

An Innovative Approach for Helping 'Explosive Children'

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Although a tendency to "explosive outbursts" is certainly not a characteristic that applies to many children with ADHD - and is not part of the diagnostic criteria for ADHD - many of the parents I worked with over the years reported this to be one of the most difficult aspects of their child's behavior to deal with. At the time that I was practicing, I could certainly relate to this, as my wife and I were dealing with similar issues with one of our children. We were helped tremendously by an excellent book called 'The Explosive Child: A New Approach for Understanding and Parenting Easily Frustrated, "Chronically Inflexible" Children'.

The book is authored by Dr. Ross Greene, a clinical psychologist from Harvard Medical School. Dr. Greene's approach impressed me as a thoughtful and respectful way to deal with the behavioral volatility and emotional outbursts that often add to the challenges faced by many parents of children with ADHD. Below, I try to summarize Dr. Greene's interesting approach.

WHAT ARE THE COMMON CHARACTERISTICS OF INFLEXIBLE-EXPLOSIVE CHILDREN?

The label "inflexible-explosive" child is not a diagnostic term recognized in DSM-IV, the official diagnostic guide for psychiatric disorders. Instead, it is used by Dr. Greene to capture the key features of children who are extremely difficult for parents to manage. According to Dr. Greene, the key features of such children are the following:

1. A very limited capacity for flexibility and adaptability and a tendency to become "incoherent" in the midst of severe frustration.

These children are much less flexible and adaptable than their peers, become easily overwhelmed by frustration, and are often unable to behave in a logical and rational manner when frustrated. During periods of incoherence, they are not responsive to efforts to reason with them, which may actually make things worse. Dr. Greene refers to these episodes as "meltdowns" and argues that the child has little or no control over his/her behavior during these episodes.

2. An extremely low frustration tolerance threshold.

These children often become overwhelmingly frustrated by what seem like relatively trivial events. Because their capacity to tolerate frustration develops more slowly than their peers, they often experience the world as a frustrating place filled with people who do not understand what they are experiencing.

3. The tendency to think in a concrete, rigid, black- and-white manner.

These children fail to develop the flexibility in their thinking at the same rate as peers, and tend to regard many situations in an either-or, all-or-none, manner. This greatly impairs their ability to negotiate and compromise.

4. The persistence of inflexibility and poor response to frustration despite a high level of intrinsic or extrinsic motivation.

Even very salient and important consequences do not necessarily diminish the child's frequent, intense, and lengthy "meltdowns". As a result, typical approaches of rewarding a child for desired behavior and punishing negative behavior do not diminish the child's tendency to "fall apart". According to Dr. Greene, traditional behavioral therapy approaches for such children often don't work at all and can make things worse.

In addition to these key features, Dr. Greene notes that a child's meltdowns often have an "out-of-the-blue" quality, occurring in response to an apparently trivial frustration even when the child has been in a good mood. As a result, parents never know what to expect and things can seem to fall apart at any moment.

WHAT CAUSES A CHILD TO BE THIS WAY?

According to Dr. Greene, most children who become extremely inflexible and explosive do so because of biologically-based vulnerabilities and not because of "poor parenting". The list of biological vulnerabilities that may predispose children to develop these characteristics include the following:

- Difficult Temperament -

By nature, some infants come in to the world being more finicky, emotionally reactive, and more difficult to soothe than others. These "innate" aspects of personality are what psychologists refer to as temperament. (Note: It is important to recognize that even very difficult temperaments can be modified over time and this in no way "dooms" a child to a life of ongoing difficulty and struggle.)

- ADHD and Executive Function Deficits -

Many children with difficult temperaments are eventually diagnosed with ADHD. As discussed in prior issues of Attention Research Update, current theorizing about the core deficits associated with ADHD focus on problems in a crucial set of thinking skills referred to as "executive functions".

Although there is not universal agreement on the specific skills that constitute executive functions, most lists would include such things as: organization and planning skills, establishing goals and being able to use these goals to guide one's behavior, working memory, being able to keep emotions from overpowering one's ability to think rationally, and being able to shift efficiently from one cognitive activity to the next.

Deficiencies in these skills are believed to help explain not only the core symptoms of ADHD (i.e. inattention and hyperactivity/impulsivity), but also the poor frustration tolerance, inflexibility, and explosive outbursts that are seen in the "inflexible-explosive" children described by Dr. Greene.

For example, if a child has difficulty shifting readily from one activity to the next because of an inherent cognitive inflexibility, this child may feel overwhelmingly frustrated when parents say it is time to stop playing and come in for dinner. The child may not intend to be disobedient, but may have trouble complying with parents' demands because of trouble shifting flexibly and efficiently from one mind-set to another. In fact, Dr. Greene argues that most "explosive children" want to behave better and feel badly about their outbursts. He believes they are motivated to change their behavior but lack the skills to do it.

- Language processing problems -

Language skills set the stage for many critical forms of thinking including problem solving, goal setting, and regulating/managing emotions. Thus, it is not surprising that children with poorly developed language abilities, as is often true in children with ADHD, would have greater difficulty managing frustration.

- Mood difficulties -

Some children are born predisposed to perpetually sunny and cheerful moods. Others, unfortunately, tend to experience sustained periods of irritability and crankiness for reasons that are rooted largely in biology. This is not just true for children who experience full-blown mood disorders such as depression or bipolar disorder, but can apply to "sub-clinical" mood difficulties as well.

Imagine for a moment how you tend to handle things when feeling cranky and irritable. If you're like most people, you probably become frustrated more easily and lose your temper more readily. For children who are prone to these negative mood states, more chronic difficulties with frustration and temper are thus likely to be evident.

WHAT CAN PARENTS DO?

How can a parent help their "explosive" child become less explosive, develop greater self-control, and thereby create a better quality of life for everyone in the family?

According to Dr. Greene, the first step is to develop a clear understanding of the reasons for the child's explosiveness. To the extent that parents - and others - regard a child's explosiveness as reflecting deliberate and willful attempts to "get what they want", the overwhelming tendency will be to respond in punitive ways. Dr. Greene argues convincingly, however, that punishments will not work for a child who lacks the skills to handle frustration more adaptively. That is because when these children are frustrated they are not able to use the anticipation of punishment to alter their behavior.

When one's mindset changes from "my child is acting like a spoiled brat" to "my child needs help in learning to deal with frustration in a more flexible and adaptive manner", it becomes easier to move from a punishment-oriented approach to a skills-building approach. At the heart of this effort is what Dr. Greene refers to as the "Basket Approach".

THE "BASKET" APPROACH

Because "meltdowns" can be so difficult for everyone in the family to endure, the primary objective in working with "explosive children" is to first reduce the frequency of such

episodes. Reducing the number of meltdowns from several per day to one per day, and eventually to just a handful per week, can make an enormous difference in the quality of family life and to children developing a sense of being able to control their behavior. Initially, this is accomplished largely by reducing the demands to tolerate frustration that are made on the child by sorting the types of behaviors that create problems into 3 baskets according to how critical it is to change the behaviors or to curtail them when they occur.

- Basket A -

Some behaviors are so problematic that they must remain off-limits even if enforcing the rule against them will result in a meltdown. Initially, Dr. Greene suggests that the only behaviors to be placed in Basket A are those that are clear safety issues (e.g. wearing a seat belt in the car; not engaging in dangerous or harmful behaviors such as hitting others). This is where parents must continue to stand firm and insist on compliance. Dr. Greene's specific criteria for what goes in Basket A are as follows:

1. The behavior must be so important that it is worth enduring a meltdown to enforce:
2. The child must be capable of behaving in the way that is expected.

For example, Dr. Greene would argue that there is no point insisting that completing assigned homework be placed in Basket A when the child lacks the skills and frustration tolerance to do this consistently.

By reducing the number of behaviors for which compliance is non-negotiable to those that are really and truly essential and that the child is capable of performing, the number of exchanges that are likely to set off explosive episodes can be drastically reduced.

- Basket B -

Basket B - the most important basket according to Dr. Greene - contains behaviors that really are high priorities but are ones that you are not willing to endure a meltdown over. These can include such items as completing schoolwork, talking to parents with respect, complying with reasonable expectations, etc.

It is around Basket B behaviors that Dr. Greene believes that critical compromise and negotiation skills can be taught to your child. For example, suppose your child is watching TV and you know it is time to stop and get started on homework. You tell your child to turn off the TV and get started, and he refuses.

The temptation here would be to insist on immediate compliance and to threaten punishment (e.g. no TV for the rest of the week) if your child does not comply. But, in Dr. Greene's framework, this is not a safety issue, and thus should not be placed in Basket A. He would ask what is likely to happen if you make such a response? One likely consequence is that your child's frustration will increase, he or she will lose control, and a full-fledged meltdown will ensue.

Is this worth it? If standing firm and tolerating this meltdown made it more likely that your child would comply the next time you made such a demand, the answer would be yes. If, however, standing firm and triggering the meltdown does not increase the likelihood of

compliance in the future, or reduce the probability of future meltdowns, Dr. Greene would suggest it was definitely not worth it.

What to do instead? Dr. Greene argues that these Basket B behaviors provide wonderful opportunities to try and engage your child in a compromise and negotiation process. In the scenario above, the parent could say something like, "I know that it is important to you to keep watching TV. I would like for you to be able to do this, but I also know that you have homework that needs to get done. Let's try to come up with a compromise where you'll get some of what you want, and I'll get some of what I want."

The goal here is not only to get the child to give in and do what you want, but to begin teaching your child the compromise and negotiation skills that will contribute to his or her becoming more flexible over time. Dr. Greene points out how this process can be extremely difficult for inflexible-explosive children, and that it is not unusual for them to become increasingly agitated when trying to negotiate a solution.

As a parent, if you observe this starting to occur, and sense your child is getting closer to a meltdown, the goal becomes trying to diffuse the tension so that a meltdown does not take place. This can mean offering compromise solutions for the child in an effort to help things calm down. When this does not work, Dr. Greene suggests just letting things go so that the meltdown is avoided. In the example above, should the efforts to negotiate fail and lead the child to the verge of a meltdown the parent might say, "Well, I can see you are getting really upset about this. I appreciate that you tried to work out a compromise with me but we have not been able to come up with a good one yet. So, why don't you just watch a bit more TV for now and we can try again in a little while to work out a good compromise."

This can be very difficult to do and many parents along with mental health professionals would be concerned that such actions would result in teaching the child that he or she can get what she wants by refusing to give in and becoming upset. This is what a traditional behavioral therapist would argue. From Dr. Greene's perspective, however, insisting that the child turn off the TV when a compromise was not reached would accomplish little more than triggering a meltdown that would also prevent homework from getting started on and be much more upsetting for everyone. Because of this, he advocates doing your best to help your child develop some much needed negotiation skills, but dropping things when it is clear that an explosion is imminent. Later, when the child has settled back down, you can resume your efforts to negotiate.

Developing skills to compromise and tolerate frustration does not happen right away. Dr. Greene points out that progress in these areas can be painstakingly slow, but that over time, the approach he recommends can lead to substantial gains for explosive children.

- Basket C -

Basket C contains those behaviors that are simply not worth enduring a meltdown over, even though they may have previously seemed like a high priority. By placing a number of previously important behaviors in Basket C, the opportunity for conflict producing meltdowns between parents and their child is greatly diminished.

What kinds of things belong in Basket C? This depends on the specifics of each situation but may include such things as what a child will and will not eat, what clothes they wear, how

they keep their room, etc. Dr. Greene suggests that the question to ask in determining whether a particular behavior falls into Basket C is "Is this so important that it is really worth risking a meltdown over?" If not, and you've already identified a number of behaviors that seem more important and worth negotiating over (i.e. those in Basket B), then into Basket C it goes.

How does this compare to traditional parenting approaches?

Dr. Greene's approach to dealing with explosive children runs counter to what many parents and professionals believe, i.e. that if a child is not punished, for behaving inappropriately they will never develop the necessary self-control nor be deterred from continuing to misbehave. Thus, Dr. Greene's thesis here is a controversial one and is at odds with traditional behavior therapy approaches that have substantial research support. Dr. Greene suggests, however, that for children whose explosiveness stems from a basic and biologically based inability to manage frustration, Dr. Greene suggests that behavioral interventions may not be effective can actually make things worse by increasing, rather than decreasing, the frequency with which a child loses control.

- Isn't this just giving in to a misbehaving child? -

Not necessarily. Dr. Greene points out that there is an important difference between giving in and deciding what behaviors are important enough to stand firm on. It remains the responsibility and prerogative of parents to be clear about what is non-negotiable, when compromise is a reasonable way to go, and what things to let slide for the time being. As the child becomes better able to tolerate frustration and learn much-needed compromise and negotiation skills, more and more behaviors can be moved from Basket C into Basket B, thus providing your child with increasing opportunities to practice learning to compromise.

- DOES THIS APPROACH WORK? RESULTS FROM A RECENT STUDY -

Dr. Greene's approach will resonate with some people and be sharply criticized by others. However, the hallmark of a scientist is a willingness and desire to test one's theories through empirical research and I was thus quite pleased to recently come across a study published several years ago by Dr. Greene in which he tested the approach described above against more traditional behavioral parent training therapy with a sample of oppositional defiant children who also had symptoms of a mood disorder (Greene et al. [2004]. Effectiveness of collaborative problem solving in affectively dysregulated children with oppositional-defiant disorder: Initial findings. *Journal of Consulting and Clinical Psychology*, 2004, 72, 1157-1164).

Participants in this study were parents of 50 children with ODD - for a description of diagnostic criteria for ODD see www.helpforadd.com/oddc.d.htm - who also had at least sub threshold features of either childhood bipolar disorder or major depression. In addition, about two-thirds of the children were diagnosed with ADHD and many were being treated with medication.

The parents of these children were randomly assigned to 1 of 2 interventions designed to help them bring their child's behavior under better control: the collaborative problem solving model developed by Dr. Greene or a more traditional behavioral parent training program developed by Dr. Russell Barkley, one of the world's leading authorities on ADHD.

Dr. Barkley's parent training program is a highly structured behavior management program that lasted for 10-weeks. The focus is on teaching parents more effective discipline and behavior management strategies and sessions were attended primarily by parents, although children participated occasionally as well.

Families assigned to the Collaborative Problem Solving (CPS) treatment were educated about the biological factors contributing to their child's aggressive outbursts, the "baskets" framework described above, and about the use of collaborative problem solving as a means for resolving disagreements and defusing potentially conflictual situations so as to reduce the likelihood of aggressive outbursts. As with Barkley's parent training program, sessions were attended primarily by parents. The number of sessions attended by parents ranged from 7-16 and the average length of treatment was 11 weeks.

- RESULTS -

At the conclusion of treatment, parents in both groups reported a significant decline in their child's level of oppositional behavior. At 4-months post-treatment, however, the gains reported by families who received traditional parent training were beginning to erode while those who received Greene's Collaborative Problem Solving therapy reported that gains were fully sustained. Specifically, 80% of children in the CPS condition were reported to be either very much improved or much improved by their parents compared to only 44% in the traditional parent training program.

Parents in the CPS condition also reported that they were experiencing significantly less stress, that their children were more adaptable, and that hyperactive-impulsive symptoms were reduced. They also felt more effective at setting limits for their children and that communication with their child had improved. Significant improvements on these dimensions were not evident.

- SUMMARY and IMPLICATIONS -

The approach developed by Dr. Greene for developing self-control in children prone to emotional outbursts and melt-downs represents an important shift from traditional behavioral treatment methods. It is based on the premise that when this behavior has a strong biological underpinning, as he feels is true for many children, the use of punishments and rewards are not likely to be effective. Instead, he advocates that parents work to remove sources of frustration from their child's life, become clear about what behaviors they truly need to take a stand on, and focus helping their child develop the ability to negotiate, compromise, and manage their affect. Because melt-downs can be so painful for everyone to endure, parents are taught to avoid making demands on their child that would be likely to trigger a melt-down unless it is absolutely necessary.

This will be regarded by many as a controversial approach, but results from a preliminary test suggest that these ideas may have real value for children and families. Because this is only an initial study, however, it is clear that more work needs to be done, and I am hopeful that a larger trial that tests the value of Dr. Greene's treatment suggestions will be published shortly.

For those of you who would like to learn more about these interesting ideas, Dr. Greene maintains a web site at www.explosivechild.com where his published books and videos/DVDs are available. There is also a web site at <http://www.livesinthebalance.org/>

where you can find additional excellent information on Dr. Greene's collaborative problem solving approach.

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