Disruptive Behavior Assessment & Treatment

Concerns suggesting a Disruptive Behavior Disorder?

- Need for further evaluation: noncompliance, argumentativeness, hostility toward authority figures, temper tantrums, deliberately annoying others, spiteful or vindictive behavior, aggression toward peers, blaming others for mistakes and misbehavior, school suspensions or expulsions, expulsion from daycare, interactions with the legal system, truancy, lying, running away, property destruction, breaking rules
- Ask about symptoms, triggers, and degree of problem

Yes – Positive screen

Safety Screen (see Appendix): Administer every visit

- Neglect/ Abuse?
- Thoughts of hurting self or others?
  - If yes, does patient have a plan, means, and intent?

Yes

Positive for Abuse/Neglect:

- Mandated Reporting as indicated

Threat of harm to self or others:

- Consider accessing local crisis intervention services. See Appendix for link to contact information.
- Follow agency/professional protocols to ensure safety

No

Diagnosis: Use DSM-5 criteria (See Appendix)

- Consider medical conditions: head injuries, other central nervous system disorders, chronic illness, seizure disorder, organic brain disorders, prescription and non-prescription side effects
- Consider comorbidity/differential diagnoses: ADHD, Anxiety Disorder, Bipolar Disorder, Depressive Disorder, Learning Problems, Substance Use Disorder, Trauma

Is child under age 5?

Yes

Refer to Early Childhood Mental Health Specialist for Diagnostic Assessment

- Request information and coordination following referral.
- If child already has an Early Childhood Mental Health Specialist, referral can begin with this provider.

No

Refer to Mental Health Specialist for Diagnostic Assessment

- Request information and coordination following referral.
- If child already has a MH Specialist, referral can begin with this provider.

Review Collaborative Information

- **If child has a disruptive behavior disorder:**
  - Pursue appropriate treatment depending on severity – see below
  - Request feedback and coordination
- **If child does not have a disruptive behavior disorder:**
  - Exit guideline and identify appropriate treatment

Disruptive Behavior Assessment & Treatment

Mild to moderate disruptive behavior symptoms

Referral for therapy:
- If child already has a Mental Health Specialist, referral can begin with this provider
- Request information and coordination following referral
- See Appendix for evidence-based treatments and components

Initial follow-up appointment:
- If safety concerns: 1-3 weeks
  - o Monitor symptoms, triggers, and degree of problem
  - o Review safety plan
  - o Encourage patient and family collaboration with other professionals (school, juvenile justice, etc.)
- If therapy referral and no safety concerns: 6-12 weeks
  - o Monitor symptoms, triggers, and degree of problems
  - o Encourage patient and family collaboration with other professionals (school, juvenile justice, etc.)

Ongoing follow-up appointments once therapy has been established:
Frequency:
- 13-26 weeks until symptoms abate
- Consider comorbidity, safety, and symptom severity in determination of visit frequency

Appointment Content:
- Review collaborative information, symptom presentation, and monitor for additional concerns
- Review treatment response questions:
  - o Is child responding to treatment?
  - o Are other factors affecting treatment success: frequency or intensity of treatment, motivation, need for more support?
  - o Are symptoms moderate to severe?
  - o Do symptoms interfere with ability to benefit from psychotherapy?
- Incorporate recommendations from psychiatric, psychological, or mental health evaluations
- Encourage patient and family collaboration with other professionals (school, juvenile justice, etc.)

Severe disruptive behavior symptoms

Referral for therapy:
- If child already has a Mental Health Specialist, referral can begin with this provider
- Request information and coordination following referral
- See Appendix for evidence-based treatments and components

Initial follow-up appointment:
- If safety concerns: 1-3 weeks
  - o See mild/moderate at left
- If therapy referral and no safety concerns: 4-6 weeks
  - o See mild/moderate at left

Ongoing follow-up appointments once therapy has been established:
Frequency:
- Varies - consider comorbidity, safety, and symptom severity in determination of visit frequency

Appointment Content:
- See mild/moderate at left

Consider psychiatric referral:
- If symptoms interfere with ability to benefit from psychotherapy, consider referral for psychiatric assessment and treatment
- Communicate and coordinate with mental health specialist

Disruptive Behavior Assessment & Treatment

Primary References:

American Academy of Child and Adolescent Psychiatry Official Action (1997) – Practice Parameter for the Assessment and Treatment of Children and Adolescents With Conduct Disorder. http://www.jaacap.com/article/S0890-8567(09)62597-1/pdf

American Academy of Child and Adolescent Psychiatry Official Action (2007) – Practice Parameter for the Assessment and Treatment of Children and Adolescents With Oppositional Defiant Disorder. http://www.jaacap.com/article/S0890-8567(09)61969-9/pdf

American Academy of Child and Adolescent Psychiatry Official Action (2009) – Practice Parameter on the Use of Psychotropic Medication in Children and Adolescents. http://www.jaacap.com/article/S0890-8567(09)60156-8/pdf

American Psychiatric Association (2013). *Diagnostic and statistical manual of mental disorders (5th ed.).* Washington, DC: Author.

PracticeWise (2015). Evidence-Based Youth Mental Health Services Literature Database.

Appendix

Resources:

American Academy of Child & Adolescent Psychiatry – Oppositional Defiant Disorder Resource Center
https://www.aacap.org/AACAP/Families_and_Youth/Resource_Centers/Oppositional_Defiant_Disorder_Resource_Center/Home.aspx

American Academy of Child & Adolescent Psychiatry – Conduct Disorder Resource Center
https://www.aacap.org/AACAP/Families_and_Youth/Resource_Centers/Conduct_Disorder_Resource_Center/Home.aspx

Safety Screen:

Some questions to assess potential threat of harm to self: Children and adolescents may be asked the following diagnostic questions (Jacobsen et al., 1994).

- "Did you ever feel so upset that you wished you were not alive or wanted to die?"
- "Did you ever do something that you knew was so dangerous that you could get hurt or killed by doing it?"
- "Did you ever hurt yourself or try to hurt yourself?"
- "Did you ever try to kill yourself?"

*If the threat assessment (i.e., Safety Screen) indicates risk of harm to self or others, educate families on the appropriate care options and safety precautions including removal of firearms from the home and securing all medications, both prescription and over-the-counter.

Warning Signs of Suicide: (Developed by the U.S. Department of Health and Human Services – Substance Abuse and Mental Health Services Administration (SAMHSA; 2011).

These signs may mean someone is at risk for suicide. The risk is greater if a behavior is new or has increased and if it seems related to a painful event, loss, or change.

- Threatening to hurt or kill oneself or talking about wanting to die or kill oneself
- Looking for ways to kill oneself by seeking access to firearms, available pills, or other means
- Talking or writing about death, dying, or suicide when these actions are out of the ordinary for the person
- Feeling hopeless
- Feeling rage or uncontrolled anger or seeking revenge
- Acting recklessly or engaging in risky activities – seemingly without thinking
- Feeling trapped – like there's no way out
- Increasing alcohol or drug use
- Withdrawing from friends, family, and society
- Feeling anxious, agitated, or unable to sleep or sleeping all the time
- Experiencing dramatic mood changes
- Seeing no reason for living or having no sense of purpose in life

Minnesota Mental Health Crisis Contact Numbers: http://mn.gov/dhs/people-we-serve/people-with-disabilities/health-care/childrens-mental-health/resources/crisis-contacts.jsp

Current Evidence-Based Disruptive Behavior Treatments include: Parent Management Training and Multisystemic Therapy

Elements of effective disruptive behavior treatment include: praise, tangible rewards, problem solving, differential reinforcement of other behavior, time out, commands, psychoeducation, modeling, monitoring, goal setting, response cost, attending, natural and logical consequences, communication skills, maintenance/relapse prevention, social skills training, cognitive processing, therapist praise/rewards, caregiver coping, stimulus control or antecedent management, family therapy, educational support, self-monitoring, and relationship/rapport building

DSM-5 Oppositional Defiant Disorder (ODD) Criteria:

A. A pattern of angry/irritable mood, argumentative/defiant behavior, or vindictiveness lasting at least 6 months as evidenced by at least four symptoms from any of the following categories, and exhibited during interaction with at least one individual who is not a sibling.

Angry/Irritable Mood

1. Often loses temper.
2. Is often touchy or easily annoyed.
3. Is often angry and resentful.

Argumentative/Defiant Behavior

4. Often argues with authority figures or, for children and adolescents, with adults.
5. Often actively defies or refuses to comply with requests from authority figures or with rules.
6. Often deliberately annoys others.
7. Often blames others for his or her mistakes or misbehavior.

Vindictiveness

8. Has been spiteful or vindictive at least twice within the past 6 months.

Note: The persistence and frequency of these behaviors should be used to distinguish a behavior that is within normal limits from a behavior that is symptomatic. For children younger than 5 years, the behavior should occur on most day for a period of at least 6 months unless otherwise noted (Criterion A8). For individuals 5 years or older, the behavior should occur at least once per week for at least 6 months, unless otherwise noted (Criterion A8). While these frequency criteria provide guidance on a minimal level of frequency to define symptoms, other factors should also be considered, such as whether the frequency and intensity of the behaviors are outside a range that is not normative for the individual's developmental level, gender, and culture.

B. The disturbance in behavior is associated with distress in the individual or others in his or her immediate social context (e.g., family, peer group, work colleagues), or it impacts negatively on social, educational, occupational, or other important areas of functioning.
C. The behaviors do not occur exclusively during the course of a psychotic, substance use, depressive, or bipolar disorder. Also, the criteria are not met for disruptive mood dysregulation disorder.

Specify current severity:
Mild: Symptoms are confined to only one setting (e.g., at home, at school, at work, with peers).
Moderate: Some symptoms are present in at least two settings.
Severe: Some symptoms are present in three or more settings.

DSM-5 Conduct Disorder (CD) Criteria:

A. A repetitive and persistent pattern of behavior in which the basic rights of others or major age-appropriate societal norms or rules are violated, as manifested by the presence of at least three of the following 15 criteria in the past 12 months from any of the categories below, with at least one criterion present in the past 6 months:

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 good 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 the parental or parental surrogate home, or once without returning for a lengthy period.
15. Is often truant from school, beginning before age 13 years.

B. The disturbance in behavior cause clinically significant impairment in social, academic, or occupational functioning.

C. If the individual is age 18 years or older, criteria are not met for antisocial personality disorder.

Specify whether:

312.81 (F91.1) Childhood-onset type: Individuals show at least one symptom characteristic of conduct disorder prior to age 10 years.

312.82 (F91.2) Adolescent-onset type: Individuals show no symptoms characteristic of conduct disorder prior to age 10 years.

312.89 (F91.9) Unspecified onset: Criteria for a diagnosis of conduct disorder are met, but there is not enough information available to determine whether the onset of the first symptom was before or after age 10 years.

Specify current severity:

Mild: Few if any conduct problems in excess of those required to make the diagnosis are present, and conduct problems cause relatively minor harm to others (e.g., lying, truancy, staying out after dark without permission, other rule breaking).

Moderate: The number of conduct problems and the effect on others are intermediate between those specified in "mild" and those in "severe" (e.g., stealing without confronting a victim, vandalism).

Severe: Many conduct problems in excess of those required to make the diagnosis are present, or conduct problems cause considerable harm to others (e.g., forced sex, physical cruelty, use of a weapon, stealing while confronting a victim, breaking and entering).