

Treatment of Impulsive Aggression In TS: A Collaborative Problem-Solving Approach

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Tourette Syndrome

- Motor and/or vocal tics
- High comorbidity rates (Tourette Syndrome International Database (2000))
 - TS-only: 12%
 - ADHD: 60%
 - OCD 27%
 - Mood: 20%
 - Other Anxiety: 18%
 - CD/ODD: 15%
 - Many children have >1 (ave. = 2)

****CHILDREN WITH TS+ ARE AT HIGHER RISK FOR AGGRESSION/RAGE ATTACKS
(esp. the "trio" TS-ADHD-OCD)****

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"Rage Attacks" in TS

- Sudden, unpredictable, and uncontrollable physical and/or verbal aggressions that are excessive given the child's developmental level and the provocation.
- "out of character", not tantrums, extreme
- 25-70% of children with TS
- More common in comorbid TS (esp. ADHD, OCD)

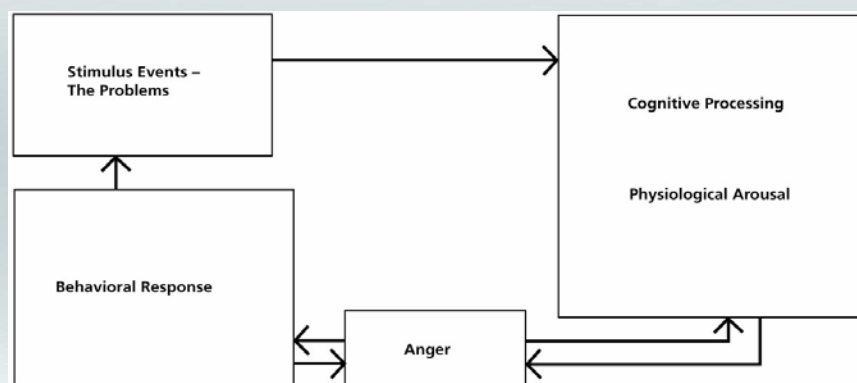
"It is as if he enters a tunnel and as soon as he starts down this path, there is no way back"

"She has the temperament of Dr. Jekyll and Mr. Hyde. We joke about calling an exorcist, but when she is having these rage attacks it seems as if she is possessed."

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CBT model of Anger & Aggression



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Types of Aggression

- Reactive-
 - Affective/impulsive aggression
 - Frustration response associated with poor impulse control
 - Usually in response to some provocation

- Proactive-
 - Serves to secure a reward
 - Instrumental function
 - Also referred to as the coercion model

Dodge et al., 1981;1997

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5-step information processing view of aggression

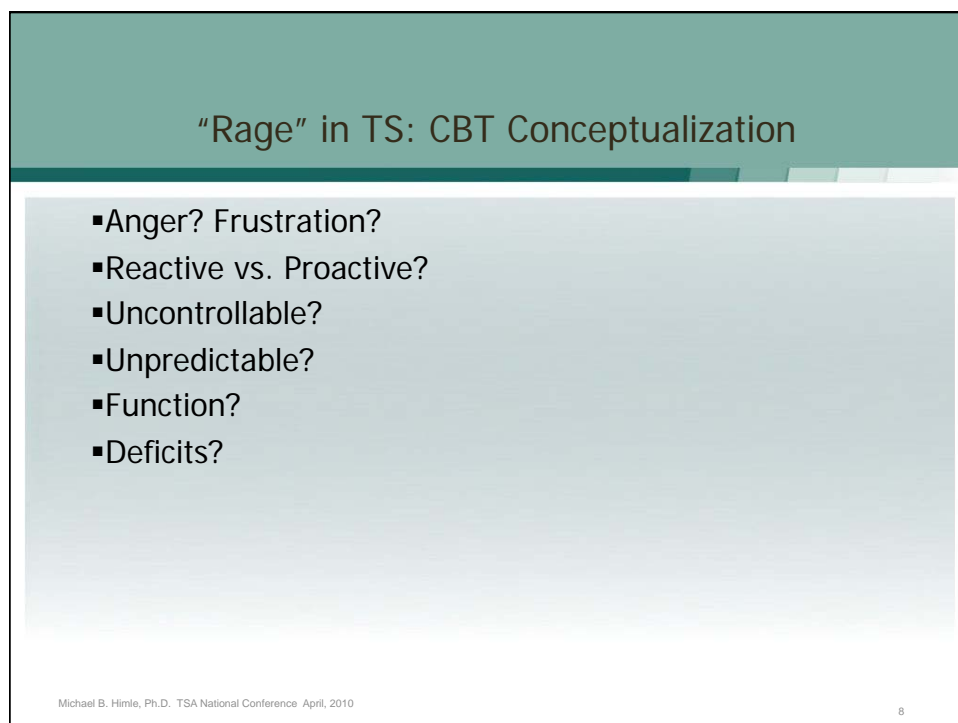
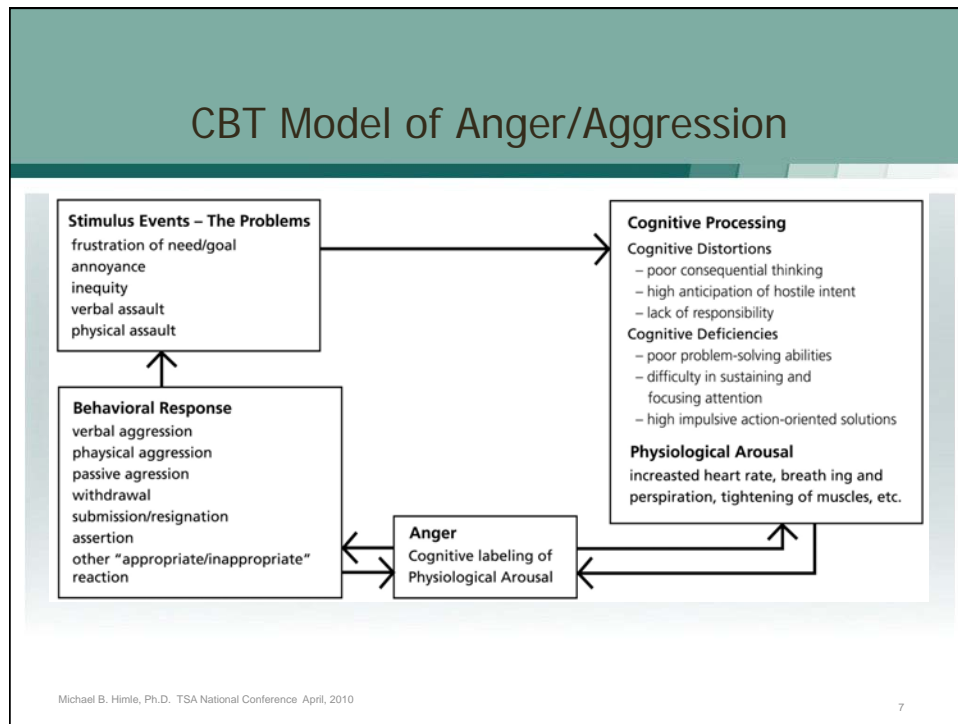
- Step 1: select from multiple cues available
- Step 2: decode & make meaningful inferences
- Step 3: search & select response
- Step 4: weigh response options
- Step 5: enact chosen response option

- Problems common in children with aggression:
 - Step 1: Cue utilization deficits, decoding problems (input & selection)
 - Step 2: Cognitive deficits, deficiencies, distortions
 - Steps 3 & 4: Problems solving deficits
 - Step 4 & 5: Skills deficits- limited bx repertoire, selection problems

- Dodge & Colleagues (1980, 1987)
- Kendall et al. (1991)

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Impulsive Aggression in TS

- Rage Attacks Questionnaire (Budman et al. 2003)
 - 65% uncontrollable
 - 94% at home
 - 92% parent as target
 - Common antecedents: hunger, illness, stress
 - Triggers:
 - being told "no" (81%),
 - Unanticipated change in plans (75%)
 - Not getting their way (81%)

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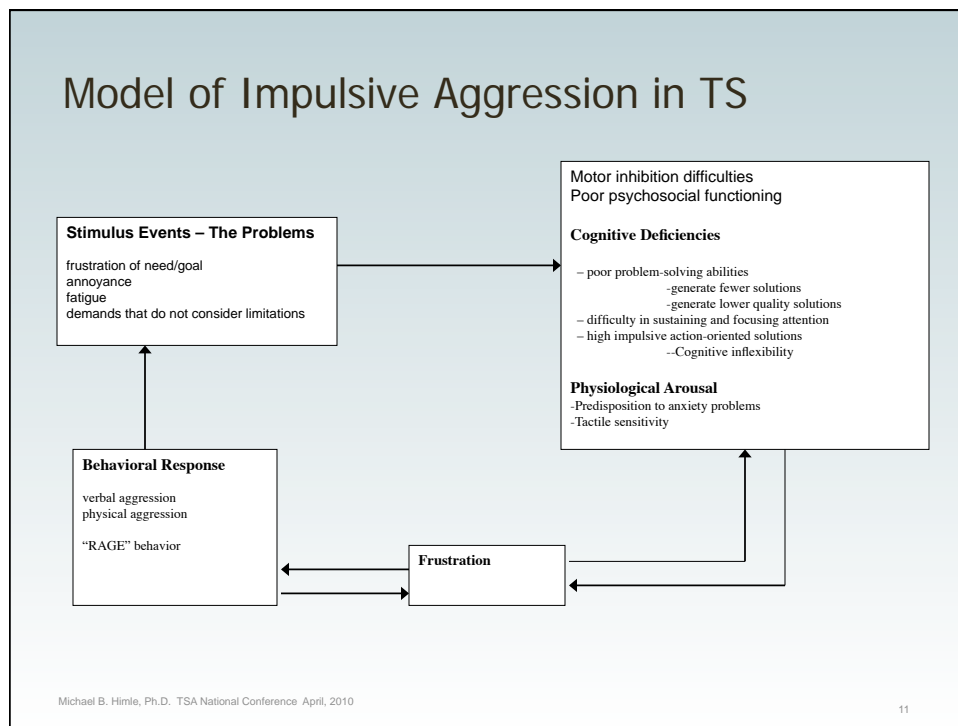
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Deficits in Tourette Syndrome

- Neurobiological deficits
 - CSTC circuits- deficits of inhibition
 - Recent attention to PFC and executive functions
 - Inhibition, flexibility, working memory, response times
 - Confounded by high comorbidity rates
- "Real-life" problem solving deficits
- Poor psychosocial functioning
- Family Functioning
 - Parent psychopathology
 - Impact of the disorder
- Comorbidity
 - Especially multiple comorbid conditions (ADHD, OCD)

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Existing Treatment Approaches

- **Parent training** for proactive aggression (Webster-Stratton, 1990; Kazdin et al., 1992; 2003)
 - Almost exclusive focus on parent
 - Largely assumes operant function
- **CT** for cognitive distortions (Lochman et al., 1989; 1992; 1993; Sukhodolsky et al. 2000)
 - Almost exclusive focus on child
 - Typically with proactive-type aggression
- **Self-control training** for impulsivity (Kendall et al., 1992; 1993; Hinshaw et al., 1992)
 - Child focus
 - Effectiveness questionable
- **Problem solving** for cognitive deficiencies (Kendall & Bartel, 1990; Webster-Stratton et al., 1997; 2003)
 - Child focused
 - Generalization poor
- **CPS:** focus on parent **and** child (Greene, 1999; 2003; 2004)
 - Problem solving involves interaction
 - Increase generalization?

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Transactional Emphasis

- Parent-child interactions are key
- Child Characteristics
 - Emotion regulation, problem solving, frustration tolerance
- Parent Characteristics
 - Inflexibility, frustration tolerance, psychological health, parenting skills
- "Lack of fit"
 - Focus on teaching parents to recognize & appreciate their child's characteristics
 - Teach, model, and respond to child in a way that does not fuel frustration
- Collaborative Problem Solving

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Assumptions of CPS Approach

- #1: "Children do well if they can" (Greene, 2001)
 - Alternative: children can do well but won't (coercion) or children cannot learn to overcome their deficits (e.g., cannot learn to problem solve)

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Swimming metaphor

- *Imagine that you are a lifeguard and you see a child drowning. How you view the problem is likely to determine how you react. If you view the child as faking to get attention or to get you to jump in the water (because the child is "mean" or "likes to have his way") then you will probably ignore the child. Unfortunately, if you are wrong, he drowns. However, if you view the child as having a skills deficit, that he has not learned how to swim, especially in waves and current, then you are likely to jump in the help the child. After you save him, you teach him how to swim so it doesn't happen again. In this case, if you are wrong, the worst that happens is you get wet (or the child gets his way).*

*Ross W. Green (2000)
The Explosive Child*

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Assumptions of CPS Approach

- #2: Assuming a skills deficit has advantages
 - Flexibility and frustration tolerance are skills that develop throughout childhood and into adulthood
 - If we buy into this assumption, we are forced to consider that "children do not choose to be explosive and noncompliant- any more than a child would choose to have a reading disability- but are delayed in the process of developing [or learning to apply] the skills that are critical to being flexible and tolerating frustration." (Greene, 2001)
 - "It is hard to imagine how a child could be actively "yanking your chain" or know "just the right buttons to push" when s/he is not thinking rationally in the midst of frustration." (Greene, 2001)

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Assumptions of CPS Approach

- #3: Impulsive aggression in TS is reactive
- #4: The coercion model does not fit
 - Fighting inflexibility with inflexibility does not = flexibility
 - Parent's have been sticking to their guns long enough
- #5: Hard to control, not uncontrollable
 - There may be a point of no return, so don't get there
 - Children don't learn well during "vapor lock", problem solving is done at the "crossroads"
 - One of the most important things to learn in treatment is to be proactive

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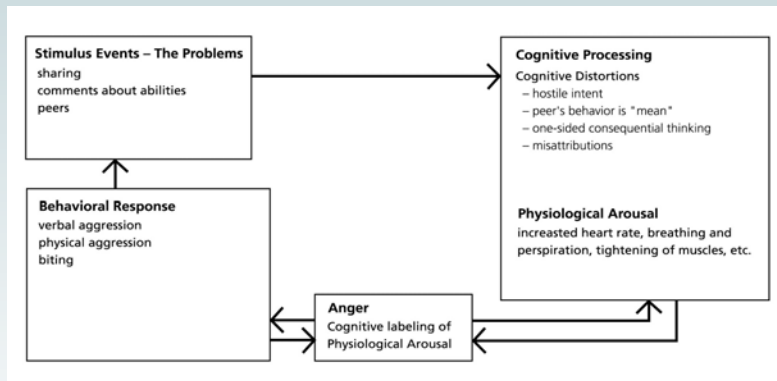
Assumptions cont.

- #6: Hard to predict, not unpredictable
- #7: The child needs to use the skills at home
- #8: Parents are involved in the disorders, they need to be involved in treatment
- #9: The therapist must teach the parents & child, not instruct them
- #10: One size does not fit all~ these kids may need different disciplinary practices than other kids

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Example #1

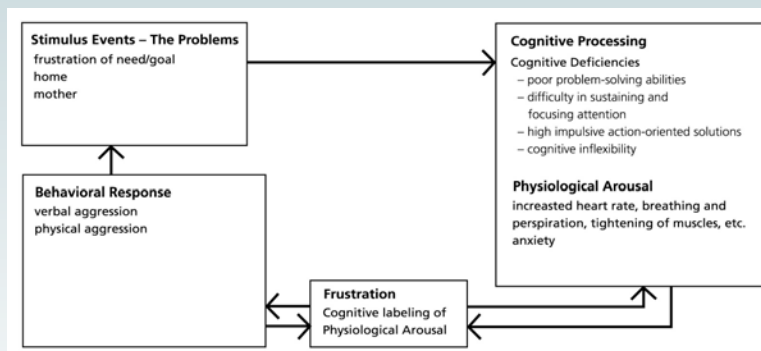


The typical CBT conceptualization, along with existing treatments, fits this case rather well.

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Example #2



This case represents the typical impulsive-aggressive act. Notice the predominance of deficiencies rather than distortions.

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Assessment considerations

- Assessment of TS
- Assessment of comorbid conditions
- Academic Abilities/learning probs.
- Executive functioning/problem solving
- Triggers (sleep, eating probs)
- Proactive vs. Reactive Aggression Inventories (Dodge & Cole, 1987)
- Impulsivity- Interviews, neurocog. (Kendall, 1997)
- Functional Assessment
- Social skills
- Parent characteristics
 - Family, occupational, financial, etc.
 - Parenting style

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Some notes about the CPS Approach

- Not intended to reduce tics
- Not intended to reduce ADHD, ODD, anxiety, etc.
 - But this is important and may indirectly influence aggression
- The CBT model assumes that aggression is a functional response to an arousing stimulus and the response is mediated by both inter- and intra-personal factors.
- The transactional nature of the model stresses that aggression, and alternative- more adaptive responses (e.g., problem solving)- are abilities that a child develops within the context of interactions with others
- Intervention needs to be at the level of the parent and child.
- The manual is flexible
- Don't throw the baby out with the bathwater~ different behaviors require different techniques.

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CPS for Impulsive Aggression in TS: The Manual

- Primary goals:
 - Eliminate/minimize triggers
 - Identify & understand child and parent characteristics contributing to aggression
 - Teach parents to recognize and appreciate these factors
 - Change those factors that can be changed
 - Teach parents to set realistic expectations
 - Teach parents how to respond to unmet expectations in a way that will facilitate learning
 - Teach CPS
 - Recognize early warning signs, solve the problem, do it while the child is calm enough to think

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What is CPS?

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CPS begins with appreciating and reframing the problem and factors related to the problem

A child's ability to process information when frustrated is greatly diminished (so now matter how hard the parents try to "reason" with them, the child is not capable of processing the information). Using an example about parents might help:

- *"We all get overly frustrated from time to time, and when we do, we do some pretty stupid things. When we can't figure something out, we might swear at it. Only after the fact do we realize that we didn't really think that the object or person we swore at was to blame. For example, we don't really want the "damn dog to disappear". In fact, that would just make things worse. Unfortunately, it is rare for a child to say "I am really frustrated right now because I am not very good at switching tasks, mom and dad will you please help me to feel better". Rather, the child tells his "damn parents to disappear". (Greene, 2001)*

Punishing a child after an aggressive episode does not teach him/her anything. A better approach is to problem-solve with the child. That is what we are going to learn today.

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It assumes that problem solving is a skill that can be learned - there are good times to learn and bad times to learn

- **Step 1:** Recognize the child's warning signs/frustration.
- **Step 2:** Quickly Identify factors that are contributing to the frustration.
- **Step 3:** Determine which "basket" these factors belong in. If the answer is A, the parent should be prepared to endure an aggressive episode. If the answer is B, initiate the step 4 below. If the answer is C, the parent should appease the situation in any way possible in order to prevent an episode.
- **Step 4:** If the parent decides that situation belongs in basket B, he/she begins the CSP process by utilizing dialogue such as:
 - Parent: "CHILD'S NAME, you look frustrated, let's see if we can work this out. What are you frustrated about?"
 - Child: "Nothing. Leave me alone" or "I don't want to" or equivalent.
 - Parent: "Well, it looks like you are frustrated about _____. I know that you don't like to do _____ because it is hard for you."
 - Child: "I hate _____."
 - Parent: "Well, mom wants you to do _____. You don't want to do _____, what would be a good way for both of us to be happy?"
 - Child: "I will do _____ tomorrow".
 - Parent: "That will make you happy, but that won't make mom happy. What else can we do?"
 - Child: "Nothing"
 - Parents: "Well, how about we do _____"
- **Step 5:** If the problem-solving does not work and the child has an episode, return to the problem-solving technique after the child calms and try again using statements such as "what could we have done to work that out".

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CPS: The Baskets

- **Basket A:**
 - Not negotiable
 - Establish the parent as an authority figure
 - Any behaviors that the parent is willing (and may always be willing) to endure an aggressive episode over.
 - "must", "can't", "no"
 - Always includes safety
 - Cannot include behaviors the child is unable to perform
 - not open to discussion
 - Basket A does not teach skills, it simply teaches the child that the parent is an authority figure that must be listened to on this particular issue- no questions asked. There will be very few items in Basket A.
- **Basket B:**
 - Problem solving basket
 - Includes behaviors that the parent feels are important for the child to learn, but are not important enough to endure repeated aggressive episodes over.
 - Most learning of new skills takes place here
 - Behaviors the child can do, although not necessarily when frustrated
 - 3-5 behaviors should be placed in basket B initially. More can be added as the parent becomes more skilled in CPS.
- **Basket C:**
 - Any situations that are not worth enduring an episode over and are not high priority for problem solving.
 - The parent is reminded that they may move these items into Basket B at some point in time, but for now- "back burner"
 - Helps reduce the child's overall level of frustration
 - Helps the parents set realistic expectations for their child given his/her limitations
 - Basket C will include the most items early in treatment.
 - "just not worth fighting over".
- Over time, the parent learns to prioritize "on the fly"
- Must decide which basket ahead of time

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The CPS Sessions

- **Session 1: Introduction & Education**
 - Lay groundwork for re-framing the problem
 - Introduce frustration model as alternative to coercion model
 - Outline & establish a CPS "environment"
- **Session 2: Problem Definition**
 - Understand parent's/child's unique strengths & weaknesses and how these relate to the problem
 - Conceptualize problem from frustration model
 - Review previous approaches
 - Identify high-risk situations (setting, activities, parent- and child-characteristics)
- **Session 3-4: Antecedent manipulation**
 - Behavioral hygiene
 - Emphasize frustration model over coercion model
 - Therapist begins to use CPS with parents to solve problems

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Treatment cont.

- Session 5
 - Identify warning signs
 - Present CPS
 - Introduce “baskets” framework
- Session 6:
 - Baskets cont.
 - Refining, identifying triggers, reviewing episodes, etc.
 - Explicit “reinterpretation”
 - Teach CPS
 - Recognize, Identify, Choose Baskets, Act accordingly
- Session 7 & 8:
 - Refine
 - Review
 - Reinterpret
 - Practice
 - Prepare

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Treatment cont.

- Session 9:
 - Introduce child to treatment
 - Model CPS for child (implicitly)
 - Rapport
 - Rationale
 - Behavioral reward system
 - Observe parent-child interaction
- Session 10:
 - Teach child to recognize feelings
 - Teach child to express feelings
 - Teach parent to use behavioral reward system

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Treatment cont.

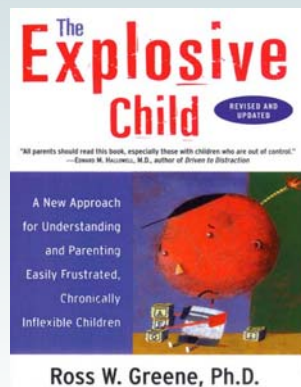
- Session 11-14:
 - Teach CPS to child
 - Practice CPS
- Session 15+ :
 - Communication training (crashes on a 2-way street)
 - Sarcasm passive-aggressiveness
 - Ambiguity subtle insults
 - Speculation/ "mind-reading" interrupting
 - Overgeneralization lecturing
 - Catastrophizing talking through a 3rd person
 - Making assumptions getting the last word/ one upmanship
 - Communication alliances
- Session X:
 - Wrap-up

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THE CPS APPROACH:

- Much of the material from this presentation was cited or adapted from:
Greene, R.W. (2001). *The Explosive Child*. HarperCollins, NY,NY.



Dr. Himle has no affiliation/ interests with HarperCollins, Dr. Greene, or this book.

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