Managing Very Aggressive Behaviors in PCIT

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Overview

- Referrals for Aggressive behavior
- Barriers to CDI and PDI
- Modifications to CDI
- Modifications to PDI
- Case Example
- Reflective Thoughts
Most children referred to PCIT will have disruptive behaviors.
Some children present with extreme aggression.
Referrals for very aggressive behaviors have increased over time.

McNeil & Hembree-Kigin, 2010
Common Presentations

- Children with very aggressive behaviors commonly have histories of child abuse and/or exposure to domestic violence
- Typical clinical presentation is an unassertive mother who feels victimized by her child’s aggression, and a father/partner with anger control problems/antisocial behaviors

McNeil & Hembree-Kigin, 2010
To PCIT or not to PCIT?

• A common trend is to diagnose with bipolar disorder and use medication management instead of behavioral intervention
• PCIT can be effective with this population
• PCIT is a “high-risk” therapy with older children (ages 7-10) who have highly aggressive and defiant behaviors

McNeil & Hembree-Kigin, 2010
Barriers to CDI

Common CDI Pitfalls with Aggressive Children

• Typical CDI activities/interactions may not be reinforcing to the child
• Ignore may not be appropriate or effective
• Parent does not yet have CDI skills to prevent or redirect behaviors
• Therapist may lose credibility with parent
• Modify CDI if session ½ are spent primarily managing disruptive behaviors

McNeil & Hembree-Kigin, 2010
CDI Adaptation Decisions

When to make CDI adaptations

• It’s taken 2-3 sessions to get client into the clinic
• Client is unresponsive to structure of session
• Client has caused problems in the waiting room
CDI Adaptations

Recommended modifications to CDI in the PCIT manual

• Modify the clinic environment
• Explain CDI “rules” in advance
• Therapist entering room for aggressive behaviors
• Parent leaving room for aggressive behaviors
• Build up CDI skills in advance
• Breaks and session time modifications
• Reward Program
• PDI before CDI
• Ending on a positive note
Barriers to PDI

Common PDI Pitfalls with Aggressive Children

- Parents may have great difficulty following through
- Parents with anger management problems
- Children with extreme escalation
- Therapist liability
- Safety concerns

McNeil & Hembree-Kigin, 2010
PDI Adaptations

Recommended modifications to PDI in the PCIT manual

• Few adaptations to PDI are needed; PDI was developed to target disruptive behaviors
• It may be helpful to enter the room when parent starts time-out procedure
• Physical guidance
• Use delayed consequence for older children at risk for dangerous behavioral escalations
• “Slow roll” Compliance Training

McNeil & Hembree-Kigin, 2010
Case Example: “S”
A case of severe aggressive behaviors

• 6-year-old Caucasian Hispanic boy
• Lives alone with mom
• Referred by psychiatrist due to noncompliance, tantrums, and severe verbal and physical aggression
• Has previous dx of ADHD
• Child has been sent home from school every day and has no accommodations
Biopsychosocial and Developmental Context

Chrono System

Meso System

Exo System

Meso System

Micro System

Joshua
## Assessment and Diagnosis

### ASSESSMENT:
- Clinical Interview
- Collateral Contacts
- School Observation
- Standardized Measures

### DIAGNOSES:
- ADHD
- ODD

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‘S’ PRE DPICS
Initial Treatment Plan

- Standard PCIT (modifications added later)
- Behavioral support for secondary caregiver
- Coordination of care with the psychiatrist
- Referral for support for parent
- School advocacy
  - Placement in special education setting
Treatment Strengths

- S is bright, curious, verbally expressive, and caring
- Mother is motivated to participate
- Regular attendance and homework participation
- Stable housing
- S is liked by several school staff
Treatment Content and Timeline

PRE Assessment
CDI Teach
CDI Coaching (14 sessions)

MID Assessment
PDI Teach 1
PDI Broken Record (2 sessions)
PDI Teach 2, Mr. Bear, Role play (2 sessions)
PDI Coaching in clinic (9 sessions)
PDI Coaching in home (6 sessions)
PDI Coaching in community (7 sessions)

POST Assessment
Post DPICS
PDI Coaching in community (Booster sessions)
Early sessions spent almost exclusively on behavior management
Disruptive behaviors more stimulating than play
Severe aggression/Safety concerns
Caregiver mental health and dependency
Poor buy-in to behavioral model
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‘S’ CDI 1
CDI Treatment Modifications and Rationales

- Rules/behavior management needed in CDI
- Management of environment
- Giving child choice and control in treatment
- Additional therapist/support for bx management
- Providing hope to caregiver
- Managing environment
Video Clips

CDI Coaching Strategies
‘S’ MID DPICS
Treatment Barriers PDI

- Severe aggression
- Safety concerns
- Caregiver anxiety, dependency, and (suspected) trauma symptoms
- Difficulties generalizing skills
- Caregiver health problems (broken knee)
PDI Treatment Modifications and Rationales

• Broken record technique
• Extended PDI outside of clinic
• Increased parent support
• Increased modeling/role-play
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‘S’ PDI Session
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Treatment Outcomes

![Bar chart showing treatment outcomes over time.
- ECBI Problems
- ECBI Intensity

- Pre: Low ECBI Problems, High ECBI Intensity
- Mid: Moderate ECBI Problems, Lower ECBI Intensity
- Post: Higher ECBI Problems, Further Decrease in Intensity
- Booster: Further Increase in Problems, Significant Reduction in Intensity]
Video Clips

‘S’ Post DPICS
What’s next?

When Post-DPICS is not the end of treatment

• In clinic mastery
• “Good enough” behavior change
• How long do we keep families in treatment?
• How involved should we be to maintain gains?
Lessons Learned
Considerations when working with aggressive children

• Identify and address caregiver mental health earlier in treatment
• Avoid “taking over” in treatment
• Treatment Adaptation is necessary
• Team approach
• Adjusting expectations
Questions and Comments?
THANK YOU!

Contact us if you have questions:

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