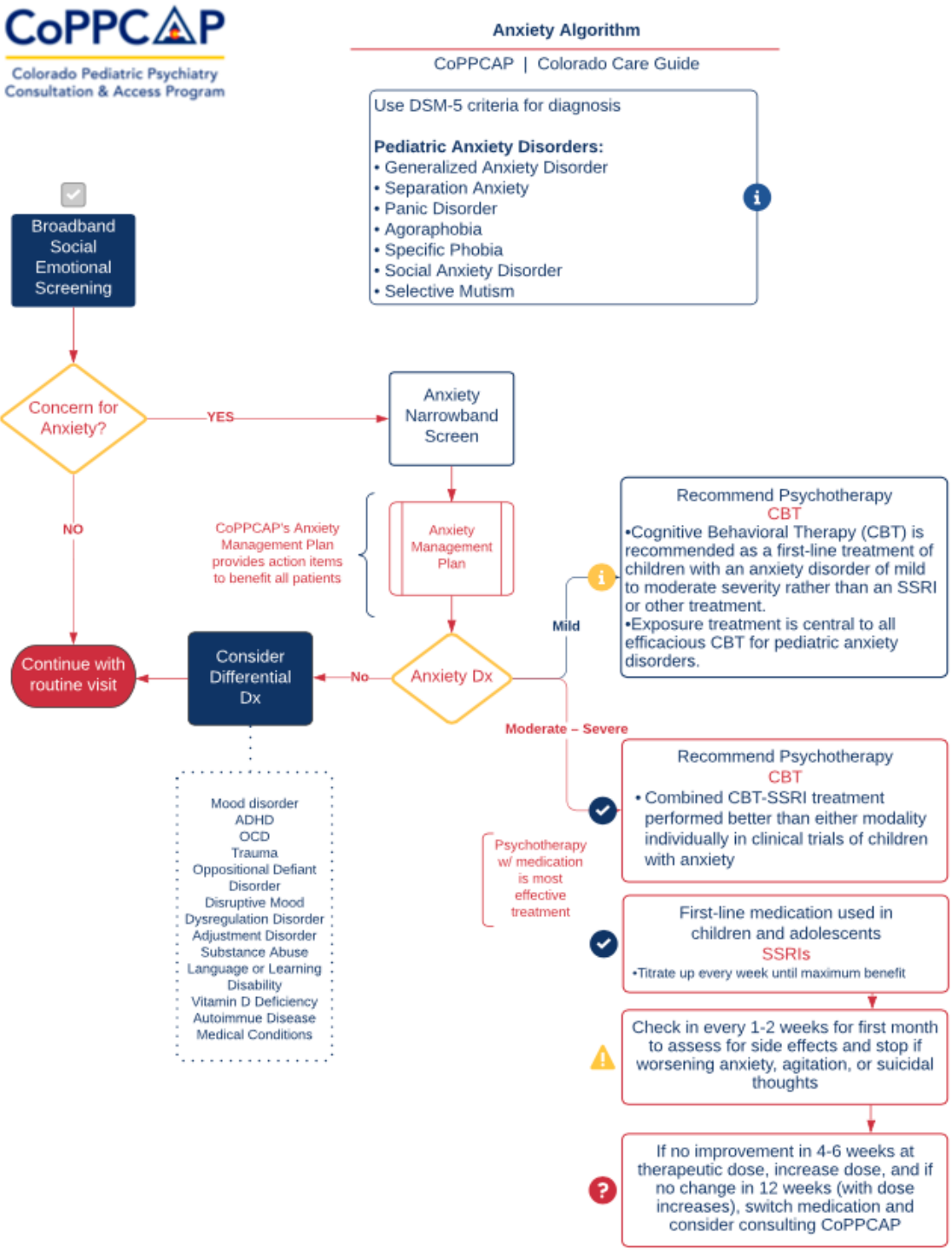
CoPPCAP recommends pediatric providers initially use an age-appropriate broadband screening measures to better understand the symptom profile. When clinically indicated, narrowband screening measures, especially ones that collect information from multiple reports and within multiple environments may 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
ADHD	NICHQ Vanderbilt Assessment Scale Diagnostic Rating Scale 6-12 years Caregiver Report	Vanderbilt ⇒ English ⇒ Spanish	The Vanderbilt Assessment Scale is a 55-question assessment tool that reviews symptoms of ADHD. It also looks for other conditions such as conduct disorder, oppositional-defiant disorder, anxiety, and depression.

	Teacher Report		
ADHD	ADHD Rating Scale IV - Preschool Version 3-5 years Caregiver Report	ADHD Rating Scale IV - Preschool Version ⇒ English	The ADHD Rating Scale-IV obtains parent ratings regarding the frequency of each ADHD symptom based on DSM-IV criteria. Parents are asked to determine symptomatic frequency that describes the child's home behavior over the previous 6 months. The ADHD Rating Scale-IV is completed independently by the parent and scored by a clinician. The scale consists of 2 subscales: inattention (9 items) and hyperactivity-impulsivity (9 items). If 3 or more items are skipped, the clinician should use extreme caution in interpreting the scale. Results from this rating scale alone should not be used to make a diagnosis.
ADHD	Swanson, Nolan, and Pelham (SNAP) Questionnaire – IV 3-5 years Caregiver Report Teacher Report	SNAP-IV ⇒ English ⇒ Spanish	The SNAP-IV 18-item scale is an abbreviated version of the Swanson, Nolan, and Pelham (SNAP) Questionnaire (Swanson, 1992;Swanson et al., 1983). Items from the DSM-IV criteria for attention-deficit/hyperactivity disorder (ADHD) are included for the two subsets of symptoms: Inattention (items 1–9) and Hyperactivity/Impulsivity (items 10–18).
ADHD	Connors, 3rd Edition 6 – 18 years Caregiver Report Teacher Report Self-Report	Conners 3 ⇒ $$$	The Conners 3 assesses cognitive, behavioral, and emotional problems, with a focus on ADHD and comorbid disorders–providing teacher, parent, and student perspectives.
ADHD	Child Behavior Checklist 6 – 18 years Caregiver Report Teacher Report Self-Report	CBCL ⇒ $$$	The Child Behavior Checklist (CBCL) is a common tool for assessing depression in children, as well as ADHD, and other emotional and behavioral problems.
ADHD	Behavior Assessment System for Children, 3rd Edition 2 – 21 years Caregiver Report Teacher Report Self-Report	BASC 3 ⇒ $$$	BASC-3 applies a triangulation method for gathering information. It analyzes a child's behavior from three perspectives: self, teacher, and parent.



click the algorithm above to enlarge

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. A thorough review of Boggs et. al. (2004) demonstrated that Parent-Child Interaction Therapy shows significant positive change after completing therapy, however this was not true for parents who discontinued treatment.

Streiner and Remsing (2007) identify the importance of skill training in problem-solving and family intervention that provides behavior management training

Eyberg, Nelson and Boggs (2008) have identified 16 evidence-based treatments for disruptive behaviors. Fifteen are identified as probably efficacious while one is evaluated as having well established treatment outcomes. Two examples are:

- **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.
- **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

Early intervention during preschool years is imperative & offers promising results

Nixon (2002) has identified that effective parent management interventions may be offered via a number of modalities including face-to-face counseling, videotaped training and telephonic

Options for Treatment: Pharmacotherapy

- **CBT is always indicated as a first line treatment of pediatric anxiety**
- Medications are indicated for more moderate – severe forms of anxiety or in anxiety that has not responded to psychotherapy alone
- Approximately 55-65% of children and adolescents will respond to an initial antidepressant trial

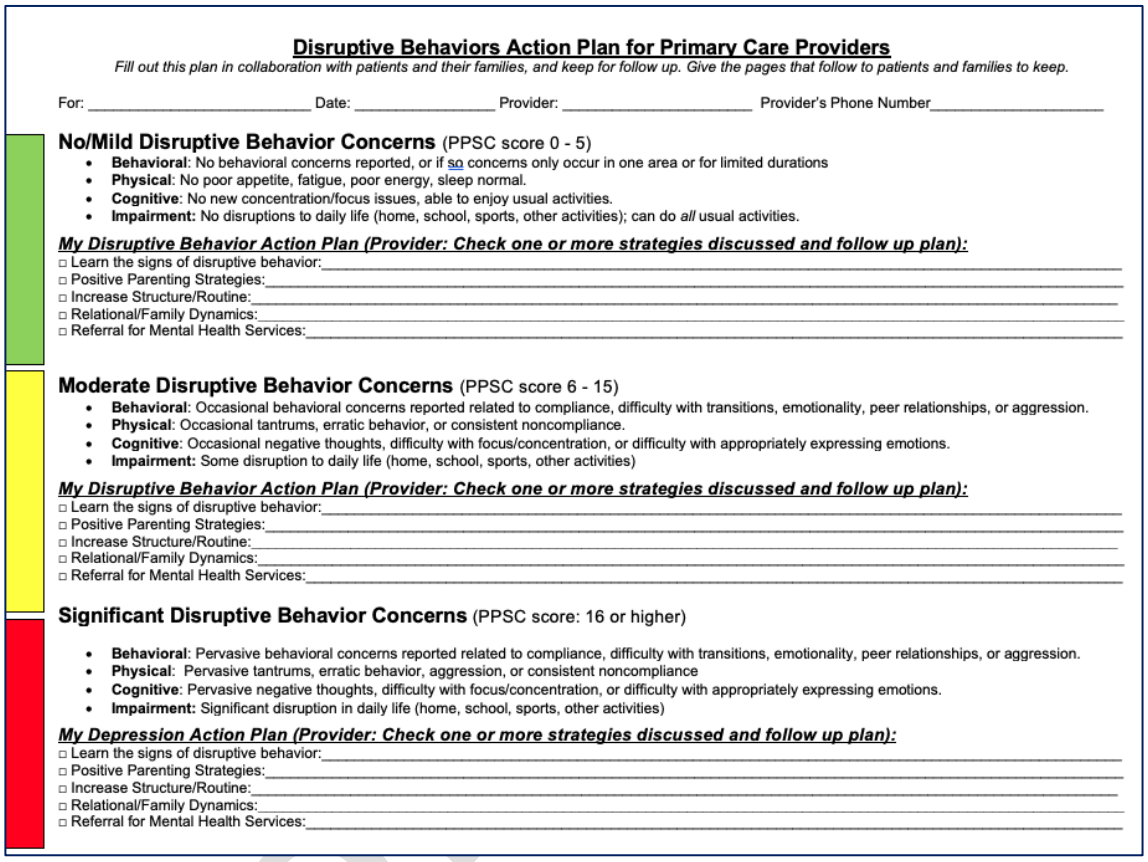
- SSRIs are typically the first-line pharmacologic treatment in children and adolescent's serotonin-norepinephrine reuptake inhibitors (SNRIs) and tricyclic antidepressants have also shown efficacy in the treatment of pediatric anxiety disorders. Because they are associated with less easily tolerated side effects compared with SSRIs, these drugs are generally used second- or third- line.
- The most common side effects of SSRIs are gastrointestinal symptoms, headaches, agitation, sleep changes, irritability, motor restlessness (need to constantly move), and behavioral activation. These side effects are most likely to occur in the first 1-2 weeks after starting the medication, or when making dosage increases. Side effects experienced may be different based on individual medication.
- Concerning side effects of SSRIs include serotonin syndrome and increased suicidal thoughts.
    - When discussing antidepressant medications with families, always provide education about the FDA black box warning for increased suicidal thoughts when used in children and adolescents. This warning is based upon a 2004 review 24 clinical trials of children and adolescents who had been prescribed antidepressants. No suicides occurred in any of these studies, but 4 out of 100 children taking antidepressants reported suicidal thoughts or behaviors while 2 out of 100 children not on medication reported suicidal thoughts or behaviors. As a result, the FDA applied the black box warning for increased suicidal thoughts to all antidepressant medications.
- Frequent check ins are recommended during the first month to monitor for development of side effects or suicidal thoughts. Medication should be stopped if patient develops intolerable side effects or suicidal thoughts during this period.
    - Consider phone calls directly or via support staff to monitor mood and functioning weekly when first starting medication
- SSRIs can be titrated weekly, as tolerated, to a therapeutic dose (see depression medication chart below)
- Patients may have to take SSRIs for 4-6 weeks at an effective dose before experiencing any reduction in anxiety symptoms
    - If no benefit after 4-6 weeks, increase dose. If no benefit after 12 weeks, switch to a different medication.
- Patients should continue medication for 6-12 months following resolution of symptoms
- When discontinuing medications, taper slowly to minimize side effects (going down by the lowest titration increment every 1-2 weeks)

Anxiety Medications

Medications that may be used to treat anxiety disorders in children and adolescents						
Class	**Medication (Brand name)**	**Common dose range (mg/day)**	**Tablet size (mg)**	**Common side effects**	**Serious side effects**	**Uncommon, serious side effects**
SSRI	Citalopram/escitalopram (Celexa/Lexapro™)	10/5 – 40/20	10/5, 20/10, 40	• 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
	Fluvoxamine (Luvox™, Luvox CR™)	100 – 300	25, 50, 100, 150			
	Sertraline (Zoloft™)	25 – 200	25, 50, 100			
	Fluoxetine (Prozac™, Sarafem™)	10 – 60	10, 20, 40, 60			
	Paroxetine (Paxil™, Pexeva™)	10 – 50	10, 20, 40			
SNRI	Venlafaxine ER (Effexor™)	37.5 – 225	37.5, 75, 150, 225	• Sleepiness • Insomnia • Restlessness • Sexual dysfunction • Headache • Dry mouth • Increased anger/irritability • Increased blood pressure • Increased heart rate • Muscle pain • Weight loss/gain	• Boxed warning—suicidal thinking and behavior in children, adolescents, and young adults • Mania	• Serotonin syndrome • Bleeding problems
	Duloxetine (Cymbalta™)	30 – 120	20, 30, 40, 60			
	Atomoxetine (Strattera™)	10 – 100	10, 18, 25, 40, 60, 80, 100			
Tricyclic antidepressant	Clomipramine (Anafranil™)	75 – 250	25, 50, 75	• Sleepiness • Dry mouth • Weight gain	• Boxed warning—suicidal thinking and behavior in children, adolescents, and young adults • Heart rhythm problems; electrocardiogram and blood levels • Mania	• Serotonin syndrome
	Imipramine (Trofanil™, Trofranil-PM™)		10, 25, 50			
Benzodiazepine	Alprazolam (Xanax™, Alprazolam Intensol™)	0.5 – 1.5	0.25, 0.5, 1, 2	• Drowsiness • Clumsiness • Dry mouth • Dizziness • Abdominal pain	• Possible dependence • Withdrawal symptoms when used at high doses, especially when administered over long periods. Decreasing the dose gradually is a common strategy to decrease the risk of withdrawal symptoms. • Disinhibition • Memory impairment • Worsening depression	• Respiratory depression (possible at high doses and when combined with other central nervous system depressants)
Atypical anxiolytic	Buspirone (Buspar™)	15 – 60	5, 10, 15, 30	• Dizziness • Lightheadedness • Tiredness		
Antihistamine	Diphenhydramine (Benadryl™, Banophen™, Diphenhist™)	12.5 – 50	25, 50	• Sleepiness • Dry mouth • Decreased sweating	• symptoms. • Abnormal heart rhythms • Agitation • Difficulty completely emptying the bladder • Harm to certain types of blood cells • Seizures	
	Doxylamine (Unisom™, WalSom™)	12.5 – 50	25, 50			
	Hydroxyzine (Atarax™)	25 – 50	10, 25, 50			

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

Resources:

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

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.

Primary References

[1]Bitsko RH, Claussen AH, Lichstein J, et al. Mental Health Surveillance Among Children — United States, 2013–2019. MMWR Suppl 2022;71(Suppl-2):1–42. DOI: http://dx.doi.org/10.15585/mmwr.su7102a1

1.

Acknowledgements: PMHCA sites across multiple states.

This project is supported by the Health Resources and Services Administration (HRSA) of the U.S. Department of Health and Human Services (HHS) as part of an award totaling $1,851,222.00 with zero percentage financed with nongovernmental sources. The contents are those of the author(s) and do not necessarily represent the official views of, nor an endorsement, by HRSA, HHS or the U.S. Government.