Walking on eggshells

AN APPROACH TO SEVERE EMOTIONAL OUTBURSTS

An approach to severe emotional outbursts

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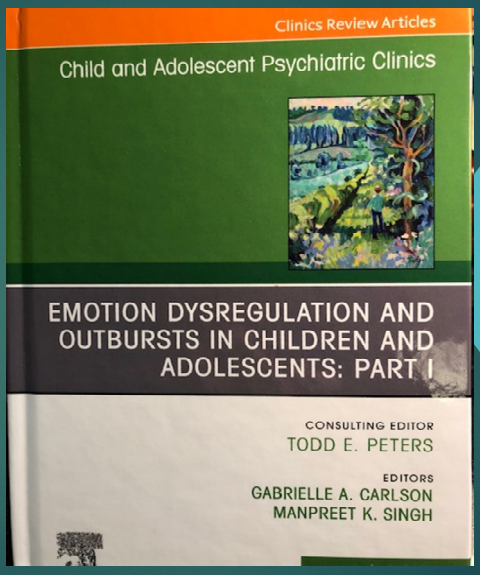
Learning objectives

- Recognize transdiagnostic factors involved in rage outbursts.
- Apply evidence- based psychopharmacology for these outbursts
- Understand environmental factors affecting rage outbursts and what to do about this.

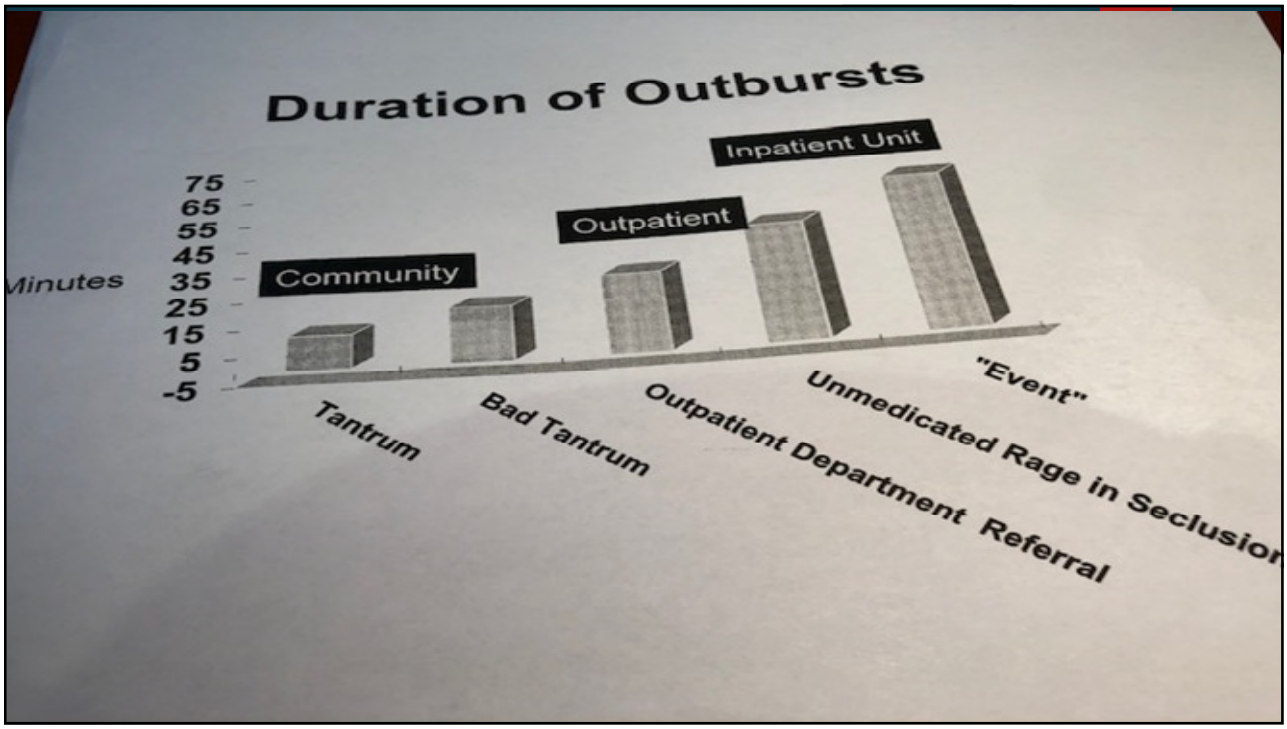


Normal temper tantrums

- Temper tantrums normal part of development.
- Children 18-60 months
- 2 components: anger (screaming & occasional kicking) followed by distress (whining & crying)
- Median duration 3 minutes
- Frequency (less than daily)
- Bad temper tantrums last 5- 20 minutes

Rage outbursts (emotional dysregulation)

- 1-2% of 6 year olds
- Endure & regulatory attempts ineffective
- Inappropriate to the trigger (short fuse)
- Quick start and slow recovery
- Destroy property, throw , spit, kick, threaten, may need restraint.
- Resemble a bad temper tantrum, but last 30 – 60 minutes



Causes are transdiagnostic

- Poor frustration tolerance
- ADHD
- Avoidance of overwhelming emotions
- Anxiety
- Depression
- Exaggerated fear of threat
- PTSD

Diagnoses made in children<13 referred to psychiatry with rage outbursts

- ADHD (80%)
- ODD/CD (67%)
- Mood or anxiety disorders (41%)
- Autism (24%)
- DMDD (34%)
- Learning disorder (33%)

Oppositional defiant disorder (irritable, angry defiant behavior)

- Argumentative/Defiant cluster (ADHD)
- Argue with adults
- Defiance/non compliance
- Deliberately annoy others
- Blame others for their behavior
- Angry/irritable cluster (anxiety/depression)
- Often loses temper
- Touchy/easily annoyed
- Angry & resentful

Pharmacology mood dysregulation & ADHD)

1. Optimize stimulants, but may not be enough.
2. Combined stimulants & alpha agonists works better than either alone.

Pharmacology (mood dysregulation & anxiety/depression)

- SSRI's
- Alpha agonists (trauma or anxiety with ASD/ADHD)

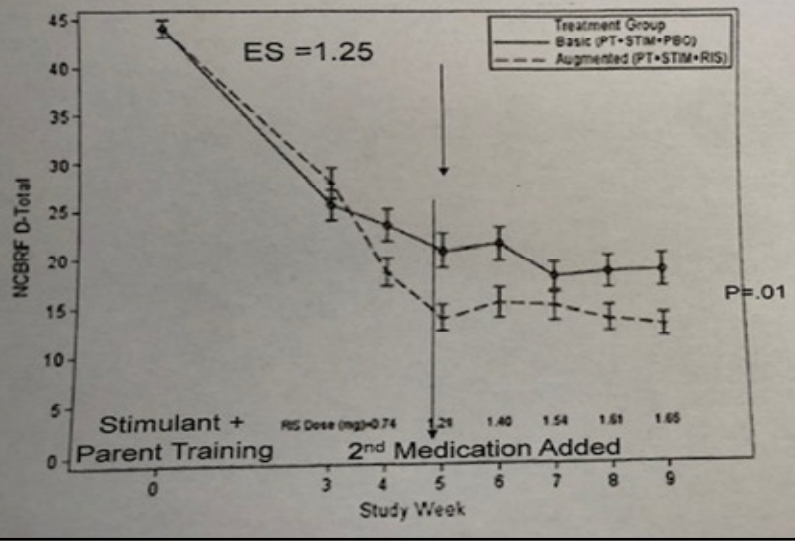
What to do if stimulants, alpha agonists and/or SSRI's not enough

- Parent training helps, but also may not be enough
- MTA study showed 44% of kids with ADHD still impaired by aggression despite best treatment with stimulants & parent training.

What Does Risperidone Add to Parent Training and Stimulant for Severe Aggression in Child Attention-Deficit/Hyperactivity Disorder?

- All children had ADHD & ODD.
- Mean age 9 years.
- Children were optimized on concerta (average 45mg daily) for 3 weeks, while parents received parent training.
- If there was room for improvement at the end of week 3, placebo or risperidone was added.
- *Augmented* treatment with risperidone (average 1.65 mg daily showed statistically significant improvement
- What Does Risperidone Add to Parent Training and Stimulant for Severe Aggression in Child Attention-Deficit/Hyperactivity Disorder? Aman, 2014, JAACAP

ADHD + Aggressive Children Treated With Stimulants and Parent Training X 3 Weeks, Then Randomized to Placebo or Risperidone

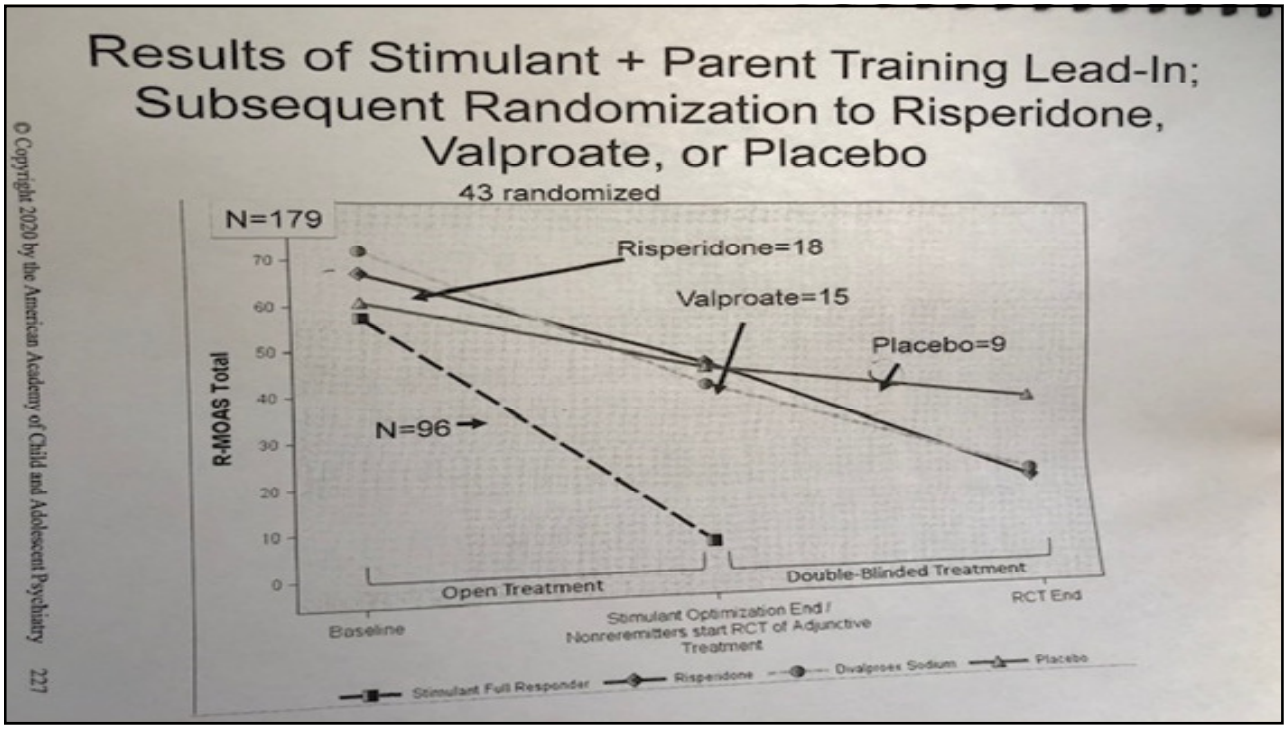


Effect Size for Completers:
.51 from baseline
.62 from week 3

Amen et al., JAACAP, 2014;53:47-60.

Stepped Treatment for ADHD & Aggressive Behavior

- All children had ADHD & previous stimulant treatment
- Average age 9
- Open stimulant optimization phase with parent training showed high response rate.
- Suggests that rigorous titration of stimulant medication with concurrent behavioral therapy may avert the need for additional medications.
- Among non-remitters, risperidone & Valproate were equally efficacious adjunctive treatments.
- Weight gain (Risperidone > Valproate).
- Stepped Treatment for Attention-Deficit/Hyperactivity Disorder and Aggressive Behavior: A Randomized, Controlled Trial of Adjunctive Risperidone, Divalproex Sodium, or Placebo After Stimulant Medication Optimization, Blader et al, JAACAP, 2020



Summary

- Rage outbursts << common than temper tantrums , but require expertise.
- Causes are transdiagnostic & not always easily categorized by DSM5.
- Comorbid ADHD is commonest comorbidity.
- ODD is useful clinical construct.
- Pharmacology should be targeted to specific behaviors.

Bursting at the seams

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Overflow: So full that contents go over the sides

Points to Cover

- Questions to ask families to gather more information
- Understanding Function
- Balancing safety vs treatment
- Assessing family resources and readiness
- Making meaningful referrals

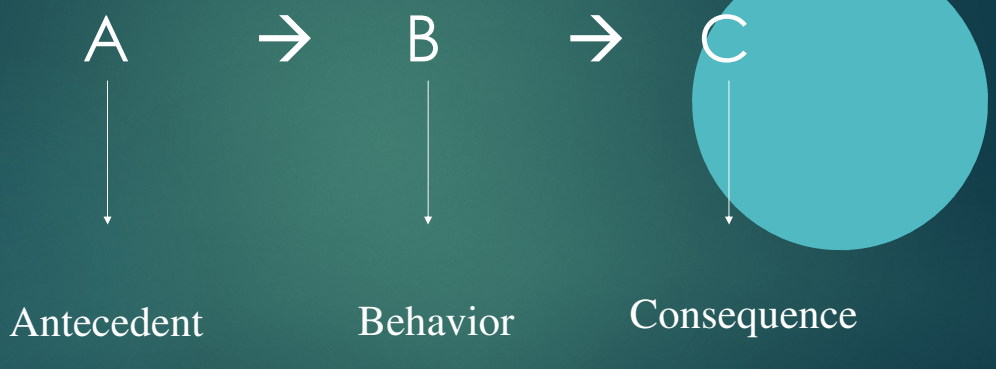
Outbursts are not created equal

- Topography:
  - What behaviors are they engaging in?
  - Is there a clear escalation or hierarchy of behaviors?
  - Are the behaviors present in all outbursts or do they differ?
- Environment:
  - Where does this happen/happen most/happen least/never happen?
  - Who is around and what are they saying/doing?
  - Does the child seem aware of other people?
- Metrics:
  - Frequency: How often does this occur (daily/weekly/monthly)
  - Duration: How long typically does the outburst last?
  - What is the normal time in-between outbursts?

Questions cont.

- De-escalation:
  - How does the child eventually calm down?
    - By themselves or with the help of others?
    - Are other objects/activities needed to de-escalate?
    - How long until you feel they are truly calm?
- Safety:
  - Is the child safe while the outbursts occur?
  - Are others in the environment safe while the outburst occurs?
  - Is there a safe environment where the child can de-escalate?
  - What needs to be added or removed from the environment to make it safe?

Three Term Contingency



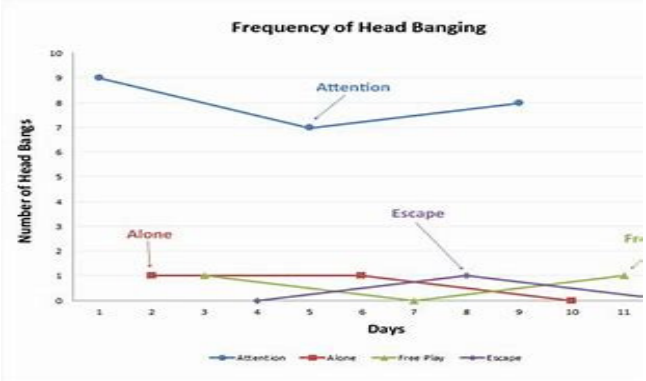
Relation to Function

A → B → C = Function of Behavior

- Relationship across time
- Repeated presentations
- Function of behavior = maintaining variable = reinforcer

Behavioral Function

- Attention (positive or negative)
  - "Don't do that you'll hurt yourself"
  - "I'm so proud you tied your shoes!"
- Escape from demands:
  - Academic work, situations, procedures
- Access to tangible
  - Food, toys, a preferred way of playing
- Automatic reinforcement



Establishing Operations

A → B → C = Function of Behavior

- Establishing Operations: Effect the potency of the reinforcer and function of the behavior
- E.g., Hunger, deprived attention, loud environments, presence of tangibles, new people, change in routine

Suggestions

- Create a safety plan for outbursts that is the same every time
  - Create criteria to define an outburst beginning that is objective
  - Create criteria for child behavior that is objective to conclude outburst
    - Often the child and adult are looking at each other for clues of when this is finished
- Teachings skills like grocery shopping tolerance should be done proactively and at a time when the caregiver does NOT need to get groceries.
  - If necessary, use behavior contracting, first/then contingencies, and visuals to incentivize the child and make clear what they need to do
  - Create incompatible behaviors to challenging behaviors
- Honor functional communication if available
  - This includes antecedent challenging behavior as well as communication
  - Often outbursts occur because other more appropriate attempts to communicate were not successful

Factors for Recommendations

- Safety first: current outburst
  - Decrease duration, intensity, injury, impact
- Treatment: for future outbursts
  - Addressing function
  - Reinforcing contingencies
  - Increase other skill areas that are incompatible

Family resources and capacity

- How many adults are needed to manage the outburst? Does the family always have those numbers available?
  - **Can you advocate for respite hours, access to a behavior interventionist?**
- Is the child much bigger/stronger than the child? Can the parent physically keep themselves, their child, and others safe?
  - **Contact MCFD social worker if there are concerns**
- How is the family doing? Do parents/caregivers have the mental stamina to continue working through outbursts?
  - Are outbursts occurring because parents can no longer carry the load alone of caring for their challenging child?
- Are their siblings? How are they coping with the distress of outbursts within their family?
- If family or child is not safe during an outburst and de-escalation strategies have failed…
  - **Contact 911**

Conclusions

- There is no one treatment or remedy for outbursts. They are not created equal; they are all different
- Common strategies can be implemented and assessed to see if they are helpful
- Safety first when dealing with an outburst and behavior management to reduce overall frequency based on function
- Families that are doing well, do well.
  - Support families across all areas of wellness so they have the capacity to help through child with outbursts
  - Check in on them frequently, validate their experience, provide advocacy