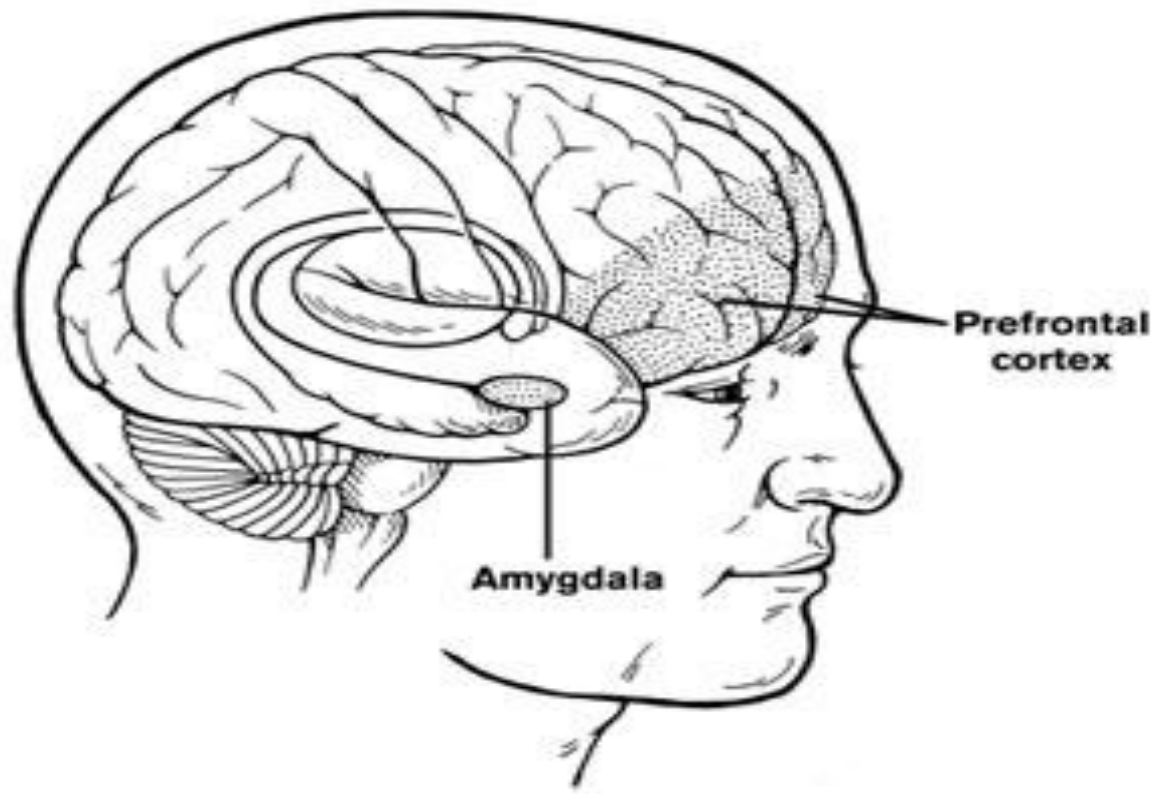




A Research Based Approach To The Treatment of Anger, Aggression & Addiction

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SELF-IMAGE



- **Violation of our image of ourselves (ego) leads to.....**
- **Defenses in the form of narcissistic character defects such as judgmentalism and anger fueled by...**
- **A fear of losing control**

SELF-IMAGE



- Heraclitus (5th Century BC)- “*Know Thyself*”
- People with faulty self-images tend to have...
 - *High levels of anxiety*
 - *High levels of defensiveness*
 - *High levels of self-doubt*
 - *High levels of narcissism*
- ***IN OTHER WORDS... CHARACTER DEFECTS***

REMOVING DEFECTS OF CHARACTER



- THE EGO FUNCTIONS IN THE PAST AND THE FUTURE AND IS FEAR BASED
- CHARACTER DEFECTS CAN BE SEEN AS SPIRITUAL DEFICITS
- CHARACTER DEFECTS RESPOND BEST TO SPIRITUAL METHODS SUCH AS...
 - THE STEPS OF AA
 - BEATITUDES
 - HINDUISM
 - BUDDHISM

ANGER AND FEAR



- **NO OTHER PERSON CAN MAKE YOU FEEL ANYTHING- YOU DO IT TO YOURSELF**
- **THERE IS NO ANGER OR FEAR IN REALITY-IT ONLY RESIDES WITHIN YOU**
- **WHEN WE GET ANGRY AT ANOTHER IT IS BECAUSE THEY DIDN'T LIVE UP TO YOUR EXPECTATIONS**
- **FEAR OFTEN COMES FROM CONCERN ABOUT LOSING SOMETHING VALUABLE TO US**

TREATMENT OF FEAR



- **MAY PRESENT AS ANXIETY OR ANGER**
- ◆ **Want energy but not feeling**
- ◆ **Disassemble**
 - ◆ **Physical symptoms**
 - ◆ Can you handle them?
 - ◆ **Emotional symptoms**
 - ◆ Can you handle them?
- ◆ **Not experiencing fear just a bunch of symptoms**
- ◆ **“Fear is not you, it is just a symptom**

Violent Behavior Multi-determined



- **Genetic Tendencies**
 - Serotonin transporter gene 5-HTTLPR
 - MAO low activity allele
- **Traumatic childhood experiences**
 - Orbitofrontal Cortex
 - Reduction in serotonin levels
 - Disorganized Attachment
- **Paranoid personality style**
 - Organized or Disorganized
- **Frontal cortex injury**
- **Alcohol/Drugs-acute and chronic**

Violent Behavior Multi-determined



- **Girls and women are not necessarily less violent than boys and men**
 - **Female**
 - Indirect
 - Covert
 - **Men**
 - Immediate outward physical aggression
- **Various Psychiatric Disorders**
- **Hormones-Testosterone**

Anger, Aggression and Addiction



- **Alcohol**
 - Serotonin
- **Stimulants**
 - Fight or Flight
 - Increased Dopamine in Prefrontal Cortex
- **Arylcyclohexylamines**
 - PCP
 - Ketamine

Differential Diagnosis



- **Neurological Dysfunction**
 - ADHD
 - Autism
 - Dementia
- **Brain Damage and Injury**
 - Frontal lobe injury
 - Exposure to toxins
 - Maternal alcohol/ drug usage

Differential Diagnosis



- **Personality traits and disorders**
 - **Antisocial traits or ASPD (Antisocial Personality Disorder)**
 - **Paranoid traits or PPD (Paranoid Personality Disorder)**
 - **Borderline traits or BPD (Borderline Personality Disorder)**
- **Neurotransmitters and hormones**
 - **Serotonin**
 - **Many antiaggression meds work thru this system**
 - **Testosterone**

Differential Diagnosis



- **Mental Illness**
 - **With paranoid symptoms**
 - **Panic Disorder**
 - **Schizophrenia**
 - **Mania**
 - **Depressive Disorder**
 - **Drug Intoxication and withdrawal**
 - **Mental Retardation**
 - **Oppositional Defiant Disorder**
 - **Conduct Disorder**
 - **Posttraumatic Stress Disorder**

Differential Diagnosis



- **Medical Diseases**
 - **Encephalitis**
 - **Alzheimer's Disease**
 - **Cerebrovascular Accident**
 - **Seizure disorders**

Brief Assessment



- ***Information about past and current behavior***
 - Client/Patient
 - Friends and family
- ***Review of past treatment***
 - Successful
 - Unsuccessful
- ***Clinical evaluation over time***
 - Medical
 - Psychosocial

RISK ASSESSMENT



- **Tools**

- **Psychopathy Checklist-Revised (PCL-R)**

- Widely used to attempt to predict violent behavior
 - Interview may take up to 3 hours

- **Psychopathy Checklist: Screening Version (PCL:SV)**

- 12 item subset
 - Takes about 90 minutes
 - MacArthur violence risk assessment study found stronger association with this tool than other variables evaluated
(www.macarthur.virginia.edu/risk.html)

RISK ASSESSMENT



- **Tools**

- **Historical, Clinical, Risk Management-20 (HCR-20)**

- 20 item instrument completed via interview, chart review, clinical presentation and collateral information
 - Incorporates past actions, present conditions and future outlook
 - Instrument of choice in many circles

- **Violence Risk Appraisal Guide (VRAG)**

- 12 item actuarial tool to predict violence
 - Successfully predicts misconduct during incarceration and recidivism (Harris, GT, et al. *Law and Human Behavior*. 2002; 26:377-395.)

RISK ASSESSMENT



- **Tools**

- **The Classification of Violent Risk (COVR)**

- Chart review and a 10 minute interview
 - Good in predicting risk for inpatients being discharged into community
 - No special training required although might be cost prohibitive to small practices (Monahan, J et al. *Psychiatric Serv.* 2005;56 (7):810-815)

- **Psychopathy Checklist: Youth Version (PCL:YV)**

- High scoring adolescents were 3 X more likely to commit a violent crime than those with low scores (Gretton, HM et al. *J Consult Clin Psych.* 2004;72:636-645.)

RISK ASSESSMENT



- **Past violence is most robust predictor of future violence**
- **Best source of historical data might be from past treatment records and from collaborative sources such as caregivers and significant others**
- **Internet sources such as publically accessible court records, police blotters and social networking sites can often yield helpful and sometimes very surprising information.**

RISK ASSESSMENT



- **Research suggests narcissistic injury often involved in fueling strong anger and resentment (Knoll, JL. *J Am Acad Psychiatry Law*. 2010;38(1):87-94) (see Exhibit Two)**
- **HIPAA is no help when patient will not sign releases of information, especially when involuntary hold about to conclude**

MANAGING RISK



- **Give yourself time to review your options**
- **Consult a colleague**
- **Develop a safety plan**
 - **Developed with the patient to reduce violence risk and might include avoiding triggers, using mindfulness, how and whom to ask for help; include caregivers or significant others in the discussion**
- **Assess level of care**
 - **Increased intensity or increasing number of outpatient contacts; telephone check-ins; for non-adherent patients outpatient commitment might be viable in some states**

MANAGING RISK



- **Reassess medications**
- **Be informed about medication risks**
 - **Some medications associated with increase in violent acts; utilize the website for the Institute for Safe Medication Practices (www.ismp.org); subscription required**
 - **See Exhibit One**
- **Refer when needed**
 - **If patient requires treatment in areas where you are not well trained consider referral**

MANAGING RISK



- **Duties to warn and protect**
 - **Acute hospitalization temporarily removes the threat with release predicated upon reduced threat**
 - **Some states include threats to property and some require you to inform police, as well as, the potential victim**
 - **If decide to warn might consider including the patient if believe it will minimize damage to relationship with the clinician and with person being warned**

MANAGING RISK



- **Guns**

- Understand what a gun means to the individual (for example, a veteran who has been in combat)
- Document a firearm disposition plan
- If will not relinquish guns they might agree to place them with a friend or remove the ammunition
- Gun safes or trigger locks

MANAGING RISK



- **Psychiatric Advanced Directive**
 - In states where this is allowed, document states what kinds of treatments they would prefer
 - You can check each state's law through the National Resource Center on Psychiatric Advance Directives at (www.nrc-pad.org)
 - Can get sample forms from Bazelon Center (www.bazelon.org); the forms can be downloaded from (<http://bit.ly/XQMRF5>)

Case Study



29 yo male (Marcus) was physically abused by his father. When his father was drunk he would hit Marcus with a belt. At age 12 Marcus made a decision to never let anyone hurt him again. From that point on whenever he felt threatened by a male authority figure he would “get in their face”.

Case Study



27 yo female (Gina) would listen to her parents scream obscenities and hit each other. One day when she was 11 yo she decided that she would no longer put up with the situation. Every time her parents would fight and scream at each other, she would run away from home.

Learned Coping and Survival Skills



- **Fear or threat (real or perceived) of being out of control leads to:**
 - *Withdrawal*
 - *Attack of others*
 - *Avoidance*
 - *Attack of self*
- **“Freeze, Flight or Fight”**

Modulation Ratio



- IN ORDER TO USE THE COGNITIVE AND BEHAVIORAL RECOVERY STRAEGIES TAUGHT IN TREATMENT AND SELF-HELP WANT CLIENT TO HAVE:

INHIBITION
EXCITATION

Clinical Example of Vertical Integration



- **Can be used with anger and many Anxiety Disorders where lower brain overrides cortical areas**
- **“Checker System”**
 - **Amygdala**
 - **Basal Ganglia**
 - **Brain Stem**

Clinical Example of Vertical Integration



- ***“Checker System”***
 - **Scams**
 - **Alerts**
 - **Motivates**
- **Helping the client have a different relationship with themselves**
 - **Psychoeducation**
 - **Promotes integration**

Clinical Example of Vertical Integration



- **Intervention**
 - **Personify the “Checker”**
 - **Observe what is going on**
 - **Cortex**
 - **Discernment**
 - **Teach meditation**
 - **Breathing**

Clinical Example of Vertical Integration



– Promote Dialogue

- Have Cortex communicate with subcortical areas

- *“Thank you for trying to keep me safe”*

- *“You are my friend”*

- *“Here is the deal, we need to talk about being safe” (contingent communication with self)*

– Cortex and “Checker” as a team

- Convince “Checker” that it does not have to be hyperactive

Pharmacotherapy



- **Aggressive Episode**

- **Oral**

- Risperidone 2mg oral soln & Lorazepam 2mg
 - Benzodiazepines
 - Atypical Antipsychotics

- **IM**

- Lorazepam 2mg
 - Diazepam and chlordiazepoxide are absorbed slowly and erratically
 - Pts abusing stimulants are more conducive to seizures and EPS

Pharmacotherapy



- **Haloperidol 5mg & Lorazepam 2mg**
- **IM Atypical Antipsychotics**
 - **Olanzapine (Zyprexa)**
 - » **Agitation associated with schizophrenia, bipolar mania and dementia**
 - **Ziprasidone (Geodon)**
 - » **Agitation associated with schizophrenia and schizoaffective disorder**
- **FDA approved long-acting form of injected risperidone called Risperdal Consta**

Pharmacotherapy



- **History of Impulsivity**
 - **SSRIs**
 - **Lithium**
- **History of mood swings**
 - **Mood stabilizers**
 - **Lithium**
 - **Tegretol**
 - **Depakote**

Non-Pharmacological Management



- ***Don't Personalize***
- ***Understand your personal reaction to anger***
- ***Assess the environment for potential danger***
- ***Know where the client is at all times***
- ***Keep an appropriate distance***

Non-Pharmacological Management



- **Validate the client**
- **Shift from Emotional to Cognitive or Behavioral Stance**
 - **What lead up to you feeling this way?**
- **Give the client a sense of being in control**
- **Clear the area of other clients or move client to safe place**

Case Study



Larry was a 23 yo alcoholic and addict. His therapy group had a new therapist and before he even met the therapist he looked at him and said, “I’m going to break your _____ head.”

What would you do in this situation?

Dialogue between client and clinician



- **Larry: *“I’m going to break your___head.”***
- **Therapist: *“Whatever you do don’t stop behaving the way you are now because you know and I know that it saved your life-didn’t it?”***
- **Therapist: *“I’d like to talk to that part of you that made a conscious decision to never let anyone hurt you again.”***

Empirically Proven Approaches



- **Relaxation**
 - Reduce physiological and emotional arousal
- **Cognitive**
 - Reduce anger inducing information processing
 - Increase problem-solving ability
- **Behavioral**
 - Teach adaptive behaviors

Why Change ?



- **Responsibility and blame**
- **Other condemnation**
- **Self-righteousness**
- **Cathartic expression**
- **Short-term reinforcement**

Therapeutic Relationship



THE ESSENCE OF A RELATIONSHIP OCCURS IN A MOMENT. THE DEPTH OF THE RELATIONSHIP TAKES TIME. WHY IS IT THAT ONE STAFF MEMBER CAN WALK INTO A ROOM AND THE CLIENTS IMMEDIATELY CALM DOWN WHILE ANOTHER STAFF MEMBER WALKS IN THE ROOM AND ALL HECK BREAKS LOOSE? THE ESTABLISHMENT OF THE RELATIONSHIP IS A PRELUDE TO CLINICAL EFFECTIVENESS.

Relaxation Therapy



- **Start early**
- **Techniques include:**
 - ***Control breathing***
 - ***Voice tone and tempo***
 - ***Progressive relaxation***
 - ***Caution with mental imagery***

Meditation Procedure



- Establish a routine
 - Times
 - Places
- Choose Technique
 - Repeat a prayer or special saying
 - Focus on a word or phrase
 - “One”
 - Directed Breathing
 - Progressive Muscle Relaxation

Meditation Procedure



- Choose Technique (continued)
 - Warming of the hands
 - Warming of another part of body
 - Chest
 - Feet
 - Focus on a spot on the wall
- As a part of the meditation close with “What am I grateful for today?”

Smell the Flowers, Blow Out the Candle



Case Study



Samantha was a 17 yo female who smoked marijuana because it helped her to “mellow-out”. In early recovery she was having problems with anxiety and anger. Her therapist taught her several strategies that involved tensing and relaxing muscles along with cognitive and behavioral techniques.

Labeling Our Feelings



- **Verbalizing our feelings and labeling emotions makes them less intense.**
- **Photograph of an angry or fearful face causes increased activity in the *amygdala***
 - **Creates a cascade of events resulting in “fight or flight” response**
- **Labeling the angry face changes the brain response**

Labeling Our Feelings



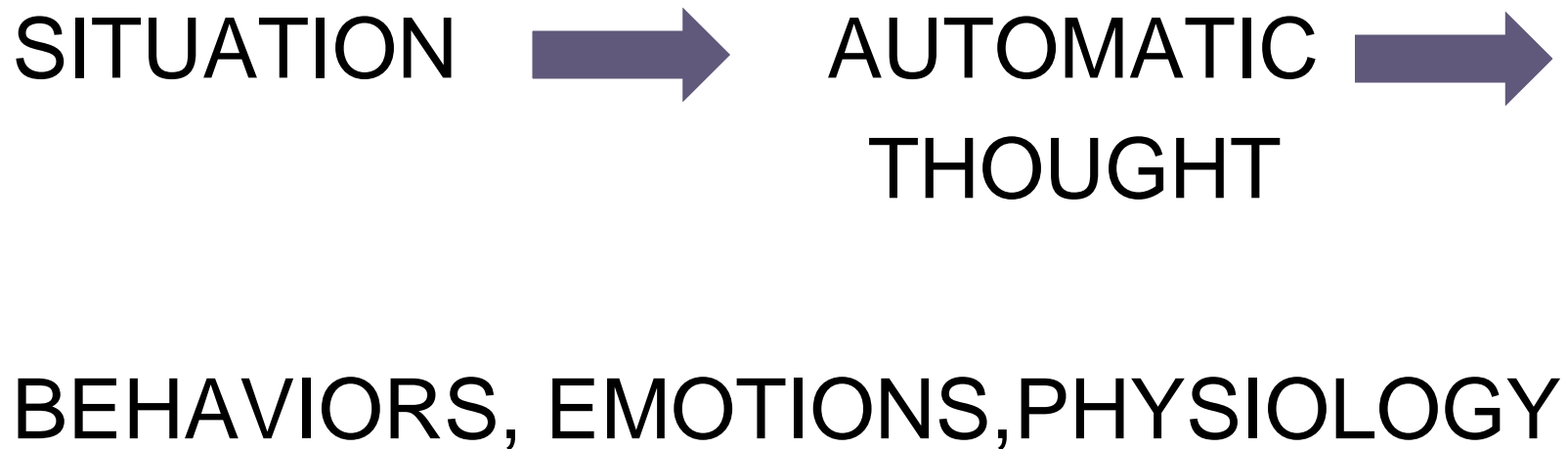
- Labeling the response caused the *amygdala* to be less active and the *right ventrolateral prefrontal cortex* to activate.
- Using mindfulness and labeling the feelings one experiences allows the *prefrontal cortex* to override the *amygdala*.
 - Matthew Lieberman, UCLA, Psychological Science, May 2007

David Creswell, UCLA



- “We found the more mindful you are, the more activation you have in the *right ventrolateral prefrontal cortex* and the less activation you have in the *amygdala*. We also saw activation in widespread centers of the *prefrontal cortex* for people who are high in mindfulness. This suggests people who are more mindful bring all sorts of *prefrontal* resources to turn down the *amygdala*.”

Cognitive Therapy



Cognitive Therapy



- **Our thoughts, behaviors and emotions are related**
- **Patients are often oblivious to these connections**
 - **Example-Client felt despondent but did not realize this emotion was triggered by a friend's failure to greet him. When asked, "Try to remember what you were thinking when your mood changed to sadness" the patient responded, "I assumed my friend was ignoring me because she does not like me anymore."**

Cognitive Therapy



- **Example- Sometimes people infer their mood from their behavior. A speaker giving a presentation on the lower deck of a cruise ship assumed because his legs were shaking he was nervous until he realized the floor was vibrating because it was close to the propeller shafts.**
- **Controlled experiments show people infer their feelings from their behavior or what they think is their behavior**

Cognitive Therapy



- **Example- Men looked at nude pictures of women in a *Playboy* magazine as they listened to what they thought was their heart rate. The men were then asked to rate their attraction to the nudes. Experimenters found men gave the highest ratings when they thought their hearts were beating faster or slower than normal although this feedback had nothing to do with their actual heart rates.**

Valins, S. *J Pers Soc Psychol.* 1966;4:400-408.

Cognitive Therapy



- **Correcting Thinking Errors (distorted thinking can affect mood)**
 - Clients overgeneralize from a single failure and assume they are failures
 - Sometimes they extend this distorted thinking with catastrophizing where one negative incident mushrooms into an imagined chain of events ending in disaster.

Cognitive Therapy



- **Other common distortions include...**
 - **Black-and-white thinking**, also known as **polarized or all-or-nothing thinking** is imagining that events will lead to one extreme or another. For example, if I am not a complete success then I am a complete failure.
 - **Focusing on the negative** involves filtering out the positives from an experience.
 - **Mind reading** involves guessing what others are thinking and feeling without sufficient evidence.

Cognitive Therapy-Dysfunctional Thought Record



<u>SITUATION</u>	<u>AUTOMATIC THOUGHT</u>	<u>EMOTION</u>	<u>ALTERNATE RESPONSES</u>	<u>OUTCOME</u>
SAMANTHA MET A NEW FRIEND WHO SAID HE WOULD CALL HER AND DID NOT	"HE REALLY DOESN'T LIKE ME" "WHY DO PEOPLE ALWAYS LIE TO ME"	ANGRY HURT	"MAYBE HE IS BUSY" "MAYBE HE WILL CALL IN THE NEXT TWO DAYS IF HE DOESN'T I WILL CALL HIM	HER FRIEND DIDN'T CALL SO SAMANTHA CALLED HIM, HE WAS GLAD TO HEAR FROM HER AND THEY ARE GOING OUT ON SATURDAY

Cognitive Therapy- Reframes



CT: *“My mother is always angry at me.”*

TH: *“Let’s see you are 15 yo and have been around you mom for 5475 days. In all of these days she has always been angry at you?”*

CT: *“Well no-not everyday”*

TH: *“Tell me about one of the days that you really had fun together.”*

Cognitive Therapy- Reframes



CT: *“I get so mad when my husband says, ‘Are you going out to another meeting’?”*


TH: *“You have been clean and sober for over 90 days now and you average 4 meetings a week...so that’s 48 meetings. So your husband has said this to you approximately 48 times.*

CT: *“Yes”*

TH: *“Why does this still surprise you.”*

Behavior Therapy



STIMULUS  **RESPONSE**



SETTING LIMITS





Behavior Therapy-Changing Response



57 yo male (Lyle) came to treatment with his wife. She said, *“My husband gets mad at other drivers, starts to curse and gives them obscene gestures. He is going to get us killed.”* Lyle said, *“I cannot help it. Those idiots on the highway really make me nuts.”* His wife stated, *“We drive a VW and last week the driver of a large truck chased us off of an exit ramp.”*

Behavior Therapy-Changing Response



CT: *“When I talk to my sister on the phone, she keeps telling me that I am not an alcoholic.” She says, “With will power you can control your drinking.”*

TH: *“How does that make you feel.”*

CT: *“Angry and Frustrated. She just cannot admit that alcoholism runs in our family.”*

TH: *“For right now, why don’t you email your sister instead of speaking with her on the phone.”*

Behavioral Exposure



CT: *“I am afraid to go home for Christmas because everyone will be drinking.”*

PLAN:

- **Use group role play to provide imaginal exposure**
- **Incorporate relaxation and cognitive techniques**
- **Limit “in vivo” exposure**
- **Create a safety plan**

Safety Plan



- **On a 3x5 index card**
 - **If things get too heavy at home during Christmas I will:**
 - **Call my sponsor**
 - **Find a meeting to attend**
 - **Practice my relaxation technique**
 - **Use the cognitive strategies I have learned in treatment**
 - **If I need to, I can always leave**

Use Of Humor



CT: *“My supervisor is a “flaming asshole” and every time I am around him I get angry.”*

TH: *“I’ve never seen a flaming asshole, can you draw me a picture of one?”*

CT DRAWS A PICTURE

TH: *“Every time you see your supervisor think of this picture.”*

THANK YOU FOR ATTENDING



**CHILDREN WANT
TO DO WELL
AND PLEASE.
ADOLESCENTS
BELIEVE THEY
ARE AS BAD
AS THEY HAVE
BEEN TOLD.**

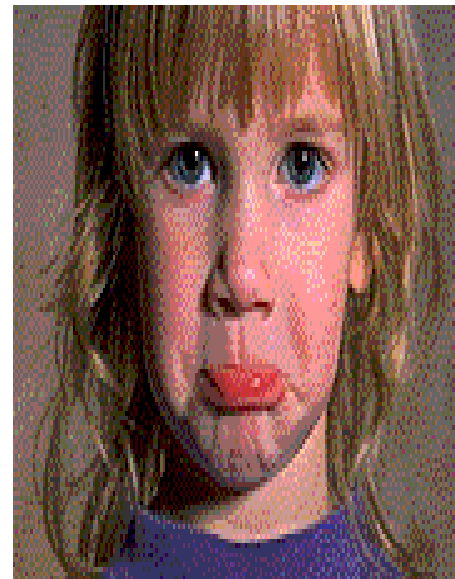


EXHIBIT ONE: MEDICATIONS WITH VIOLENCE POTENTIAL



- 10. **Desvenlafaxine (Pristiq)** An antidepressant which affects both serotonin and noradrenaline, this drug is 7.9 times more likely to be associated with violence than other drugs.
- 9. **Venlafaxine (Effexor)** A drug related to Pristiq in the same class of antidepressants, both are also used to treat anxiety disorders. Effexor is 8.3 times more likely than other drugs to be related to violent behavior.
- 8. **Fluvoxamine (Luvox)** An antidepressant that affects serotonin (SSRI), Luvox is 8.4 times more likely than other medications to be linked with violence
- 7. **Triazolam (Halcion)** A benzodiazepine which can be addictive, used to treat insomnia. Halcion is 8.7 times more likely to be linked with violence than other drugs, according to the study.
- 6) **Atomoxetine (Strattera)** Used to treat attention-deficit hyperactivity disorder (ADHD), Strattera affects the neurotransmitter noradrenaline and is 9 times more likely to be linked with violence compared to the average medication.

EXHIBIT ONE: MEDICATIONS WITH VIOLENCE POTENTIAL



- 5) **Mefoquine (Lariam)** A treatment for malaria, Lariam has long been linked with reports of bizarre behavior. It is 9.5 times more likely to be linked with violence than other drugs.
- 4) **Amphetamines: (Various)** Amphetamines are used to treat ADHD and affect the brain's dopamine and noradrenaline systems. They are 9.6 times more likely to be linked to violence, compared to other drugs.
- 3) **Paroxetine (Paxil)** An SSRI antidepressant, Paxil is also linked with more severe withdrawal symptoms and a greater risk of birth defects compared to other medications in that class. It is 10.3 times more likely to be linked with violence compared to other drugs.
- 2) **Fluoxetine (Prozac)** The first well-known SSRI antidepressant, Prozac is 10.9 times more likely to be linked with violence in comparison with other medications.
- 1) **Varenicline (Chantix)** The anti-smoking medication Chantix affects the nicotinic acetylcholine receptor, which helps reduce craving for smoking. Unfortunately, it's 18 times more likely to be linked with violence compared to other drugs — by comparison, that number for Xyban is 3.9 and just 1.9 for nicotine replacement. Because Chantix is slightly superior in terms of quit rates in comparison to other drugs, it shouldn't necessarily be ruled out as an option for those trying to quit, however.

Read more: <http://healthland.time.com/2011/01/07/top-ten-legal-drugs-linked-to-violence/#ixzz2QwiOzgip>

EXHIBIT TWO: FAMILY ANNIHILATORS



- **Slaying of family by parent**
- **Increased by over 50% in first decade of 21st century**
- **Typically perceived as a spree killing or serial murders**
- **Mostly male (59%)**
- **Very few had criminal justice or mental health history**

EXHIBIT TWO: FAMILY ANNIHILATORS



- **By age: 55% in 30's; 10%-20's; oldest was 59 yo**
- **Over one-half on weekends especially Sunday**
- **81% attempted suicide after the event**
- **No recorded case of stand-off with the police**
- **71% employed often successful**
- **Stabbing and CO most common methods**
- **Causation-66% family breakup (including access to kids) and financial difficulties**

EXHIBIT TWO: FAMILY ANNIHILATORS



- **FOUR TYPES:** masculinity and perception of power set the background with family role of the father being central to masculinity; may be last ditch attempt to perform masculine role
 - **SELF-RIGHTEOUS**
 - Blames mother as responsible for family breakup
 - Sees their bread winner status as key to their image of an ideal family

EXHIBIT TWO: FAMILY ANNIHILATORS



– DISSAPOINTED

- Believes his family let him down or undermined his vision of ideal family
- Example-children not following the traditional religious and cultural customs of father

– ANOMIC

- Family has become firmly linked to the economy
- See family as a result of his economic success allowing him to display his achievements
- If father becomes a failure the family no longer serves the function

EXHIBIT TWO: FAMILY ANNIHILATORS



– PARANOID

- Perceive an external threat to family (often social service or legal system) which father fears will side against him and take away children
- Twisted desire to protect family
- Yardley E., Wilson D., Lynes A. “A Taxonomy of British Family Annihilators”, 1980-2013. *The Howard Journal of Criminal justice*, 2013.

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