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Treatment of Anger and Aggression in Early Recovery

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This distance learning coursework was developed for CEUMatrix and is based on a live presentation by Cardwell C. Nuckols, Ph.D.

This course is reviewed and updated on an annual basis to insure that the information is current, informative, and state-of-the-art. This package contains the complete set of course materials, along with the post test and evaluation that are required to obtain the certificate of completion for the course. You may submit your answers online to receive the fastest response and access to your online certificate of completion. To take advantage of this option, simply access the Student Center at http://www.ceumatrix.com/studentcenter; login as a Returning Customer by entering your email address, password, and click on 'Take Exam'. For your convenience, we have also enclosed an answer sheet that will allow you to submit your answers by mail or by fax.

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About the Instructor:

Dr. Cardwell C. Nuckols has been described as “one of the most influential clinical trainers in America”. For over 30 years, he has successfully served the healthcare industry in multiple capacities as a clinician, supervisor, program director and hospital administrator. Dr Nuckols has led numerous corporate start-up and reengineering projects including involvement in the development of three publicly traded companies. One of these corporations is helping to bring to market new medications to help those suffering from the devastation of AIDS. For his entrepreneurial efforts, Dunn and Bradstreet nominated Dr. Nuckols to receive placement in the 2004 National Business Registry.

Dr. Nuckols is widely published, having authored more than 50 journal articles, 28 books and workbooks, 32 DVDs, CDs and videos, and 17 audiotape series. Dr Nuckols first book, Cocaine: Dependency to Recovery, is a trade best seller, as is, his booklets Quitting Heroin and Quitting Marijuana (Hazelden). He is the author of the book Healing an Angry Heart (HCI) and video Chalk Talk on Drugs with Father Martin (Kelly Productions). A series of workbooks on “Adolescent Disruptive Behavior” and a CD on “Anger Management” has been released by Hazelden Publications as a part of their Adolescent Co-occurring Disorder Series. Dr Nuckols recent works include four DVDs entitled The Evidence Based Treatment of Co-occurring Disorders, A Research Based Approach To The Treatment of Anger, & Aggression In Early Recovery, Treating Early Life Trauma Related Issues In Early Recovery From Addictive Disorders and The Science Based Treatment of Addictive Disorders. He has completed a four part video series entitled “Breaking the Chains” of Addiction; *Using Science to Aid Recovery* and is developing a patient education and workbook series entitled “Discovery To Recovery”. This series will utilize the latest scientific research to assist alcoholics and addicts in their personal recovery.

During his career he has been awarded national honors including the SECAD, Swinyard and Gooderham awards, as well as, being recognized for his contributions to The American Society of Addiction Medicine’s Patient Placement Criteria. Dr. Nuckols is on the review boards of Counselor Magazine and the Dual Network and is an active member of the American Association for the Advancement of Science. He writes a column entitled “Pharm Report” for Counselor Magazine.

Dr. Nuckols’ educational background includes advanced work in medical research, pharmacology, education and psychology. His practical approach comes from working with people in various business and clinical settings. Dr Nuckols has consulted with The Central Labor Council (AFL-CIO), United Auto Workers, Stouffers, Boeing, Dupont, General Motors, Bechtel-Bettis, Ford Motor Company, United Airlines, and other industries in the area of enhancing

Using the Homepage for CEU Matrix - The Institute for Addiction and Criminal Justice Studies

The CEU Matrix – The Institute for Addiction and Criminal Justice Studies homepage (www.ceumatrix.com) contains many pieces of information and valuable links to a variety of programs, news and research findings, and information about credentialing – both local and national. We update our site on a regular basis to keep you apprised of any changes or developments in the field of addiction counseling and credentialing. Be sure to visit our site regularly, and we do recommend that you bookmark the site for fast and easy return.

The Treatment of Anger and Aggression in Early Recovery

Part 1

I want to thank you for spending your valuable time with me today. We're going to talk about a research-based approach to the treatment of anger and aggression in early recovery from addictive disorders. We're not going to spend a lot of time talking about the psychiatric part of anger. We really don't have a lot to say there anyway because DSM-IV has beautiful chapters on affective disorders and depressions and wonderful material on anxiety disorders, but has absolutely nothing on anger. Anger and violence are often secondary or symptomatic to multiple psychiatric disorders. We'll talk about a differential diagnosis of what these types of disorders might be; but I think that we want to spend most of our time talking about how anger is learned.

It's learned in a home. It's learned by watching others who are angry, and it's perceived as a way to control. If a young man, for example an 8-year-old, sees his dad physically abusing his mom, what has he learned from that experience? He learns that this is what a man is. He learns that this is how a man establishes control; and he learns that anytime someone goes against you, this is the way you get them back in line. This is the way you manage life, this is the way you push people away, and this is the way you get them to do what you need them to do. Anger solves a lot of things that are very, very positive for the individual at the moment.

Anger is a dominant emotion. It is not submissive. People learn how to turn it on and turn it off. If you've been in a business, for example, you may have noticed a coworker is extremely angry at another worker, then all of a sudden the supervisor shows up, and that anger seems to go and that person can talk very cogently with the supervisor. We know in many, many different ways that anger can be used from a learned perspective.

It is a dominant emotion. This is going to be the thrust of what we talk about – more of a learned coping survival skill.

I want to read something to you – this is from Gerry Spence. I don't know if you're familiar with Gerry Spence, but he is the trial lawyer who wrote the book about how to negotiate and win or how to argue and win. He has a website called www.gerryspence.com if you want to look up his material, but he talks about being afraid, and this is sort of a self piece that he does. He says:

> *"I've always been afraid. It's a painful feeling, fear. It sits down on the bottom part of the belly and hurts, but it is the energy of survival. I have always been afraid of fear and, at the same time, grateful for it – afraid of its pain and grateful that because of the pain I can take steps to eradicate it by overcoming what frightens me. One who is afraid reacts to it as an animal. If one is a rabbit, one runs into one's hole and hides. If one is a turtle, one pulls back into one's shell. Some, wrongfully, call people like this 'cowards'. Never reach your hand down into a rabbit's hole and try to pull the rabbit out. You'll only extract a bloody finger. But some people, me included, react to fear like a lion. We get angry. It is easier to be angry than to be afraid. It is less painful. The frightened lion attacks whatever frightens him. So does the grizzly. So do I. But it is fear, nevertheless, that motivates the attack, and our fear generates fear in others, which may not always be what we hope for."*

I think that what Gerry Spence talked about is almost thematic of what we want to talk about today. That we learn to do these things. We learn many different ways to react to stress in our life. Some of us run away. We're depressed. Others of us hurt ourselves. Some of us put other people down to feel good. Some of us use alcohol and drugs. There are multiple ways. Others get angry, get hostile, and get violent. There are many ways that we learn to manage life at an early age. These are modus operandi that we carry with us into the future unless we take some time and some understanding and possibly therapy to make some changes in those old patterns. We also want to talk about, 'What is available to us out there? What can we use? What types of therapies have been empirically proven through research to be effective with people who are angry and aggressive?" So this will be, I guess, the menu for this session, if you will.

Let's also talk about just some thoughts that people have had – Dr. Bruce Perry, for example. I'm not sure if you're familiar with him. He is a very interesting man. He's out of Houston and has the Child Trauma Center, and he does a lot of work around neglect with kids. One of things he said is that most of the violence against men is committed by men. Watch the flow of this, if you will, from strong to weak. Most violence against women is committed by men. Most violence against children is committed by women. Isn't that interesting?

I don't know if you'd have guessed that. I wouldn't have. Most violence against pets is committed by children. When you start to look at that, there is a hierarchy here, isn't there? The stronger to the weaker. Somehow this anger, this rage, and this hurt tend to work just in that way.

"Most Violence Against Men Is Committed By Men. Most Violence Against Women Is Committed By Men. Most Violence Against Children Is Committed By Women. Most Violence Against Pets Is Committed By Children."…..Bruce Perry, MD

Now, if we look at hurt, anger, violence – these things are very, very difficult to come to grips with. What is anger? How do we define violence? Can words be violent? I think they can. I remember working with a large industry once, and we spent two days trying to define what violence was in the workplace. All the way down to angry words intended to hurt – is that violence? I think we agreed that it was. But, maybe the worst violence is not the type that causes physical pain, but the psychological violence that breaks both mind and soul.

Maybe the Worst Violence Is Not the Type That Causes Physical Pain But the Psychological Violence That Breaks Both The Mind And The Soul

When you have a child, for example, growing up in a family where there is neglect, where there is hurt, where there is total chaos, where things are unpredictable, where a 5-year-old has to be concerned about his 3-year-old sister because his mother who's a heroin addict, may or may not be home to feed her. When you start to look at these sorts of things, and you start to look at the hurt inflicted upon children, there is a horrible price paid for that; and we'll certainly look at that price.

Now, if you look at the effects of abuse on a toddler, and this is a very old study – this is one of the seminal studies – in looking at children and how they respond to trauma. This study was done by Maine and George, and it was, published in 1979 in a journal called Child Development. In this particular study, they took 20 toddlers. In these toddlers, they matched them up so that 10 of toddlers were abuse victims. They had had a history of being physically hurt, emotionally hurt, or sexually hurt. The other 10 were non-trauma survivors.

Effects of Abuse on Toddler Behavior

- 20 toddlers (1/2 with abuse history)

- Classmate cries
- Without abuse history
  - Showed concern
  - Tried to help
- With trauma history
  - Angry and threatening
  - Physically aggressive

They had a matched set, and they contrived the situation. If you've ever seen situations like this where you have a room and you have kids and then something happens in that room – a contrived situation. Well, what they did was they brought another kid into that room, and that kid sat on the floor and started screaming and yelling. Now what they watched was how the other kids reacted. They wanted to know how these other kids reacted to this child sitting in the middle of the room screaming and yelling his head off. What they found was the ones without an abuse history tried to console the child. They really tried to help. Actually, some of the kids cried themselves.

But when you start to look at the children who had a trauma history, you see quite a different type of expression - quite a different type of physical behavior. What we saw in these children – the abused ones – was that they themselves became angry and threatening and even physically aggressive, actually hitting that child trying to make it quit. This is a very old study and it's not a complicated one, but it says bunches, doesn't it? It tells us that when we hurt kids, kids learn to hurt others.

When we start to look at a lot of anger and violence, we can treat the kid, we can treat the adolescent; but if we don't treat the family and get into the community, then how successful are we really going to be? We can bring anybody who's angry and addicted, for example, into a treatment program and do an exceptional job of working with the addiction and working with the anger issues. But put them back into the same home, put them back into the same craziness from which they came, and what we'll see are the same problems because the anger often is something that they've learned to use to help them survive. This simple experiment by George and Maine, I think, gives us something to think about here. Right from the start, we are seeing how early in life kids are really influenced by what their families do. I mean, into mother-father as well as to mother-father-child. So as we look at these things, it gives us something to think about.

Let's look at a case study for a moment and see if we can make some sense out of this.

Case Study

29 year old 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”.

When Marcus was 12, he was in his room one Friday when his dad came home from work. Dad was pretty drunk, and it was payday, and he could hear dad’s heavy work shoes on the stairs as he walked up those stairs. He knew his father had a belt with him, and he was going to hit him with it.

Remember at this point in time, Marcus is not 29, he is 12 – he is 12 years old. He said to himself in some way, “I’m never going to let anybody every hurt me again.” When his father came into the room, he attacked him. His dad beat the crap out of him; but from that moment on, anybody who tries to get into Marcus’ face, Marcus lets them have it.

Now, let me tell you a little bit more about Marcus. Marcus came into treatment with 20 good drinking buddies – 20 guys he called his friends and he drank with – but he could not get along with police officers, supervisors, and male therapists. For years and years, he has had problems with male authority figures. But we see where that comes from. That relationship with his dad set up almost a modus operandi for life.

Now, the problem with this is that we see something in Marcus – it’s a learned coping survival skill. This is at age 12. Often what we’ll see is that kids between the ages of 8 and 14, maybe 8 and 16, will make a conscious decision never to let anybody hurt them again. This is interesting because look at what you’re doing from a developmental perspective. As a child matures and gets into that 10-, 12-, 14-year range, they’re developmentally changing. The world does not revolve around them anymore. Now they’re looking at the world, and they’re a part of it. Their friends become more important, for example. As they look outside at that world when they mature, they start to see that, ‘Hey! I’m getting screwed over. This isn’t right, and I’m going to make it right. I’m going to try to do whatever I can to make it right. I’m going to run away from home. I’m going to fight. I’m going to drink. I’m going to do whatever I have to just to survive. You know? And along the way if I can cause my parents some pain, that’s a darn good thing!’ There’s a vindictiveness about it sometimes that is quite obvious.

Case Study

27 year old female (Gina) would listen to her parents scream obscenities and hit each other. One day when she was 11 years old, 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.

Let me tell you about another scenario. I had a client whose name was Gina. When she came into treatment she was 27 years old. She came in with multiple diagnoses, some type of affective disorder. She had been labeled bipolar. I think depression probably fit fairly nicely for her. Depression may be fear induced in many ways, but let's look at her story for a moment.

Gina would listen to her parents scream and yell. They lived in a single story house, and Gina was in a back room. They had sort of a living room area, and late at night as mom and dad drank and got a little more drunk, they would start to get on each other. It would start with the screaming and foul language. Sometimes it actually led to fisticuffs and blood, emergency room visits. When Gina was 11, she decided not to listen to the fights anymore.

How do I know this? I asked both of these clients this question in Group, "Tell me when you made a decision never to let anybody ever hurt you again?" I am amazed how many people could tell you that the precise moment in their lives when this event took place.

In this particular situation with Gina, she listened to this all of her life. At age 11, she just said, "I'm not going to put up with this anymore," and every time her mom and dad would get into it, Gina would sneak out the window of her room and run away from home - as often as she could. They tried nailing the windows shut and all sorts of different things, and Gina found different routes of egress.

But in looking at this, now Gina is 27 and if something happens around her that in any way reminds her of that old hurt, what does she do? She takes off. She acts likes a turtle in a shell sometimes. She actually depresses it very, very well. She is one of those clients who can depress so well that if you ever try to confront them, the rest of the patients kind of take up for them. Have you ever seen that? You know, she is very interesting; she is a very talented lady.

If you put Marcus and Gina in a group with several other alcoholics and addicts with different levels of problems, and you suddenly turn the heat up on group just a little, you'd notice that Marcus would probably just stare you right in the eyes, and he would dare you to come at him. Now, what would Gina do?

Have you ever seen a group, where after it's all over where you have chairs that are 18 to 24 inches out of group? She would literally take her heels and dig them in and move those chairs right out of group over and over again, every group. As soon as it got too heavy, she was trying to get out of there as best she could. She'd have one foot behind her, one trying to get out the door, but that's her modus operandi. So the question that we have to think about is do Marcus and Gina have any chance of having a good relationship, really getting along well on the job, really being totally happy with themselves, having an opportunity to be a wonderful mother and father?

What we probably have in both cases is a multigenerational phenomenon. I'm sure if we looked at Marcus, his dad was probably whipped by his father; and I'm sure some of the stuff that we're seeing in Gina's family could go back multiple generations. As we look at this in therapy, we're often trying to interrupt multigenerational, very deep-seated ways of dealing with life and managing reality. This creates a pretty big problem.

Now, look at where all of this comes from. I talked to you earlier about the concept of learned coping and survival skills.

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"

Instead of saying that Marcus and Gina are psychiatrically impaired or saying they're bad people because they get angry or they do this or they do that, what if we looked at them developmentally, and we started to appreciate the fact that what Marcus and Gina did was what I would have done, what you would have done if you were in the same situation. Because at 8, 10, 12 years of age, we don't have marvelous coping styles. We don't have great support groups. It's not like we could just say, 'Hey! I'm leaving!' You know, 'I'm going to get my own apartment, get a job, and to heck with you folks!'

What we've got is a person with limited resources, limited support, and developmentally limited ways of coping. They can run away; they can fight; they can do a few other things; they can learn a few other things as they go along, and they can start to cut. Many of your cutters, for example your borderline alcohol/drug-addicted trauma survivors, will cut and actually get pleasure from that. They actually get dopamine released in their brain that creates pleasure.

As we look at learned coping / survival skills, we're looking at them from an entirely different perspective. We're asking the question here, which is more in the tradition of family therapy. When we start to ask this question, it is not to see this behavior as negative; but to ask the question, "What did this behavior solve for the individual?" Now, as we look at it, what is it not allowing them to get from the world that they want, that they require?

So I think in looking at it this way, unless we have someone who truly is bipolar or schizophrenic or having other psychiatric problems, it means that we could have someone that came from this type of environment who was also bipolar. They're not one or the other. They can be mutual.

But in looking at it in this way, I started to notice that clients seemed to have about 4 different ways that they would generally react, especially around 10-, 12-year-old, give or take a few years: they would withdraw like Gina or attack. They might withdraw inside of themselves, become depressed or run away. Some would attack others, not necessarily physically attack them, but sometimes use words to put others down. Because if you can make somebody else seem small in your eyes, it can make you feel bigger.

When we start to look at this, and we talk about bullying and concepts similar to this, we start talking about attacking others to elevate one's esteem. We can look at avoidance. People can avoid: alcohol and drugs are a pretty good way to avoid. You know, we learned that and we practice it very well. Many alcoholics and addicts know that better than anyone. The other thing we can do is we can attack ourselves. We can actually cut ourselves, we can burn ourselves, and we can do self-injurious types of things.

As we start to look at this, it goes along the lines of a freeze, fight, or flight phenomenon. The more avoidance styles of withdrawal, depression, and running away are often more of a freeze. We may see a freeze very early in life. We're talking about it here as more numbing or altered association in this type of individual, which is an opiate-induced response. Or we might see the old fight or flight. Remember what Walter B. Cannon described. This is the norepinephrine that's kicked out of the locus ceruleus in the base of her brain all through the brain, causing us to react as the caveman would react to a saber tooth tiger.

Choices are a little different today. We're not trying to figure out whether we're going to run or fight the saber tooth tiger. Today, most of what we deal with is ambiguous, right? Six of one - half dozen of the other. This is where anxiety comes from.

Anger, Aggression and the Brain

- Hierarchy of functions
  - Brainstem
  - Diencephalons
  - Limbic System
  - Neocortex
- Modulation ratio
  - Excitation
  - Inhibition
- Frontal Cortex

If you start to look at it, anxiety comes from the ambiguity of life. As we start to look at anger and aggression in the brain, there's a lot of hierarchy of functions here. This is a very important thing to understand – to understand why some people have more difficulty with anger than others.

The bottom line is that we use a lot of terms for this. We use the term stabilization. We talk a lot about stabilization. To me, stabilization is getting the frontal cortical part of the brain in charge. If we wanted to talk about it a little differently, we could use the term modulation ratio, which we're going to talk about. Or if we want to go back to Father Martin in *Chalk Talk*, we could say 'I over E, and E over I.' When I have intellect over emotion, I make good judgments. I'm working from intellect. I'm relatively stable. But when I have emotion over intellect, I have poor judgment. I make poor choices. I end up suffering from those choices quite often, whether it's relapse or getting into a fight or whatever.

Now, let's look at the hierarchy of functions. We know that our brain is developed from the bottom up. In utero, the brainstem starts. The brainstem and the lower parts of the brain often called the diencephalons, which are very low parts of the brain, are the first to develop. This is where all your survival stuff is. This is also your breathing, heart rate – this is staying alive, okay? So if you think about that for a minute, what we have in this fetus and in this toddler as they grow up, in this very young child, is a very well-developed brain stem and mid brain.

As we get older, we start to see the other areas of the brain. The limbic system and neocortex – especially the frontal cortex – start to develop. Now think about this frontal cortex. Have you ever noticed in an ape that they may

have a forehead that kind of goes in and a snout that goes out? If you were just to take your fist and hit that ape right in the nose - knocked that nose in and jut the forehead out - what you would see is a space that sort of looks like the back of a U-Haul trailer, you know? With the little compartment up there. This is where a frontal cortex is, and this is what separates us from all other forms of animal – the development of this frontal cortex. We're going to look at that because this is important.

When we have a client who is in control, who is stabilized, whose frontal cortex is working well, they can use all the cool stuff you taught them in group and in individual sessions about how to deal with life and how to deal with what's going on in their life. As we look at this, we understand also that in many of the clients that we look at because of abuse, because of other problems in their life, what may have been more developed is not the frontal cortex, but the lower part of the brain.

Modulation Ratio

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

  INHIBITION
  EXCITATION

Let's take a look at how this works if we can. Modulation ratio is a term that's often used to describe this. Let me go back – stabilization – I over E, E over I. In this case, what we're talking about is inhibition over excitation. So we've got another formula here. All of these things are the same, though. They're very, very similar, so no matter what your education or experience is, we can all understand this in one way or another. But in order to use the good stuff that we give them in treatment, we have to have a client who can exercise inhibition over excitation.

Modulation Ratio

THREAT ⟹ HYPERAROUSAL

EXCITATION / INHIBITION ⟹ ANGER AND AGGRESSION

As we talk about modulation ratio, let's imagine that we have a young child who was neglected or hurt early in life. Let's imagine – and we call this transference as another name for the phenomenon we're talking about now – that they're out in the world. Maybe they're in treatment, maybe they're at a grocery store, maybe they meet somebody, and maybe they're in a certain part of town in the city someplace.

When this happens, something reminds them of the old hurt, right? That's the transference. All of a sudden they're now back to age 6 or 7, and what they do is they can hyperarouse. Now, when we talked more about your trauma survivors, we'll see they hyperarouse and they numb off or dissociate, but we're just going to talk about hyperarousal because this is where the anger tends to come from more often.

So we look at that hyperarousal. That is your fight or flight, right? Now, what happens here is we have excitation now over inhibition, which leads us to anger and aggression. Anytime we have a formula where the survival part of the brain – the old brain stem - diencephalons if you will, midbrain – is in control over the higher brain areas of the limbic and cortex, we have a person who is not reacting from reason right now. They're reacting in a survival mode. The more they were hurt as kids, the more that lower part of the brain developed.

In other words, with the brain, the more you use it – whatever area of the brain you use – the more you use, the better developed it gets. We have this kid who's in constant chaos, around trauma all the time, so what part of their brain becomes more dominant? Yeah, that lower part of the brain. It takes less for that individual to have excitation over inhibition, as opposed to someone who grew up in a home where they were taught how to problem solve. Where there was a bit of fairness and consistency in the home. This person is going to take a lot more to get excitation over inhibition because the top part of the brain is well developed. When the cortex and limbic system are well developed; it's going to take a lot more time and a lot more stress to

get that excitation over the inhibition. That's the important thing we want to remember in people who are angry. You know, we have some people who because of abuse, because of other things in their life, just fly off the handle.

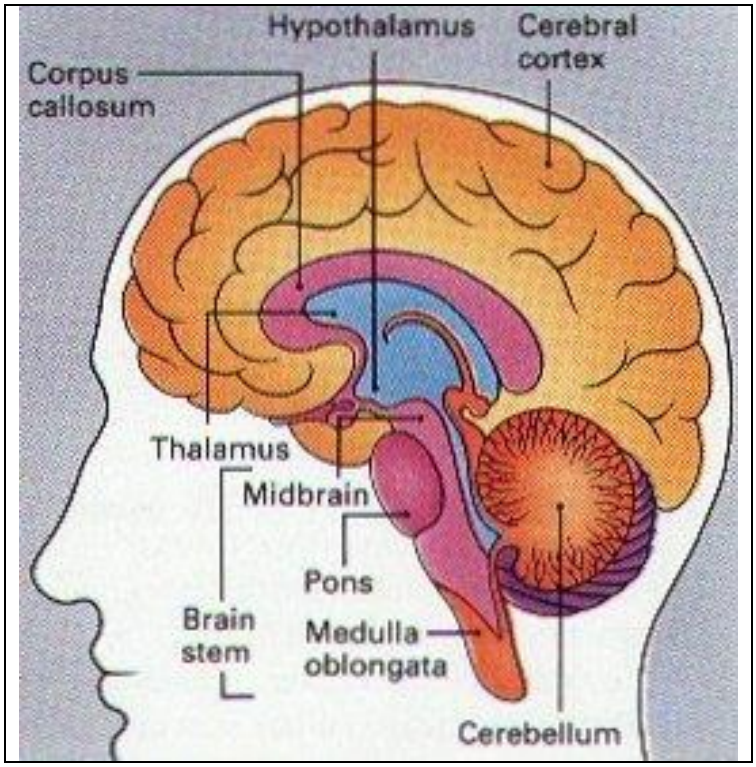
Now, if we look at what changes this ratio –that if you have a child and this child is starting to develop and mature – what in life can change this modulation ratio and increase the risk of them acting out angrily or behaviorally?

What Changes Modulation Ratio and Increases Risk of Anger and Aggression?

- Anything that ⇧ excitation in the lowers areas of the brain (brainstem and diencephalons)
- Anything that ⇩ inhibition in the areas of higher brain function (neocortex and limbic system)

Now, let's think about this for awhile. Anything that increases excitation in the lower areas of the brain – that brain stem and diencephalons, right? – is going to cause a greater chance for anger and acting out. Anything that inhibits the higher brain function can lead to more acting out.

There are a lot of things that can cause this. When you look at this, I want to first show the areas of the brain we're talking about.



If you look at the picture, you can see this lower area of the brain. You see the brain stem, for example, the midbrain area. As we look at this, this is the part that is developed early on. Okay? It's not until about age 20 that the frontal cortex is fully developed. When we're talking about adolescence and acting out, they don't have a fully developed frontal cortex. Adolescents are not little adults. I sometimes ask my son when he does something kind of stupid, "Son, why'd you do that?" He just looks at me, and he says, "I dunno." And I think sometimes he's telling the truth. He just kind of does it, you know? And that's the way adolescents are. They don't always think about it because this part of their brain is not that well developed.

Now, women develop their frontal cortex at about age 20, us guys often 22, 23, or 24. So you see, we have a developmental reason for taking our adolescence well into our 20s. I think most of the women have seen this – that a lot of times it takes us a few more years to get our frontal cortex together, so college sort of lasts up until about 24, for example. This is just the way it is.

What we've got – especially in adolescence – is almost a developmental vulnerability here, don't we? In these days and times, we have adolescents who are dealing with adult issues on a day-to-day basis without the brain

development to handle it. In and of itself that is a statement that slows me down a bit when I start to look at a lot of the things that happen out there. But let's go back to this issue of what can cause the upper part of the brain to be inhibited or what can cause the lower part of the brain to be more excited and to cause more angry acting out.

Excitation in Lower Brain

- A child growing-up in a traumatic environment will develop an exceedingly active brainstem and midbrain
- The majority of stress response systems (locus ceruleus) reside in these areas
- Leads to more anxiety, impulsivity and potential rage

Increased excitation in the lower brain - a child growing up in a traumatic environment will develop an exceedingly active brain stem, diencephalons if you will – midbrain. This part of the brain is about kicking out adrenaline, norepinephrine like crazy. It's about fight or flight. It's about staying alive. This part of the brain causes your heart to beat rapidly, your blood to be shunted to the brain and to the big muscles so that you are able to fight a friend. We call this fight or flight – as part of the reticular activating system.

For example, if you had a wonderful meal and let's say after the meal is over you're walking down an alley way and you're just talking about how nice the meal was and you're feeling very nice – it was a very pleasant evening – and right behind you somebody kicks a trashcan. What are you going to do? What happens to your body? This is involuntary – you don't have to think about it. All of a sudden, you're just not too concerned about digestion, are you? Now, elimination's another matter, but digestion we're not so concerned about. Now, if you think about that for a minute, what has happened is that the brain has told your body to get ready to run or fight, just like what the caveman had to deal with the saber tooth tiger.

Now, most things in our life, as I've mentioned, are not all or nothing. Most things are ambiguous and, again, this is where we have a lot of anxiety mixed in with anger, for example. If you look at the area of the brain, the majority of stress response systems are in this area called the locus ceruleus. Locus ceruleus is a part of the brain that if you look at alcohol, heroin – any

withdrawal – that's what causes all the symptoms in alcohol withdrawal. It puts out norepinephrine, pupils dilate; all of a sudden the heart rate goes up, blood pressure goes up, you get a little tremulous, you start to sweat a little bit, and pupils dilate – the same thing that happens when you're angry, the same thing that happens when you're frightened.

Remember when I first started to talk about fear? I think that beneath most anger is fear – fear of being hurt maybe, fear of being out of control, fear of not being good enough, and fear of powerlessness (which is an interesting issue in early recovery from addiction). I believe that every alcoholic and addict comes into the treatment center with fear. The way they manifest that fear has a lot to do with this modus operandi. Some of them will get angry at you, some of them will go hide, and some of them are so depressed they can't get out of their beds when it's time for group. You know, we see it all playing out right in front of us – it's like a theater on a daily basis.

This leads to more anxiety, impulsivity, and potential rage. *Anxiety, impulsivity, potential rage, potential anger.* Impulsivity is one of the most difficult things in the world to deal with. If we have people who get angry and they build up to it, we have all sorts of points along here to intervene, right? When we have someone who all of a sudden something happens, they're very impulsive and kaboom! – they go off – there are not many places to put an intervention in between there. That causes a lot of problems, so people who are impulsively aggressive are sometimes one of the more difficult types of clients to treat.

Many times, though, what we see is that someone may look impulsive, but it has been building up for hours and hours and days and days; and even on a treatment unit, often we do not deal with the issue very well. I want to talk to you later about our part in this. When we deal with angry clients or clients who are traumatized, it does something to us, doesn't it? It's very frightening. It causes a lot of subjective distress. A lot of us don't want to have anything to do with that, so we have to look at where we come from in this too. We've got a client who brings all this stuff in, but we may not react appropriately to it because maybe we grew up in a home where mom and dad argued just a little bit too much – like my home.

It was a hard thing for me to overcome because my first response was, "I'm going to take a break!" You know? "Let me get out of here." Because I had so much subjective distress that I had to master to be effective with people who are angry and potentially violent. When someone says to you, "I'm going to kill you," there are not a whole lot of cool options anyway at that point in time if you think about it. You know, I usually just say, "I understand that you

can," and then switch into something behavioral, "but how about your urinalysis?" – you know, just get him out of there as quick as possible.

Now let's get back to this issue of increased excitation in the lower brain. What if we know that trauma, abuse, neglect (neglect is equally as devastating for a child, you know, as sexual, physical, emotional trauma), but what if we looked at the higher brain – this limbic and frontal cortical areas – and what could reduce the dominance of that? What could reduce the amount of inhibition?

Inhibition in Higher Brain

- Neglect (emotional and cognitive) and other forms of trauma lead to an underdevelopment limbic and cortical areas
- Leads to problems with empathy, problem solving, and the ability to abstract and conceptualize
- Adding alcohol and drugs further decreases the ability of the higher brain to control the excitatory brain

Inhibition would kind of put a clamp on the lower brain's desire to hit you in the face. It's the upper brain that says, "No, let's not do that. Let's walk away." Neglect (emotional or cognitive) and other forms of trauma lead to an underdeveloped limbic and cortical system. When we have someone who's in chaos all through their early life, this part of their brain does not develop well. I could show you pictures of 3-year-olds brains where one had been neglected and the other had been nurtured very well, and you will be amazed at the size of the brains. The neglected brain may be significantly smaller in size. We're not seeing this brain grow. We're not seeing the density. We're not seeing the connections in the brain that are important.

What happens is that this neglect and other forms of trauma can lead to problems with empathy, for example. We can see problems with problem solving, the ability to abstract and conceptualize. We look at these kids and young adults today, and we say, "They don't have a conscience." How many books have you seen about kids without a conscience? Well this is where it usually comes from. These kids don't have a conscience. They've been hurt. The part of the brain that develops universal ethical principal in the frontal

cortex is not being developed very well, and so they just don't have a conscience. They go out, and it's not that they're an antisocial personality who is disordered all the time; it's just that developmentally they lag behind. And when we add alcohol and drugs, we totally knock out this frontal cortex. If you get drunk, you can actually create what is called a frontal cortical syndrome, which means you knock out your seat of reasoning. This is your executive functioning, the seat of reasoning, frontal cortex – we have a lot of names for it – but when we knock that out, what we're left with is whatever our lower brain wants to do whether it's ride down the road at 100 miles an hour or smack somebody around. There's absolutely no override on it. This is why we see alcoholics' and addicts' behave in a way that is just something they would have never done in a sober or drug-free state. This inhibition of the higher brain can be caused by alcohol and drugs as well as the developmental issues of neglect and other forms of trauma.

Case Study

35 year old male (James) was a husband and a father to his 7 year old step-daughter. One day his wife came home to find James in a compromising position with the young girl. 4 months prior to this incident James was in a serious car accident and had surgery to remove blood clots and reduce swelling in the frontal cortical area. What happened to James?

Now, let me give you another case study. This particular case is pretty interesting in a lot of different ways. It takes us into the area of neuropsychology. One day – well, let me give you a little history. It seems that James was a very good husband, a very good provider, and he was a very good man. One day his wife came home from work in the evening, and James was on the couch with his 7-year-old stepdaughter in a compromising position. James gets thrown into jail.

When you start to look at the history of James, about 3 or 4 months prior to this incident, James was in a serious car accident. James himself was not alcoholic or drug addicted; he was hit by a drunk driver. James had problems in his left and right frontal cortex. He had bleeding and swelling. He was taken to the emergency room and immediately into surgery to reduce the pressure, to the stop the hemorrhage; and when James was finished, he looked fine. He seemed to react well. He seemed to be coming back and working and doing okay. Then all of a sudden this incident happened.

If you talk to James a little more, James would tell you something like this. He would say, "You know, when I was young, I was abused as a child. I have had these fantasies of abusing other children all of my life. I've never done it before, and I don't know why it happened this time."

But you understand why it happened. When you start to knock out that frontal cortex and injure it, all of a sudden that inhibition is lower. I mean, it takes a really intact brain to negotiate this world, it really does. When your cortical areas are not working well, you're going to end up with problems. You're going to have a lot of problems in the world. You know, you're going to have problems with empathy. I mean, we can actually – I can show you – just by knocking out frontal cortex in a kid, I can mimic conduct disorder, ADHD, oppositional defiant disorder, all sorts of different psychiatric problems in childhood. A lot of what we understand now about ADHD, for example, is that it is probably a delayed development of the frontal cortex in some kids. They're just a little slower getting to that point where the inhibition is there – how to keep them from acting out.

Alcohol and Drugs

- Self medication
- Alcohol
  - Reduces Serotonin levels
- Stimulants
  - Elevates Dopamine
- Intoxication can mimic frontal damage
- Alcohol makes angry people more at risk for aggression

Now, let's look at alcohol and drugs for a few minutes. We know about self-medication, that sometimes people use alcohol and drugs to medicate pathology. We medicate emotional problems, but what about alcohol? Alcohol in and of itself reduces serotonin levels, especially when you get into… Well, let me start by telling you this. Really in the initial use, you might actually have elevated serotonin, but as one gets into the chronic stages of the disease, serotonin goes down. What happens when serotonin goes down? Impulsivity goes up, right? When we have people who are impulsively aggressive, a lot of times you might see selective serotonin reuptake inhibitor or lithium or something like that used to help them.

But when serotonin goes down, all of those little things that irritated you – which you used to be able to handle – all of a sudden now they're breaking through. What we start to see is that alcoholics lose more and more control, especially emotionally – acting out more and more, not being able to contain themselves. This is something that we notice in our alcoholics.

In our stimulant addicts, a lot of times when they're using we see this increase in dopamine. Now, dopamine increase we know causes extreme paranoia. When you start having people who are paranoid, basically what you're going to see in this individual is someone who is going to start to act out based on that paranoia. Especially a stimulant addict or methamphetamine addict/cocaine addict. When they do more and more meth, more and more cocaine, their dopamine starts to rise. What we start to see at first is what I would call a paranoia that is context appropriate.

You've got your cocaine addict sitting on a couch. Every sound is a police officer, so they're running back and forth looking out the peep hole of their door. We also know that if they continue to use, they're going to cross over into a place that we could call delusional paranoid disorder. There's nobody at the wheel. When you look in their eyes, there's just nobody home.

When we look at stimulants, we can see problems with anger and violence that are caused just because of extreme paranoia. If you look in DSM-IV under delusional paranoid disorder, you'll see that there are multiple types of paranoia. For example, there's persecutory paranoia – someone's out to get me, so I better get them first. There's jealous paranoia that contributes to domestic violence; for example, accusing a boyfriend/girlfriend/lover/spouse of cheating. They beat the person up. We have seen multiple cases of that. We know that intoxication from alcohol can mimic frontal damage. We also know that the people who are angry and who use alcohol are probably more at risk for aggression at that point in time.

Case Study

Mark was a 59 year old chronic alcoholic who had been having increasing problems with loss of emotional control leading, at times, to aggressive acts. He had no prior history of violence. During early recovery he continued to have difficulty controlling his emotions and actions. He was placed on Lithium with good results.

Let's think again about a case study. Mark was a 59-year-old chronic alcoholic who had been having increasing problems with loss of emotional control. This led at times to aggressive acts. We talked a bit about this a few moments ago. No prior history of violence. During early recovery, he had some difficulty controlling his emotions and actions, and he was placed on lithium with good results.

Basically what lithium can do is elevate that serotonin level and some of the research out of the University of Chicago, for example, strongly suggests that the use of lithium for people who are very impulsively aggressive can be quite helpful. This impulsivity causes problems when we want to put in an intervention. Interventions work if there's some latency period between point of threat and action. It gives them time to use what we teach them, but if point of threat and the action are too close together, then all of the stuff we teach cannot be utilized, it happens too fast. Sometimes we might think of a medication in that particular situation because it may be much more effective.

Four Factors That Increase Likelihood of Anger, Aggression And Violence

- Abuse
- Brain damage
- Paranoid/Affective Disorders
- Alcohol and drugs

Let's spend just a minute talking about factors that can lead to anger, aggression – especially violence. When you've got somebody who's extremely violent, they're just about always going to have a history of abuse, some form of brain damage (often in the frontal cortex). Often they will have some sort of paranoia or affective disorders. When you put paranoia in there, in and of itself, it makes all these things worse. Then when you add alcohol and drugs to this, we have the perfect person for death row; the perfect person that would fit the scenario of a violent, impulsive killer. According to some of the literature, about 90% of people on death row have these dynamics or had these dynamics at the time of the crime. This gives us a little bit more context about people who are extremely violent.

Let's go back to the start. I mentioned to you that I was going to spend some time talking about some of the psychiatric problems and what I call a differential diagnostic process. I am going to go through this with you. I don't

want to spend a lot of time with it, but I want you to know that these are some of the types of problems that we can see where anger and violence can tend to cause a lot of difficulty for us.

Differential Diagnosis

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

There can be neurological dysfunction; e.g., attention deficit disorder, autism, dementia, or there can be brain damage and injury; e.g., frontal lobe injury (which we've talked about), exposure to toxins (I imagine lead and others would fit into that), maternal alcohol/drug use - in utero types of problems.

Differential Diagnosis

- Personality traits and disorders
  - Antisocial traits or ASPD
  - Paranoid traits or PPD
  - Borderline traits or BPD
- Neurotransmitters and hormones
  - Serotonin
    - Many anti-aggression meds work thru this system
  - Testosterone

We know that there can be personality traits and disorders. Personality disorders are your borderlines, your antisocials, and your paranoids. We see a little bit more of the anger, the acting out than we would generally see in the

population, so these are other psychiatric problems where we might see more acting out.

Then we have neurotransmitters and hormones, serotonin for example. Remember when we said that when it was really low, it led to impulsivity and acting out. We know that testosterone has often been looked on in this way, and there's actually some new interesting research on that. Females with high testosterone levels may be a little more aggressive. That's been around for a long, long time.

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

If you look at other mental illnesses, we can have those with paranoid symptoms like panic disorder, schizophrenia, mania, depressive disorder, drug intoxication and withdrawal. We can see some acting out in mental retardation, oppositional defiant disorder, and conduct disorder. We can see this in posttraumatic stress disorder. Certainly we can see someone, for example, who is having a flashback and may act out in a very violent way.

Differential Diagnosis

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

Medical diseases contribute to this, encephalitis, Alzheimer disease. Cerebrovascular accident, for example, can lead to more aggression/acting out. Even in seizure disorders in the preictal, ictal, and postictal state, we can see a little bit more aggression.

These are a number of the different types of disorders. It is not all consuming, there is more than this, but these are some of the types of disorders we might see where anger/acting out as a symptom. What I'm saying is that if we have these disorders, our goal would be to treat this disorder, right? – whether it's a medication or otherwise – hoping that the anger would go away because it is a symptom of an underlying disorder. When we start talking more about this learned coping survival skill, we start talking more about – instead of using a lot of medications – a psychotherapeutic approach along with medications if necessary.

Lastly, let's look at the medication piece of this. This will give us, I think, a nice place to start in terms of looking at anger and aggression from a learned coping survival perspective, but let's just go over the medications.

Medication

- Aggressive Episode
  - Oral
    - Risperidone 2mg oral solution & 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

This is reasonably state of the art. For example, when someone in an aggressive episode is really acting out – you can give him an oral medication – the risperidone 2 mg oral solution and lorazepam 2 mg work pretty well. We can use a different benzodiazepine, but usually lorazepam is the way to go or something like an atypical antipsychotic, which is what risperidone, is.

This would be an oral approach. If the person was very aggressive and there was a take-down involved or we had to give him an IM injection, lorazepam 2 mg – and, again, this is one of the benzodiazepines – the reason lorazepam is preferred is because drugs like diazepam, chlordiazepoxide (which is Valium and Librium) are not as absorbed nearly as quickly. They seem to be more erratic - the absorption is slower and more erratic. Lorazepam gives a much better response more quickly, and you get control of the client in a much more predictable fashion. Patient's using stimulants are more conducive to seizures, you know? So again, the use of a diazepam might be very helpful because it can also reduce the potential for seizures.

Medication

- **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 a long-acting form of injected risperidone called Risperdal Consta**

Just looking at medications, we can look at Haldol 5 mg, lorazepam 2 mg IM, atypical antipsychotics again in this situation work. Zyprexa, for example – especially with agitation associated with schizophrenia, bipolar disorder, mania, and dementia – works fairly nicely. Geodon, which has been out there awhile now, works very well with agitation associated with schizophrenia, schizoaffective disorders. The FDA has approved long-acting forms of injectable medications. An example is Risperdal Consta, so we have more of a long-term medication, which allows for much better control and compliance.

We've looked at theory, we've looked at the brain, we've looked at development, we've looked a little bit psychiatrically, we've looked at some of the medications, and what I want to start to do now is to look at anger and aggression as a learned coping survival skill.

The Treatment of Anger and Aggression in Early Recovery
Part II

We're now talking about this issue of learned coping survival. What I want to start out by doing is just talking about brief assessments and looking at our own responses and then talking about some of the empirically proven psychotherapeutic strategies are available to us. If you read the research, the research says that in many areas, in many different disorders, there are empirically proven psychotherapeutic strategies.

What that means is, they've been proven to be effective, but there has not been that bridge built between the research and the front line clinician, so many of the clinicians do not have that information. As you might think, as we talk about someone who's emotionally out of control / angry, we would think more about cognitive therapy, behavioral therapy, maybe relaxation, and, in fact, these are the ones that have been proven to be most effective.

MEDICATION

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

Earlier we talked about medication management. We could use different medications; for example, Tegretol or Depakote to stabilize an individual who is just having a lot of difficulty with angry acting out, and we can't seem to get it under control. If you've got a client who's just not profiting from group, who's continuously acting out, who does not seem to be able to implement the strategies you're trying to give them, that's a perfect candidate to put on a mood stabilizing type of drug because this would allow them to go into group, this would allow them to participate in individual therapy.

One of the problems that we have with some of these clients is that we put them in individual and group, but they can't use the things we're giving them. They just seem to be so impulsive in their acting out that mood stabilizers, lithium, and maybe some of the selective serotonin reuptake inhibitors may do a very good job of evening them out enough so that they can utilize some of the strategies that we would teach them in individual or group.

It is important to think about different treatment settings and use of different medications. For example, when we talked about the use of the atypical neuroleptics, that's going to be in more of an emergency situation – the IM use – when you have somebody out of control. If you have someone on an outpatient basis, we may use more of the oral medications, but certainly with the alcohol and drug population, we want to stay away from the benzodiazepines. Lorazepam may work very well in an acute situation here for us, but whenever possible, we want to stay away from the use of any benzodiazepines in an addicted population.

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

When we want to do a brief assessment of an individual who has come into our office, there is generally an intake form that people use. A lot of times the intake form has a suicide assessment, but I don't always see a violence assessment. A violence assessment should be right there, somewhere anyway, but probably right with that suicide assessment. They can be kind of opposite sides of the same door, if you will, but you need to ask people, "Do you have a history of violence? Tell me about it. Did you use weapons?" You want to know these things.

Sometimes a client will tell you about the people they have killed, the people they have hurt. They'll do it, and it's like they're getting off on a drug. Have

you ever heard of clients like that? You're dealing with a sociopath, a psychopath, okay? When you hear that, shut it down. You don't need to know anymore, alright? You know, you don't want to listen to someone tell you about the five people that s/he killed and at the end of that little diatribe say to you that, "If any of this ever gets outside the room, I'm going to kill you." I mean, you don't want to be put in those types of positions, so you've heard all you need to know. You've got someone who is probably very psychopathic. The studies would show, especially some of the work of Hare, that we have not been successful in treating that population. We manage them. We try to keep them within boundaries, but we have been very unsuccessful in treating them. As a matter of fact, Hare's work shows if we use cognitive behavioral insight-oriented treatment with some of these severely antisocial personality disordered individuals, where probably genetics is a good factor – a big factor in that – what happens is they end up back in jail more quickly than if you don't treat them. They use all this stuff that they get from the clinician to enhance their rationalizations about their ability to beat the system. When you start to look at it, there are some people out there who we just don't seem to have the key to open the lock with.

If someone's coming into your office, it's nice to have a little bit of information prior to seeing them. Certainly, common sense should be the way of the day. If you have someone who has a past history of violent behavior, the first time they're in, for goodness sakes, don't be the only clinician in an outpatient setting at 9 o'clock at night. Let your other staff members know you've got someone with a violent history. Think about keeping the door open the first time. Let people know that you have some concerns about this client. Try to use good common sense. Your office, your clinic needs to have a way of handling a client who comes in and acts out violently. We use little phone trees because when staff gets chaotic, we can't remember a thing. Next to the phones in the therapist's office or at the nursing station, we have a hierarchy of who gets called first, what's the number, second, third, fourth, fifth because it's sometimes imperative that we get police, we get a rescue squad there, the quicker the better. We could be talking about saving lives. So, again, let's just use good common sense about how we approach this.

Information that we would certainly like to know is about past and current behavior. A lot of times, we want to get that information from the client, from the patient. Now, as I mentioned earlier, if this patient says to you, "You know, I've killed these people and I've …," and I've heard several of those over my career - shut it down. You pretty much know what you've got. But I always ask questions about history of violence. "Tell me about some of things that happened. Did you use weapons? Tell me about the way you do things." I want to know this. I've got to be in individual sessions with this person, I've got to be in group with this person, and I'd like to know a little bit

of the history of this. If I've got a guy coming in who likes to beat up on police officers and male supervisors, I like to know about that, you know? It's going to give us a lot of data as to how we can predict that person might act out.

If you've got someone with a short fuse versus someone who's more antisocial/predatory - who doesn't get mad (they get even), you may have someone that will erupt in group and you can manage that. The other one may not say much to you. They don't get mad, they get even. They may split your tires or something along that line, so we want to know as much as we can going in.

I think the other thing that is important here is to get collateral evidence, get collateral documentation. If there are family members or close friends around, try to get information that will either support or not support your client's history. Make sure that they're a good historian whenever possible.

On review of past treatment, one of the things I'm going to ask is this: "Have you been in treatment before?" If they say 'yes', which often is the case, I ask them, "What is your experience? What was your experience in treatment?" If they said to me, "Well, it was a terrible experience. You know, I ended up in this emergency room. They put me in a psych unit. Before I knew it, I had one of these gowns on with my butt hanging out. You know, and these people never told me anything. It was a really crappy experience." My response to this person, who is a little bit angry – and I know from that response he's not a real happy guy or lady sitting in front of me now and is not too excited about treatment – so my response is going to be, "Well, this is going to be nothing like what happened to you the last time. I'm going to stop every few minutes and allow you to ask questions. I'm going to let you see what I'm writing down if I write down something." I try to never write anything down if possible. I try to sit with them in chairs and not write because they open up so much better if they're not concerned about what you're writing on a piece of paper, especially those who've had criminal justice experience. We'll know that they're going to try to shape the story to be of greatest assistance to them, and we understand that. But if they had a situation in treatment where they came in to a particular treatment agency – for example, there was a therapist there named Anna who was a wonderful person who they said answered all of their questions, was really helpful, wonderful, I'd say, "I'm going to be just like Anna. I'm going to do everything she did. I'm going to stop every so often. I'm going to allow you to ask questions." So either way this goes, I've got a way to answer this.

What I'm trying to do is establish a good place to start to work from. If I don't get to this issue first of all, it's going to cloud this whole session. I need to get to "How do they see me? What are they looking at this thing as? Are they

looking at this as a bad experience about to happen or are they looking at this as something that might be more reasonable?" If I've got that data, in the clinical evaluation I want to ask them a series of questions about medical problems. "Have you had medical problems over the years? Current medical problems?" Because some of these medical problems could have a lot to do with their acting out, with their behavior.

For example, if you've got someone who's hypoglycemic or someone with an adrenal gland problem, if these things aren't managed correctly, you may have a person who is going to have difficulty emotionally controlling themselves. So again, this is important.

Psychosocial evaluation – I want to know about the family, the living situation, the community. I want to know as much as I can about this client and how they got here as possible because this is going to help me help them. I also want to know, are they on any medications as well as the alcohol/drug assessment that we're going to use here.

For example, we have certain types of medications that can cause people to have an entirely different response so that they are very aggravated and aggressive. We've had people who've gone on Librium rage. When they take Librium, they go into a rage. When you start to look at this, we want all this data because sometimes some of this other stuff may be very, very important. I want to know about the Axis III issues, the medical issues. Have you just been diagnosed with HIV? I want to know that because the stress of that is going to make everything else worse. That is one of the Axis III types of medical disorders that are going to make Axis I and Axis II worse, at least initially. We want to know these things because these are things we're going to need to work on and work with.

Now, in terms of non-pharmacological management, we talked awhile back about using various types of substances from atypical antipsychotics to benzodiazepines to mood stabilizing drugs. Let's just look at it from a clinical perspective.

You have probably had clients who are angry or have a history of anger and aggression, and who will just try to get your goat. They just try to get you angry. They just try to use you for their own entertainment. They are also testing you. Can I push you off with a little anger?

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

They're pretty good at this. They've learned ways to skate the issue when you get too close. They can push you off. They can use anger in this way. Don't personalize any of this. One of the greatest problems we have is when a clinician personalizes the anger; clients may be very brutal using personal attacks about your mother, about yourself, about your family. Don't personalize it.

The way I look at clients in general is that they all do their job. They all act just the way they're supposed to. Years ago, I would have consultations where I would have to go into hospitals or clinics because the crack addicts or the borderlines or whatever were just causing chaos in the unit. The one thing I noticed very quickly when I walked into the unit was that for the most part the clients are acting just the way they're supposed to. They're doing their job. It's mostly staff problems that we find in those situations.

Remember that sometimes staff can be a problem. We have a lot of clinicians – and I understand it personally – who find anger really creates a very negative subjective experience, and a lot of us just kind of want to get away from it. I remember my mom and dad. My dad was an alcoholic cardiologist who died when I was fairly young, and I can remember him and my mother late at night arguing over his alcoholism. I don't believe there was

ever fisticuffs or anything physical, but there was some pretty vile language. I remember sitting up in my little bedroom in the dark, and a lot of times I'd sit on the floor and I'd listen to this.

In the darkness in the bedroom, there was a certain safety with the lights out and everything. I remember when I first got into the field, and I was dealing with angry clients. My feeling every time was, "Let's go back to that dark space. Let's just get the heck out of here!" because it was raising old issues in me.

We don't have to work out all our issues. All of us are a little neurotic. I mean, my goodness, if we got into this field to retire early, we made a very poor career decision, didn't we? We all have personal issues, and you don't have to work everything out. You just have to understand it. Understand how these things might get in the way. Don't personalize it. Understand your personal reaction to anger. If I say one thing that I believe is more important than any other today, it is understand how you react to anger. Understand what happens inside of you when you're around angry clients, and look at your behavior. What do you do?

There's another part of this that is more difficult to explain, and it is what we bring to the dance. It is who we are on the inside. I've noticed over the years that certain staff members can walk into a group of patients who are acting out and, without saying a word, can immediately calm them down. I've found other staff members who could walk into that same situation, not say a word, and all heck breaks loose. Why is that?

It's about who we are, isn't it? It's about our self-care, our self-development. Being a clinician is lifelong self-development, lifelong self-discovery. That is what we have to do to be good at what we do. We have to be open to what happened to us in our past. We have to learn from these things. We have to understand them.

Therapy is a very good thing for people who are clinicians. Being on the other side of the couch, if you will, is very good practice. I've used clinicians over the years. I go into any town I live in, I'll ask around, "Who do you think is the best therapist here for these particular issues?" When I hear the same name coming up 3 or 4 times, I'd go to see him. Sometimes I would go to see him because I had some things I needed to work out that were personal and other times I would go to see him because I had a case that I might have gotten a little too close to. I don't get to go away from things.

If I have a problem, I get too close. Then I take on the client's confusion. I had to have an outside person to help me. Especially when I was in private

practice by myself and I didn't have colleagues around me to help, I would go to see the therapist sometimes with a case, and we would just do a case review. I deducted it on my taxes as a clinical consultation, and I thought it was fair enough, but it really helped me. It helped me grow. It helped me get other sets of glasses in terms of particular cases I was working on. I really recommend it.

Some of the best things I have ever had in terms of clinical teaching was going to a clinical school, actually operating in a psych hospital when I was learning about schizophrenia and bipolar disorder. I had one year in National Training Lab, which is a process-oriented closed group, for a year, which was brutal. I have been to a number of different therapists over time, and I think that has probably helped me more in terms of understanding myself and keeping myself out of what the client is delivering.

In other words, we're talking about counter-transference here. If I can keep myself out of this, if I can truly listen to that client – now, you can't totally do that as it's impossible – but the more you can, the better off you're going to be. My job is to understand where the client is, where they're coming from. My job also is to start where that client is. Change starts where they are, not where I think they should be.

The other thing with this is that I want a treatment plan from strength, so I have to be tuned into that client. I have to hear where they're coming from, what they're all about, what their strengths and weaknesses are. If I'm coming from my own stuff, all I'm doing is using a shotgun approach that may hit or miss. It may make them worse, it may make them better, it may have no effect at all, but I don't know.

So, again, I think it's so important – and I want to stress this part because to me it's critical – know thyself. Know yourself; know how you react around this. If you have problems managing anger, there is no shame in it. A lot of us do. Go talk to somebody. Understand it, but make sure that you deal with it to the point where you're not personalizing it. When it is personalized, we get into a lot of projective identification and a lot of other problems. For example, the client does something or says something bad to us, and we turn around and we get angry at them. That client has probably been neglected or hurt along the way, so what that does is that just says to them, "I knew I was right. I couldn't trust this individual." Now what we've got here is a real neat situation for the next clinician who sees this client because they're going to be even angrier and tougher to work with. Take this into your heart, take it into your mind and think about it, because it's very, very important.

Always look at the environment. Is there anything in this environment that can be hurtful or harmful? It depends upon the type of clientele I'm working with. When I worked with a lot more criminal justice clientele (I was getting more referrals from parole officers) for example, the way I did things was very, very different. I actually wore a lot of clip-on ties. I had nothing about my family in the room. It was a very sterile environment.

When I'm doing a general outpatient practice with people – husbands and wives and adolescents and people who are having trouble in their lives with alcohol, drugs, or their marriage or whatever – I try to create a more homey environment in that particular situation. But, you know, I don't want to put a lot of things around me that someone who is maybe intent on hurting me, someone who might be a little psychopathic, could see my family, could know more about me than I want them to. So, I think in that way, I'd be very careful.

I want to know where the client is at all times. If they're on a milieu, if they're coming into a group room, if they're coming into my office, if I have a client who's acting out in a room – and I'll tell you kind of, for lack of a better word, a strange story. We had a Vietnam veteran, and this was probably in the early '80s who was high on PCP. He was in an intake room. This was a very nice intake room with the couches and the lamps and, you know, it's supposed to be very comfortable and homey. The guy is in there, and he's just tearing the place up. The staff is running in and out, and it was almost comedic to watch. A staffer would run in and say, "If you don't cut this out, we're calling security, we're going to…". Then he'd throw something at them, and they'd run out the door. It was just back and forth.

I said, "Let me give it a try." So I walked in and I knew exactly where the door was, and I knew where he was, so I'm not going to allow him to get between me and the door. As soon as I got inside the door, I fell right on the floor. How non-threatening can you be? This guy's probably looking at me like, you know, "Who's this spastic jerk?" You know? I'm just lying on the floor, and I'm looking a little dazed, and I look up at this guy and he's still pretty angry, and I said, "You know, they told me there was someone in here kind of tearing up the place. Have you seen him?"

He looks at me, and he says, "No." I said, "Well, why don't we go get a cup of coffee while housekeeping cleans it up?" and he walks right out the door with me. Now, I'm not recommending that as a strategy, but from a stimulus response perspective, it was a pretty neat one. Certainly, it broke the tension in the air. But I came in totally – instead of threatening – I came in totally submissive, I mean, to a point where I'm on the floor. As ridiculous as that

sounds, sometimes things like this can be effective. This is Skinner's stimulus response.

In looking at this, if the client is very, very angry, another thing that I'll tend to do if they're in an area like a milieu or an office is that I'll want to know where the door is so I can get out. Get out of the room. Don't get hurt.

My sense is that I try to do things to break eye contact. I'll walk and I'll move around and I'll do little moves and I'm talking to the client all the time, and if they're not following my hands and they're keeping their eyes directly into my eyes, I'm getting worried now. I might ask them at that point, "Do you plan to hurt me?" Based upon their decision, I'm going to try to take appropriate action.

If I'm doing this, though, one thing I'm doing is I'm keeping an appropriate distance. It's very important when you've got someone who's worked up – when you're first coming into the scene – to try to figure it out, make sure you stay further away than a step and a punch or a step and a kick because that's where you're going to get hurt. One step and a kick, one step and a punch. I want to stay further away, maybe 3, 4, 5, 6 steps away.

I want to talk to them. I want to see how they make eye contact. I'm going to ask them questions. I'm going to see how this thing goes. I might try asking a focus question, which is giving them control, "Would you rather go out and have a cup of coffee, or would you rather go out in the back here and sit on the picnic table and smoke a cigarette, or would you rather go over in that room over there?"

What I've done is I've given the illusion of being in control, right? I don't care what they do; I want to get them out of where they are, especially if they've got their peers around because if there are peers around, they've got to save face. I'm going to allow them to save face by giving the illusion of being in control. They're going to reply like, "Well, I'm going to go over there and do this, and I'll sit down over here, and that's where I'm going." Now they've saved face. You know, they've won.

In their minds, they've gotten away from the rest of the milieu. I've got a person out here. Now I can do something with them. I can sit down. I can talk to them. We'll also talk about some things to say in these situations because it's very, very important.

If you have to be close to this type of client, what you want to be is right beside them – very much beside them. You can dance and not get hurt

nearly as badly as if you're standing right in front of them. These are just some things to think about, very common sense things to think about.

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

If we start to look at a client, I believe in validating clients. Validation to me works very, very well. Let me give you a scenario. One of my clients and I did a type of therapy that was sort of interesting. We wrote it up, and we called it the Coliseum Model. It was a multifamily type of arrangement that I had two Whitaker-trained man/woman therapists working with me. If you've ever seen Whitaker and Whitaker-trained therapists, they can get your heart beating in a minute. They can irritate you quicker than any other therapist I know.

What we had were certain rules. There were two rooms for people to use, and there was a working area – the arena. Usually the new people would come in and sit in the second room and then kind of move forward – anybody could walk into the group and ask anybody else from that whole room to come into the arena and work with them. You know who they're choosing, right? Moms and dads and brothers – and this is all family stuff for the most part.

I was in the group, and there was a patient there who was relatively new. He was about 6' 2", about 220 and, I don't come very close to either of those measurements. He was looking at me. He went out and he got into the working area –the parents and family and clients are all in there around us – and he looks at me and he says, "I want you down here," and this guy is a little scary. When I walk down, I'm on the other side of the arena from him, so to speak, and he says, "I'm going to break your (and you can fill in the blank) head." Okay?

Now, I'd never met this person. Why is he mad at me? Basically, what I know now and what I guessed at the time was that as director of the

treatment program, I was the father, you know, and maybe grandfather figure, that male authority figure. This guy had been hurt by his dad, really physically hurt badly by his dad. He still had a lot of marks on him. He had been burned. This guy is looking at me, and I'm dad right now. He's probably somewhere around 8 years old. I mean, he was in his 20s. I recall this situation because he looks at me and he says, "I'm going to break your 'you-know-what'-ing head!"

Do you have a good response to that? I don't. I mean, if you think about it, what are you going to say? "If you break my head, they'll put you in jail." "I'll call my attorney." "They'll kick you out of here." I mean, there are no cool things to say, you know? As much as I'd like to have a cool thing to say then, I don't have one.

What I do is I validate the client. I believe that in these clients, they believe that what they're doing is exactly the right thing, and I believe that this type of behavior – this angry acting out – has worked for them before and worked for them on numerous occasions so that they got their way. They may have learned it, just like Marcus did, when his dad was coming up the stairs with that belt and was going to hit him.

My thought about this at this point in time is if I say, "Cut that out or we'll kick you out of there," what's going to happen? I've just replicated every failure that has ever happened in that young man's life. What he's going to do to me is say, "I knew I couldn't trust you." It's going to validate him, you know? Now what he's going to do is he's going to get more aggressive, isn't he?

What I say is – I believe in being congruent with clients – and all of you have things that you say like, "Maybe if I was in your position, I'd feel the same way," or any offshoot of that –and it is a very effective thing, I say, "Whatever you do, don't change the way you're behaving right now because you know and I know it's saved your life, didn't it?" You can kind of use a little pacing with the way I said that too. What I did was I totally validated him. I said, "I know you've got a good reason for being angry and that it has probably saved your life. Don't give it up."

The second thing that I'm going to say is, "Tell me about that part of you that made a decision never to let anybody ever hurt you again, ever get close." What you'll notice, unless a person's a psychopath, is that the client's shoulders will drop. I get a lot of them to cry because I am no threat to them. I'm totally congruent. You may be the first person who ever was. The first person who ever told them they were okay because everybody else in their history – policemen, family, everybody else – has told them they were no good. You know, "Why are you angry all the time? Why are you hurting

people? What's wrong with you?" I'm the first person who has ever acknowledged him.

Then what I could say in that situation if I wanted to move them out of that context was, "What would you like to do now? Would you like to go over to the picnic table?" I could go through that focus question, give him the control of the scenario, or we could sit down and we could work it right in group, which would be my preference. You know, based upon where we are right now, "Tell me, when did this first happen to you? When did this happen? When did you make this decision? What led to this happening right now?" If that person starts to talk, they're going to talk about something that happened to him years ago, but it's going to be very vivid to them, very vivid.

When you start to look at it, you've also got the alcohol/drug problem with this, which is making all of this worse, right? We're trying to treat the alcohol/drug problem, but we realize that this person's anger is going to take him back to the alcohol and drugs if we don't treat it because of the powerful relapse indicator that it is. If we just treat this person for alcohol/drug addiction and don't address this anger, then we've got a client who just got half the treatment. You know, you want to take care of everything and it's hard to do, but the anger is a very important issue. If we can't do it, for example, on inpatient detox, let's try to make sure we get him to a therapist who understands that working with anger can help him and who also understands addiction.

What I might say to that person after they say this to me is something along the lines of , "The way that you've been acting, you know, in group here didn't really get over, did it? It just didn't really work the way you wanted it to. Would you be willing to try something different right now, with me, in group?"

What we actually do is a little role playing. Let's try something different. We start talking about how he could approach me. How we can talk about this. Maybe we say that, "Let's talk about one thing you can do differently," and make it an exercise for him while he's in treatment. That "every time you feel angry, before you blow, you try this, especially if there's a little time to work with". We give them a couple things to work with, maybe a couple quick behavioral things, and we'll talk about a few of those later on.

If you look at this, when people are angry, when they come to us, for example, in the hallway and they're angry and they want to talk, one thing I might do is I might shift the emotion to something behavioral. It's a quick intervention, and it's very handy. I found it very good with staff members who are upset. What I would do is – they'll come and they're angry – and I'll say, "I know how important this is to you, but I really gotta go to the bathroom."

You know? "I'll meet you in my office in 10 minutes because I really do want to talk to you about it." In 10 minutes they've usually displaced all the anger and by the time they get to the office, we sit down and we just talk about what's going on. I actually had one staff member one day look at me and say, "What're you trying to do? You're just trying to show me how foolish I am?" And I said, "No, that's just part of it." But what just happened? What just transpired? Or I might say to someone – a client who's kind of angry at me – I'll say, "Jeesh! You know, I can hear that anger in your voice, but tell me, how're you doing in your urinalysis?" I'm actually just flipping him from one part of their brain to another.

In this way I'm not engaging the emotion right now, I'm just flipping them over to something; probably behavioral is the best way to do it. Have you been doing this? Have you been going to your meetings? Have you been doing that? Now, there's a part of that that works, but a part of it that bothers me because what I want to be able to do is deal with the client where they're at. Now, it may be better to take that client into an office when they're calmed down, and say to them, "Tell me, like a newspaper report, what led up to you being angry?" You can find this a lot with your borderlines, for example, and others when they're at the point of killing themselves and all of this.

I call it elaboration therapy. It's like a newspaper reporter, so I'm getting into a cognitive part of their brain. I'm asking them to tell me a story. What often happens is you can find during their day one or two slights or a couple problems or something happened with another human that they have totally blown way out of proportion, and the whole world stinks now, and they're angry as heck. If you can problem solve that little inner personal slider, something with them, often you just move right through it. You give them a way to problem solve. You give them a different way to understand it, and you can kind of move on.

That would be a preferred way of handling something like this because then we could start talking about the dynamics of it, the history and patterns. Then, what are we going to do to make sure you can interrupt that history and pattern. What strategies do we have that might work for you?

If we look at just trying to deal with the moment, if you will, these are some things that I would say to you that I think are very, very important. You know, a big part of this is to be safe. You know? Be safe. Don't put yourself in a bad position. A lot of therapists have been threatened. A lot of therapists, more than you'd expect, have been followed. They've been a victim of someone who is maybe a little erotomanic or something like this or who stalked them.

We as therapists have a lot of difficulty talking about this. Often we keep it inside. We don't even tell anybody else if we have a client who scared the heck out of us, threatened us. We need to talk about these things. We're not perfect. If you were self-actualized, you'd be bored. I mean, who the heck would you talk with? There would be nobody out there to hang out with. We're kind of all in this together, and the way that we deal with these fears and our ability to be open – if we can't do this, how do we expect the client in front of us to do that? I mean, if we can't model these behaviors or these aren't part of us, unless you have a healing part inside of yourself, you're not going to be able to constellate that healing role inside of your client. So we have to be true to ourselves in that way and to our own personal growth.

Case Study

Larry was a 23 year old 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?

I think also when we start to look at managing anger, we should go back to a case study because sometimes there is an effective way of doing this. This is the case study of the individual who was going to break my 'you-know-what'ing head, but I wanted to tell you a little bit more about him. Larry was 23. I told you about his measurements; 6'2", 220. A very strong-looking guy. Alcoholic and addict. In the therapy group he had a new therapist and before he even met the therapist, he looked at him and said, "I'm going to break your head."

The thing that I didn't know about Larry at that time was that he had been abused. Also, that his mother drank extensively while he was in utero, and he had anger about that. We had a guy who had a lot of trauma issues and a lot of anger issues who was one of those guys who had 20 drinking buddies, but just couldn't deal with authority. I call him an authority theme. We see a lot of the old developmental themes. We see abandonment themes, we see sexuality themes, and we see authority themes.

This person is having difficulty dealing with a male or female person in power based upon a relationship that had to do with his early life. We're talking about the basis of transference – hopes, wishes, and fears that occurred at a certain point in his life that are being brought to the forefront at this particular time.

Once we got to know who he was and where he came from, Larry's behavior became a lot more predictable and a lot more manageable. I think that in looking at a case like this, the history becomes so important; but I find that sometimes people just walk into the office, and they just blow right off. You see? It has nothing to do with you, even if it's directed at you. It's coming from some place else. If you can be congruent, sit them down, get them to talk about it, "Where did this come from? Tell me what happened? Let's start with this morning building up to you feeling so angry."

You may want to start by being congruent, by saying, "Jeesh! I really can appreciate the level of anger you have today, and I know how much you need to talk to me about this. Tell me what happened today. Let's start this morning." You know, something like that might really pay you a lot of dividends and very quickly kind of stabilize that person. We're trying to get the frontal cortex back in control, remember? It's called stabilization. We're using a cognitive-type of maneuver here, and your cognitive-behavioral stuff really helps get this part of the brain back in control.

All that we're doing is going back to what we talked about with the modulation ratio – we're trying to take the excitation over inhibition and convert it into inhibition over excitation so we have a rational individual. Because when we've got someone who is emotionally out of control, what are you going to be able to do with them? You're really not going to be able to do a whole lot, so our goal here is to stabilize, to get this part of the brain working again.

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."

I think in looking at this, the dialog, just to go back over it for you, Larry said to me, "I'm going to break your 'you-know-what'-ing head." And I replied by saying, "Whatever you do, don't stop behaving the way that you are because it probably saved your life at some point, didn't it?" Then I might follow that with something like, "I'd like to talk to that part of you that made a conscious

decision to never let anybody ever hurt you again." Now, what we would hope, as I mentioned earlier, is that we would have a patient or client who has calmed down considerably; who might now be able to sit down and do some significant work.

Anger and Relapse

- Most relapse is associated with…
  - Anger and Frustration
    - **"If life is this bad.."**
    - **"If no one else cares, why should I"**
  - Social pressure
  - Interpersonal Temptation
- Being around old patterns of use can increase anger and frustration
  - Cues actually cause release of dopamine in nucleus accumbens

Let's look at this issue of anger and relapse. I've mentioned two or three times today the problem with anger is that it involves relapse. When you start to look at most relapse, it is associated with anger and frustration to some level. Even when we're talking about people, places, and things, there can be anger and frustration in that. The mere act of being around people, wanting my former lover cocaine, and I can't do it right now is going to cause me to feel frustrated and angry. It's part of recovery. You've got to get through that. The best thing to do is not go into that room with those people using cocaine, right? So we would use a behavioral type of intervention that I call changing people, places, and things.

If you start to look at anger and frustration, you may hear things like this: "If life is this bad – you know? – if no one else cares, why should I?" In the first year of recovery, you know, everything's supposed to be perfect, but it's not. There are several scenarios that we might see. We might see anger in response to social pressure. We could it in terms of interpersonal temptation, some of the sexual issues in early recovery and similar issues can be problematic.

Being around the old patterns of use can increase anger and frustration. I'll give you an example. Have you ever chewed aluminum foil on a cavity or had someone take your fingernails and rake it down a chalkboard? This is a

kinesthetic feeling. It's a horrible feeling. You just want to make it go away. In some ways, this is very much like a craving. All of a sudden you get around a group of people who are using a drug you used to be very intimate with, it's like running into an old lover who's with someone else now, you know? The first thing you think of was how good it was, and then a couple minutes later you're saying, "Oh, that SOB!" You know?

Now what we're doing is the same thing with the drug. Because a lot of people anthropomorphize this stuff – they make it human. It was a true relationship, and they'd do anything to keep it. What we might see is that when they're around the cues, the old patterns of use, it might actually increase anger and frustration.

What you'll also see is it might increase a little dopamine too. They may feel like they're getting off, but the problem is that it's a tease. Then we start to see the anger and the frustration. You know, "Why can't I use this?" Or, "I bet if I just used a little bit, then I would be okay." All the stories we've told to ourselves as alcoholics and addicts during our entire career of use, one of them may come right back up at that particular situation.

Anger and Aggression in Early Recovery

- Secondary to life situations
- As part of a grief process
- Mood swings secondary to altered neurotransmitters
  - Acamprosate
  - SSRI's
- Crisis building to manage subjective distress
- Anger secondary to early life issues

We know that anger and relapse are a very big piece of early recovery. We know that anger and aggression in early recovery can be secondary to life situations. I try not to invite any defenses when talking with a client who comes in, for example, to an after care on outpatient basis. I may say something like this, "Well, how's it going?" You know? "What's up? How's it going?" And I watch how they respond. If they go, "Yeah, man, this was a great week," (with head down and eyes diverted) or "Man! This was the best week I've ever had, I think!" (with head up, smile, look of elation) Now there's something wrong with what they're telling me and they way they're acting. There's an incongruence. Some of you may remember if you studied NLP,

you might have picked up some of this. What I'm looking at is a person who's saying one thing, but acting in a different way. The meta message is the behavior.

At that point I want to go back to their treatment plan, and I'm going to ask them, "Have you been going to group? Have you been going to self-help? Have you been talking to your sponsor? Have you been doing everything you need to do?" A lot of times, what you're going to find is they've been slip-sliding a little bit. My issue in this particular session is to get them grounded and back on track.

Now, another thing that they may do in this scenario is create a crisis for you. They may even seem a little paranoid. "Why is the world out to get me? It's not fair!" You know? It sounds like my son. "It's not fair!" You know? The world isn't fair.

A lady who came in said, "You know, I just don't think I can stay sober." She was angry and said, "It's my son. He's smoking that marijuana." I asked her what I thought was a reasonable question. I asked, "Well, how long has your son been smoking pot?" And she says, "Ten years." Now, something tells me that that's not the issue at all, but when we feel angry and upset on the inside, our brain looks outside to try to explain it. "Why is my supervisor doing this?" Or, "Why is this happening to me? It's not happening to other people." A lot of times what we come in with is this alcoholic who has created this angry crisis. What's happening is it may even be depression – a subjective experience inside that's projected outwards. It could actually be depression projected outwards as paranoia. We could see a lot of these dynamics taking place, but our goal is to get back in, right? What we say to that person is, "Jeesh! I understand how upsetting this must be about your son, but tell me how you feel about this?" Which is the old standard when you don't know what you're doing, you just say, "How do you feel about this?" In that particular scenario, it's probably the right thing to do.

If we look at an alcoholic and addict coming into treatment – and I notice this a lot with adolescents – that after a certain period of time, they may start to get angry in treatment. The staff sees that as a bad thing quite often. That's actually a progression when this person starts to emote and get angry based upon the isolation and the "I don't want to have anything to do with this stuff!"

When they get angry and start to express that anger – that's a positive thing sometimes in treatment because it's part of the grief process, right? Any time we deal with any chronic illness whether it's addiction or AIDS, we're going to go through this. A person's going to go through the anger and the denial and the bargaining – all the different pieces – and so anger sometimes can be

looked at as part of a grief process and may be seen as very positive. Instead of wanting to say to this new person, "You're a bad person" or "Cut that crap out!" getting them in group might be the best place to go with something like that.

Mood swings can be secondary to altered neurotransmitters, for example. If you look at the neurotransmitter alterations of alcoholics/addicts, what you see is a lot of norepinephrine, serotonin, and dopamine totally skewed in early recovery. When we have these neurotransmitters out of whack, we can see anger, depression, impulsivity, any number of problematic types of feelings translated into behaviors that we need to look at. Again, we can see anger secondary to early life issues. This is a lot of what we've talked about today – secondary to early life hurts, if you will.

Case Study

A 36 year old female (Monique) had been clean and sober for 6 weeks . She had a history of alcohol and benzodiazepine addiction. One day she came into her therapist's office and said, "I am so angry at my son I think I am going to drink. He is smoking dope." The therapist asked how long her son had been smoking and she replied, "10 years."

This is the case we just talked about. Let's look at this in a little different way and talk about Monique. Well, upon that, asking the situation, "Well, how does that make you feel? What's going on? Let's go over your entire recovery plan. Let's see if you're upholding that plan. Let's shore up your recovery program."

By doing that particular type of intervention, the anger was gone, we had a person now who was starting to think about recovery again, behave like a recovery person, and that's how you'd recover, right? By thinking and acting like a recovering person. They say, "Fake it till you make it," or whatever, but you act that way and that also helps the frontal cortex. The frontal cortex, if you keep doing it over and over, can actually repair the old injured cells and can actually grow new ones. That's something in the last decade we've learned – that various areas of the brain can grow new cells. We just keep practicing over and over and over again, and we get this part of brain to start to think about recovery and we start acting like we're in recovery, and then – voila! – it becomes us, doesn't it? It actually becomes us in time.

This picture is one I know you will recognize from the movie “Anger Management,” and I don’t know how to really comment on the effectiveness of Jack Nicholson’s technique, but I think I would have done anything after about 10 minutes just to get out from under the torture, if you will. But, let’s look at anger and let’s look now clinically look at it in a different way. We’ve talked about managing someone who comes in to your venue who is angry, dealing with the moment. Once we’ve got a person stabilized, and we’re working on the anger issues in group or individual therapy, what types of therapies have been proven to be effective with these people?

Empirically Proven Approaches

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

Actually, there are three types of therapies. Relaxation therapy can reduce the arousal, the physiological emotional arousal. Relaxation techniques are very good. Other techniques that have been proven to be effective are cognitive techniques. Cognitive techniques work with the preconscious things we say to ourselves that cause us to behave and feel and to react physiologically in a negative way.

In cognitive therapy we're trying to reduce anger-inducing information processing. Okay, so, what we might have is an old issue and an old thought pattern. Anytime we're in a certain situation, that old tape plays and we act in that old way. We get angry, we act out, and we do whatever. As we think about this, let's look at cognitive therapy and look at it as a way to reduce the information that's being fed in the brain.

The preconscious negative self-talk, you can call it "stinking thinking," or dysfunctional thought if you're a cognitive therapist. We want to increase problem solving ability. How do we get a person to understand the dialog, and then how do we get them to change and do something differently?

Along with that comes the behavioral techniques, and we often see cognitive-behavioral techniques used together. Sort of like in AA – take the body and the mind shall follow is a very nice cognitive therapy technique. But in behavioral therapy, we're really looking to teach adaptive behaviors. Repeating positive behaviors, going to meetings, going to church, doing those things one needs to do over and over again until it becomes who you are.

In the same way, that when you're an addict and you used and you thought like an addict, you became an addict. Now we're trying to get rid of some of that stuff, even some of the old deep-seated beliefs that we hold. We want a person to regard themselves more positively.

Think about why someone who's angry would change. You listen to angry people. I do, you do. We see it on TV. We see it in our practices on the milieus. One of the things I always notice, it is never their fault. You ever notice that? I don't have angry people come and say, "I'm really pissed off and it's all my fault!" It's not the way they do it. "I'm really mad, and it's all Richard's fault!" Then the object is a worthless 'you-know-what.'

So all of a sudden, it's somebody else's problem. "If it's not my problem, why are you trying to get me to change? What you should be doing is out there dealing with Richard! That jerk's the one that needs some therapy!" You know what I mean? The thing that is so interesting about it is that angry people often have God on their side. "I'm really angry at Richard. He's a worthless 'you know what' and God knows I'm right!"

Why Change ?

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

You ever hear things like that? I mean, that's just the way it kind of comes out sometimes. We're seeing someone who doesn't have any responsibility. They're blaming the other person. That other person is absolutely useless, and God knows they're right! There's a self-righteousness about this, isn't there? When it's not my problem, why am I going to change? So this gives us a little bit of a hurdle, but if you work with alcoholics and addicts, it's not so different, is it? I mean not all of them come in and say, "Jeesh! I'm a hopeless alcoholic and addict, and I need to get into some of those highly confrontational group meetings you have and some of those Triple-A meetings might be just the thing for me!" They're usually coming in and we're dragging them screaming and yelling that they don't have a problem. So there are some similarities between our work with addicts and our work with people who are angry and potentially aggressive.

Over the years, there has been a lot of talk about cathartic things. You know, really cathartic, getting it all out. Remember the old Bob Newhart Show? Remember Mr. Carlin? That guy got mad for like 10 years! He never got better, did he? I mean, the problem that I have with cathartic stuff is that #1, it doesn't work. If you have a person cathart, and you put them into therapy that's more cognitive-behavioral for a period of time and you deal with it and you teach them all the stuff, then that's okay. But you really didn't need the catharsis to do that.

But if you get someone who's in alcoholic/drug treatment – and I've seen this happen – and they're in a group and they're doing a role play and they're taken back to the womb, because their mom was using drugs while she was pregnant with the patient. This person is angry and they're breaking out, and the clients are holding him in with all of the Styrofoam. You may have seen some of these types of things. They're not necessarily bad at all. I mean, some of it can be very good, but you have to have great follow-up if you're

going to do that. If you're going to open that up, you better have explicit follow-up because think about this – this guy was in his last day of inpatient treatment. They did this role play. He got angry. I mean, he was sweating. His shirt was all ripped. After it was over, the therapist that I was observing and all the patients got around him, and they sat on the floor and they told him how wonderful it was he got in touch with his anger, with his rage.

To me, that's just practicing to go home and beat the heck out of his wife again because he was in here for domestic violence and alcoholism. Now, how could you do something like that? That's malpractice to me. I mean, actually its basic rehearsal for being angrier.

I would say to you also, that if you ever see a book Ten Quick Steps to Getting Rid of Your Anger, don't ever waste your money on it. This is too complex. This is just too complex. It really is. Everybody is so different. We have to know where they're coming from, who they are. Ten steps are nice, but they don't work. I mean, if it was all that easy, life would be so simple, wouldn't it? Now, 10 Steps to Getting Rid of Schizophrenia and 10 Steps to Getting Rid of something else. You know, it might be good to think through and if it suggests different things you can do, it can be helpful. Often with the clientele we work with, it doesn't account for all those old belief systems and all that other stuff that's not always conscious.

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.

I think that it behooves us to again be client focused. You know, listen to the client as we talked about at first. The assessment. Get the information, listen to the client, and be congruent. The treatment plan. You can be the best cognitive therapist, best behaviorist, best whatever, but without the ability to establish a relationship, how well does it work? It really doesn't, does it? Historically, actually in 50 years of research, the only thing we know is that

the therapeutic relationship is the one thing that has the highest predictor of positive outcome.

Again, we go right back to what you bring to the dance – right? – 'who you are' is the most important feature here. The essence of a relationship, I believe, occurs in a moment. A lot of people say, "Oh, it takes a long time to develop a relationship"; but you develop an initial impression just like that, don't you? You go to the dentist or the doctor. You probably get an initial impression of everybody you meet.

Let's talk about relaxation therapy and how we would want to implement it. Now, in relaxation therapy, the following is probably something we want to do very, very early. Because later on in group or in individual when we do role plays, we want them to practice this. We're going to work with relaxation stuff, maybe some cognitive strategies, behavioral strategies, and then we'd like to put them into groups, role plays or different scenarios and allow them to practice these things in a manageable situation – a safe place like group to get some practice in.

Relaxation Therapy

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

This is something we would start early, and there are a lot of techniques that you can use. The one thing I would stay away from is mental imagery until you really know your client because you can take a person to the wrong place, or they'll end up in a bad place. I've seen this done with Vietnam veterans and others. I would stay away from anything along that line. I'd work mostly with breathing control – the deep breaths from the stomach. You know, if you just try that yourself, three deep breaths, breathing in through the nose and out through the mouth, you can actually change your experience. You can alter your experience.

There are a lot of ways to alter experience. If you cross your eyes over your nose, you can get a weird phenomenon. People who are kinesthetic tend to

do that when you ask them questions, and our feeling people will often do that, they look down across their nose. If you just try it, you'll get a weird feeling sensation from it.

Controlling breathing, voice tone and tempo. Try to get people to slow down their talk. For example, if it's chatter in their head, slow it down. Or when they notice themselves talking, make a conscious effort to say things just a little bit more slowly. When they start to slow down the tempo as well as alter the tone on the voice, it has almost a hypnotic quality. Even with voice sorts of things, we can help people make some changes. We use progressive relaxation a lot, mostly muscle relaxation. What I found is with a client, you've got to deal with this stuff on the fly. You can't say to your boss, "Sorry, I've got to go over and play my 60-minute relaxation tape." You know, that doesn't work, does it? Right in the middle of something in a relationship, that doesn't work. So we have to give him very portable interventions.

What I find is that the lower legs and the toes seem to be effective for some people. Just scrunching them, releasing them, scrunching them up, and releasing that several times may be very helpful. Also, if you can help a person to understand where they harbor stress – in their stomach, up in their shoulders, in their neck, etc. For example, I can reach behind my back with my hands and flex while talking to you. You might think, "Jeesh! This guy's a little strange. Maybe he has some sort of neuromuscular disorder." I can literally do these things and carry on a conversation. It kind of helps me to break the dynamic. A lot of times, the physical response may trigger the cognitive response.

If we look at progressive relaxation, another thing that I found that works with adolescents and not quite as well with adults, but is pretty good. Imagine taking all the anger and moving it to your body and having that anger in one of your hands and just getting that hand tighter and tighter and tighter and feeling all that anger going to it., and just let it go. You'll have a marvelous kinesthetic experience. It's a whole body experience. It's very nice.

We can teach little things like this. I try to identify and teach three or four different things. Ask them which ones they think works the best because if they believe it works, it's probably going to work, right? Then take those two things they believe that are going to work the best and really work on practicing those and honing those skills. Relaxation can work for us in this way.

Case Study

Samantha was a 17 year old 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.

I’ll give you a case; Samantha, a 17-year-old female, who smoked marijuana because it helped her mellow out. When you listen to people who smoke dope, they talk about “let’s go mellow out,” “let’s go chill.” Kids got it right, “let’s go get stupid.” You know? But in early recovery, she was having problems with anxiety and anger. Her therapist taught her several strategies involving tensing and relaxing muscles along with cognitive and behavioral technique.

Now, I’m going to talk to you about the behavioral and cognitive technique here in a minute, but there’s one thing about Samantha that I really want to address here, and that is marijuana. With many of your marijuana clients, you’re going to find that beneath it is anger – lots of anger and sometimes a lot of anxiety. But when a person uses marijuana, it seems to reduce anxiety and anger. Even in the schizophrenics who smoke marijuana, I think they get sort of a reduction in anxiety, and that’s one of the reasons that I think they use it.

I think that Samantha is a young lady who has a lot of anxiety and anger, and when she smokes it often goes away. Now she’s not smoking dope, and she’s got all the anxiety and anger, so we’ve got to help her with that. If we don’t, she’s going to end up smoking dope again. So, if we look at this, what might we do if we looked at cognitive types of strategies?

Let’s briefly talk about what cognitive therapy is. Cognitive therapy has a few things in it that I think are nice. One is that it is somewhat regressive in the way that it looks at development. It understands that the automatic thoughts that cause you to behave in a self-destructive way often come from old belief systems that were established in the past. And I think that is a good piece of what cognitive therapy is about. It’s not totally here and now.

COGNITIVE THERAPY				
SITUATION	→	AUTOMATIC THOUGHT	→	BEHAVIORS, EMOTIONS, PHYSIOLOGY

As we look at this, what a cognitive therapist would say is that there are situations that trigger an automatic thought. This automatic thought causes behavior and emotions and physiology to change. If you're a cognitive therapist, what you believe is that you have a client and they have "stinking-thinking" or some unconscious negative self-talk, depending upon your orientation – negative self-talk. What happens is that this self-talk triggers and precedes the behavior. The behavior may be doing something aggressive. The emotion may be the anger and rage. The physiology may be the changes that are happening in the brain in the amygdala and other areas of the brain.

If you're a cognitive therapist, you're thinking – thinking first and then behavior, physiology, and emotion. Now, if you're a behaviorist, you could probably put behavior where automatic thought is and say what happens first is the behavior and that causes you to think in a bad way and feel in a bad way and causes your physiology to change.

The thing that's so important to remember is they're all connected. If we've got someone who's angry – whether we're coming at them from a cognitive perspective, a behavioral perspective, and/or relaxation perspective – we're automatically dealing with everything else: thoughts, behaviors, physiology – all of these things work together. We have to choose where we want to start.

The best way to choose that is to let the client tell you. If they come in and they have a lot of "stinking-thinking" and they're going, "Jeesh! You know, I'll never make it. I always screw everything up. I'd be better off if I was dead," that might be a place where a little cognitive therapy might be pretty good. If you had a client who went in and relapsed and their behaviors were that they just totally wouldn't get into a recovery or any behavior at all, and they didn't follow through on any of their behavioral plans. Maybe the first thing to address is the behavior and what's holding them back from doing that, which is probably the fact that they're in precontemplation or contemplation and not ready to make the change yet. This might be one good way of understanding why they're there.

But, you see, it depends upon our orientation. I would think that it's best to have all of these orientations and to have a pretty good kit bag of things to use here. We haven't mentioned insight-oriented therapy. With some of the real old issues – the old hurt issues – we may actually have to go back and work with some of those things, and there are many things that can do that from Gestalt to psychodrama to dynamic therapy to Adlerian therapy. There are a lot of ways that we can do that. We can do it with art therapy. There are so many different ways.

If we were a cognitive therapist working with automatic thoughts, what we'd want to do is get the client to start to keep a little log of their automatic thoughts of things they say to themselves, and it's a good thing to do to practice that for a week or so. Just keep a little log with you and anytime you start to have a thought in your head that you're sitting there saying to yourself, write it down and try to look at which ones are positive for you and which ones are negative for you. You can actually change them.

I remember years ago (probably 20 years ago) I was doing a lot of workshops on the road and I would get tired. I would say, "Jeesh! I feel so tired." It's like my whole body would crumble. But instead of that when I said, "Jeesh! This is a lot of fun! We just have a little while to go! Let's have a good time with it," I got energized, I felt good. My whole posture changed. I think we can change so much just by changing our thoughts.

Cognitive Therapy-Dysfunctional Thought Record

SITUATION	AUTOMATIC THOUGHT	EMOTION	ALTERNATE RESPONSES	OUTCOME
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 HERE AND THEY ARE GOING OUT ON SATURDAY

If we look at it from a cognitive therapy perspective, let's go back to the case of Samantha. Let's look at something that happened to her in her early recovery. Samantha met a new friend who said he would call her, and he did not. She'd been in recovery maybe 6 months and really not looking for any heavy relationships, but she was trying to develop friendships and meet people. She had a date with this young man, and they seemed to hit it off very well. She thought they both had a great time, and she really was looking forward to him calling again. When he didn't call, her automatic thought – the old self-defeating thought – was, "He really doesn't like me. Why do people always do this to me? Why are people always screwing me over like this? Why are people always lying to me?" This is the old general negative self-talk pattern.

When we have that type of self-talk, there are a wide range of emotions that we might experience. Anger and hurt are very logical, and that was the experience with Samantha. She felt very angry, very hurt, and in terms of the therapist's role here, we would look at alternate responses. How else could she conceptualize this – using a good thought word, conceptualize – how could she conceptualize this situation in a way that's much more productive for her and helps her emotionally?

For example, with the help of a therapist, maybe we can come up with a lot of different things. Maybe he's busy. Maybe he just hasn't had time to call. Maybe you should call him. Maybe you should wait a couple days and see if he calls. Then if he doesn't call, why don't you give him a call?

In this situation a strategy that was comfortable for Samantha was that she was going to wait a couple days. If he didn't call, she was going to call him. In fact, that's what happened. When she talked to the young man, the outcome was a positive one. They got back together.

Now, what if it was, "I never want to see you again." I mean, a possible outcome is also the worse case scenario, right? What if it doesn't work out? Is this the worst thing that ever happened to you? This is not the end of the world. Life will go on. You'll meet other people. Try to get a person from this negative, generalized, sort of self-defeating perspective. When we do this and we help a person grow in this way – by going through this and solving this problem on their own and coming out of it with a different problem-solving strategy, we've given them a gift. We've used their utility. Things that they had inherent in them, but we've helped them understand how to make it work a little bit better on the inside.

We can see this, for example, around one year in the program. At one year in the program, a person thought everything was going to be wonderful. At one

year they still had screwy relationships, things weren't very good. So what happened? They started to think, "If this is what recovery is all about, I might as well get drunk!" And so they're feeling frustrated and angry, and so that alternative response might be, "Well, let's look at early recovery. Tell me about when you came into treatment. Let's go back to that picture. Who you were, all the problems you had. Now let's look at the picture of you today. What do you look like today? Do you believe that today you're much better off than you were a year ago?" It doesn't take a rocket scientist to figure out that generally that's pretty true. In that case, what we're looking for is an outcome that would be more along the lines of gratitude. So, again, a way of thinking.

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."

Now, there are a lot of different types of strategies. Some of my favorites are reframes – cognitive reframes. When you've got someone coming in, in absolutes, who is angry, you can't work with it. You know? For example, "My mother is always angry at me." I mean, what do you do with that? You see, we act as salespersons. I think that more than anything else, we try to get a client to see something in a brighter way, in a different way, in a more positive way, a more recovery oriented way. In this situation – my mother is always angry at me – I might respond by saying, "Well, how old are you? Fifteen years old." And I might multiply 15 times 365 days in a year and come up with a number about 5,475 days. I'm doing this and saying, "Jeesh! Let me figure this out. Fifteen years (I'm very serious about this) times 365. You know, 5,475 days that you've been with your mother since you were born, and you mean to tell me every moment of those 4000 plus days your mother has been angry at you all the time?"

Now, I don't think it's possible for a person to be angry that long consistently. The client's going to naturally say, "No, not all the time." Now, I'm right where I want to be because my response is, "Tell me about one of those times when

you and your mother really got along." Now that's where we can work, right? Because our follow-up to that is, "How could we create a situation where you and your mother can have better days, and you wouldn't feel hassled all the time, and feel like your mother's always looking over your shoulders and you could have a little more freedom? And you'd do better and your mom would do better."

That's what we can do. We can help people change in that positive way, but to sit there and argue, "She's not really angry all the time, is she?" "Yes, she is!" "No, she's not." "Yes, she is." I mean, this is stupid. I've seen clinicians try to do that – convince a client that mother wasn't always angry. You've got to take an angle with that, and that's why I'm talking about reframe. That's what a salesperson does. You know, the same way with a car, right? They want to get you to see that car just the way they do with those leather seats and that panel that looks like a 747. It's a hook, isn't it? It's a nice hook, but it's getting you to see that product they way they do. Not seeing it as something you can't afford. So if we look at this, we can use different types of reframes to be helpful cognitively.

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."

Let's look at another one. "I get so mad when my husband says, 'Are you going out to another meeting?'" We need a little couples' therapy here – but we've got a husband who is seeing his wife who used to go out drinking and drugging, now she's going out to these meetings. What's the difference? You know what I mean? When we look at something like that, we'll go it just a different way, and this technique is one where no matter how they respond, you've got a nice out, okay? I would like to say to her, "You've been clean and sober for over 90 days now, and you go to 4 meetings a week, so that's about 48 meetings. You mean to tell me that for all these 48 meetings, every

time you went out, your husband was angry? And that you were angry because your husband was angry at you - because you're always going out."

What if she says, "Yeah."? Then my response is going to be, "Well, why does it still surprise you?" You know, if you think about it, we've got ways that we can deal with this that are therapeutic no matter what type of response we get here. These are some of the cognitive things that we might do.

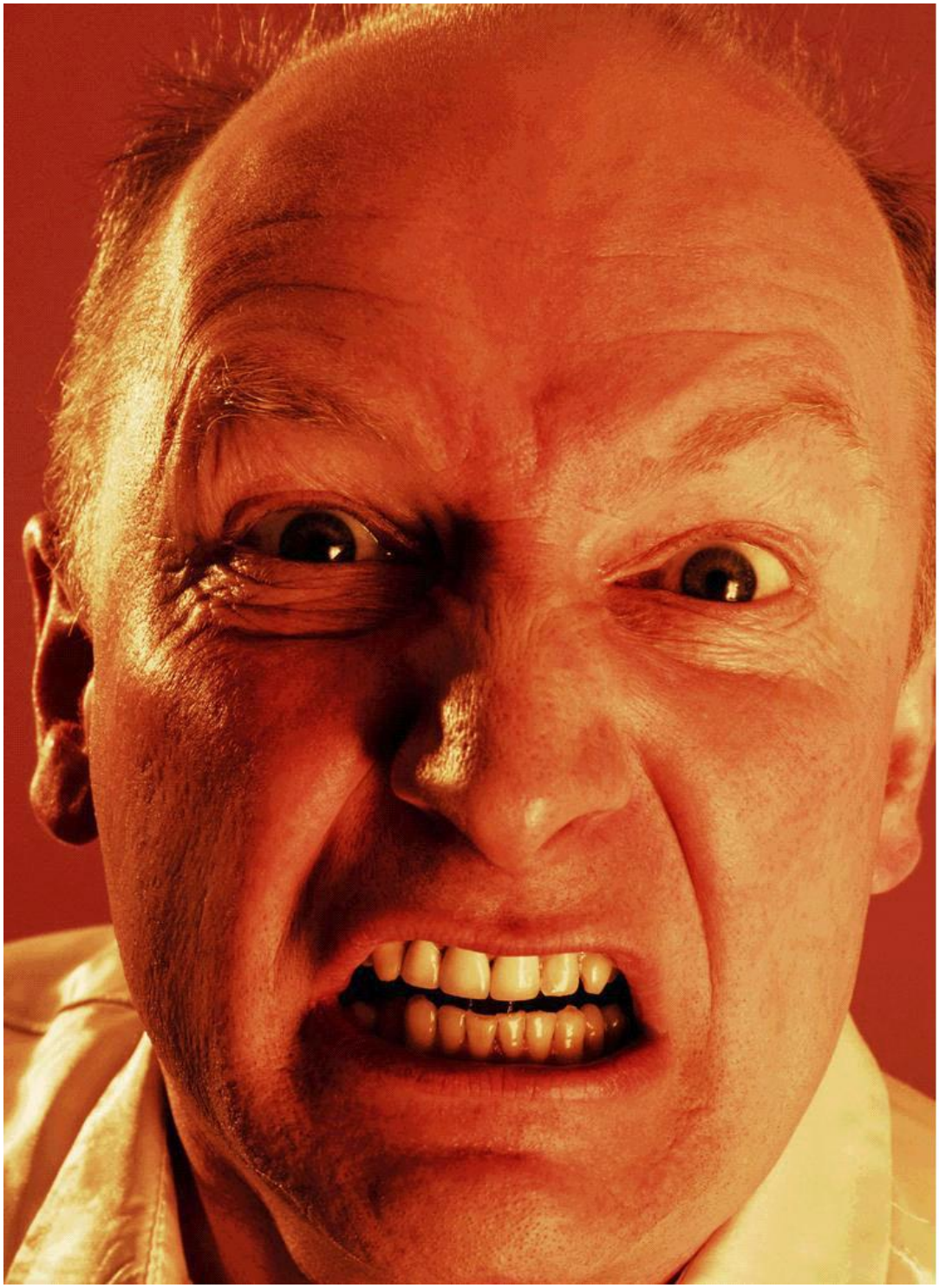
Behavior Therapy

STIMULUS → RESPONSE

- Setting Limits

Now, behavioral therapy is basic stimulus response, okay? If we have an old stimuli, we have the same response. It's like an alcoholic walking past their old watering hole. Sometimes come in and say, "Well, Jeesh, I wasn't planning on drinking, but before I knew it I was sitting there, you know, ordering a shot and a beer." When we understand how all of these little anchors and situations, the old stimuli are stored in the brain, we can be aware of the pattern. Once we introduce that person to it, especially in early recovery, basically there's a pattern that happens every time they do that, right? It's like a trance. I can say that it is almost similar. Have you ever driven home and not quite remembered getting home, or you were going to go some place else, but you ended up going home? It's almost like a trance, isn't it? It's almost like your executive functioning is working, but you're some place else for awhile. It's an interesting thing to think about. The old response is the old way we do things. You know, if we always go home this way and we're going that way, we don't always even remember it anymore. We've just got parts of us that are in charge, thank goodness.

We could also talk about setting limits as a behavioral strategy. Let's look at some of the things we might do. But first, I'll show a picture of a fellow, Lyle. I actually had a guy who looked exactly like this guy in treatment, and I'm going to tell you about him a little bit later, but he was quite a character.



Behavior Therapy – Changing the 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.”

Lyle is a 57-year-old male, who came to treatment with his wife. His wife got him to treatment, and she said, “My husband gets mad at other drivers.” This was sort of a typical road rage scenario. “And he starts to curse and gives them obscene gestures, and, you know, he’s going to get us killed.” Lyle is there saying, “Well, you know, I can’t help it, you know? They really irritate me. They’re such jerks out there.” Lyle’s an interesting guy. He was an old Vietnam vet. He was a good guy. You know? He was just having a few problems.

Right before they came to see me, he was going down an Interstate and he was flipping the bird to this truck driver, and the truck driver actually went off the exit after him. Lyle and his wife drive a Volkswagen, which is not exactly the ideal road rage car, you know? A tank may be better. If we looked at this particular scenario, Lyle would be a difficult person to work with, wouldn’t you think? He’s dead set on the fact that what he’s doing is exactly right. But he’s come in, and I’m only going to get one shot at him.

When I listen to him, I try to understand where he’s coming from. I said, “Look. Lyle, I know you don’t want to be here, and I understand that – and that’s okay with me – but I appreciate you coming in. Let’s do this. I’m going to ask you to do one thing this week – just one thing. Change one behavior this week. When you come in next week to see me, if this has not been helpful and if your wife’s not more satisfied and you’re putting your family in less danger – if that’s not happening – you know, you can try another therapist or do what you want. But if this works, I want you to sign a contract with me that you’re going to work on this issue.” In a contract, I might make it closed ended or open ended or whatever, probably closed ended in 5 or 6 sessions, and then renegotiate if there’s probably a better way to do it.

I said, "When you're riding down the highway and somebody really makes you mad – like a truck driver or something like that – I want you to feel it. I want you to really feel it. I want you to feel that anger with that brain you've got, and instead of flipping him the bird, I want you to flip him a peace sign." This guy's from the 60s, you know, a peace sign. So, it was really interesting. He's going down the road, and he's doing this to truck drivers and others, and what they're doing is they're blowing their horn and giving him the peace sign back. So the next week he comes in. His wife's ecstatic. No one had chased them off an exit. This guy still had big problems, right? But in using a little behavioral strategy, I just changed the feedback, the loop so to speak. He then signed on for about 6 sessions, and we were able to look at where some of this anger came from.

This is basically stimulus response, right? We've changed the stimuli from flipping the bird to flipping the peace sign, and it actually worked. I'm not saying these are wonderful techniques you should try on a lot of people, but in that situation, it was one understanding he was from the 60s and other things that were going on with him. It was one I thought would work because of the response he would get. I knew when he shot peace signs to people, they would not get angry at a peace sign. They would either shoot one back or ignore him. His wife was a whole lot happier about that, and he was happy that his wife wasn't always on his back. So we did get a little bit of positive out of this.

Behavior Therapy – Changing the 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."

Now, in terms of behavioral therapy, we can change the response. When families are in chaos, or let's say mom or dad dies and they're fighting over inheritance, or sisters who can't get along and all these things we run into sometimes. Every time they get on the phone with each other, like someone in early recovery trying to talk to their parents, they always get angry at each

other, and it always ends up very poorly. For example, a client says, "When I talk to my sister on the phone, she keeps telling me that I'm not an alcoholic. She says, 'With will power, you can control your drinking.'" This happens a lot in families. They don't want to admit that there's alcohol addiction in the family, so they say, "Well, maybe you had a little problem with the drug, but you can still drink, can't you?" or something like this.

We've got a situation and every time they get on the phone with each other or talk personally, this is one of those little hot points, and as soon as that happens, everything goes sour. They walk away mad at each other. At this point I said, "Well, how does this make you feel?" And the response is, "Angry and frustrated. She just cannot admit that alcoholism runs in our family." I told her, "For right now, why don't you just e-mail your sister? Send her e-mails, send her letters." I've had clients who've worked through family disputes where they couldn't get on the phone actually e-mail and write letters. I mean, even in the e-mail they can throw a little something in there, but they just can't do it the way they can do it when they're in person or on the phone. I try to keep it a lot less subjective, more objective in trying to work things out. I think that these are simple things that we might think about. Just trying again – changing the pattern, change what we're doing. Sometimes the simple ones are the best.

Behavioral Exposure

- CT: "I am afraid to go home for Christmas because everyone will be drinking."
- PLAN:
  - Use group role play to provide hypothetical exposure
  - Incorporate relaxation and cognitive techniques
  - Limit "in vivo" exposure
  - Create a safety plan

Another one. "I'm afraid to go home for Christmas because everybody will be drinking." The person is in early recovery, and we've got to help them out with this. There's a part of them that really wants to go home and see the kids and be a part of Christmas, and it's an important thing for them to do – to come back into the family. So as we look at this, we can come up with a plan. We could use role play as a behavioral exposure technique to create just practice. Now, we could also, in this practice, have them use the relaxation stuff, the cognitive things they've learned. We want them to use all of these

things when we put them under the gun in something like a little behavioral exposure technique. So we might have the group role play to provide the exposure, and then we want to incorporate relaxation and cognitive interventions into what we're doing and right now we're limiting the in vivo exposure. We're trying to keep her a little bit away from the family – maybe e-mailing or doing whatever – but when we do this, we practice in having the patients take on various roles, and we try to help her come up with a behavioral 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

In this case, the safety plan was very, very simple. Often I do these on 3 x 5 index cards. What it might say is, "If things get too heavy at home during Christmas, I will ___." Okay? So remember, when excitation takes over inhibition, or E over I, we lose stabilization, the frontal cortex isn't in charge. We want is something that pulls it right back, gets the intellect back over the emotion, and gets our frontal cortex to be the one that's in charge. We also had her go early in the morning, spend the day with the family, and in the late afternoon, she left. The reason for that is the drinking started in the late afternoon, and that's when things would probably be worse. In the safety plan – call a sponsor, find a meeting to attend, practice your relaxation/your cognitive strategies. If you need to, you can always leave. Give them therapeutic injunction to walk away if they need to. Right now their recovery is going to be more important than what might happen in terms of trying to convince this family that alcohol runs in it. When we start to look at this, a safety plan may be something that's valuable to us.

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.”

Lastly, I just want to talk about the use of humor. Sometimes humor is sort of a helpful side door that we can use with certain clients. For example, I had a patient once who came in and said, “My supervisor’s a flaming asshole.” Now, I’ve never seen a flaming asshole before. I don’t know what one looks like. So I actually got him a piece of paper and said, “Well, show me what a flaming asshole looks like.” His butt wasn’t so good, but the flames were exquisite. I’m talking about nice yellows and oranges and reds, and he did a great job. He drew the picture, and I said to him, “From now on, every time you see your supervisor, you see this flaming asshole.” He came back the next week, and he was so happy. He said, “When I see my supervisor, I smile at him or I laugh. He doesn’t know what’s going on, you know?” But they’re not getting into arguments. I’m buying a little time, okay? I know this guy needs a lot more than that, but I’m buying him a little bit of time.

I think that sometimes we can use various strategies that can be helpful. I think that the combination of relaxation, humor, cognitive behavioral strategies, sometimes medications if there are more psychiatric problems – use of the appropriate medication – I think that there are a lot of ways we could approach this clientele, and especially in early recovery.

Anger is an issue that I would always want to look at. I think that it’s one that if we can help them get under control and give them some different ways to manage it, we can give them a lot of things that can help them to have a much more rewarding recovery.

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Appendix A: Post Test and Evaluation for Treatment of Anger and Aggression in Early Recovery

Directions: To receive credits for this course, you are required to take a post test and receive a passing score. We have set a minimum standard of 80% as the passing score to assure the highest standard of knowledge retention and understanding. The test is comprised of multiple choice and/or true/false questions that will investigate your knowledge and understanding of the materials found in this CEU Matrix – The Institute for Addiction and Criminal Justice distance learning course.

After you complete your reading and review of this material, you will need to answer each of the test questions. Then, submit your test to us for processing. This can be done in any **one** of the following manners:

1. *Submit your test via the Internet.* All of our tests are posted electronically, allowing immediate test results and quicker processing. First, you may want to answer your post test questions using the answer sheet found at the end of this appendix. Then, return to your browser and go to the Student Center located at:

   http://www.ceumatrix.com/studentcenter

   Once there, log in as a Returning Customer using your Email Address and Password. Then click on 'Take Exam' and you will be presented with the electronic exam.

   To take the exam, simply select from the choices of "a" through "e" for each multiple choice question. For true/false questions, select either "a" for true, or "b" for false. Once you are done, simply click on the submit button at the bottom of the page. Your exam will be graded and you will receive your results immediately. If your score is 80% or greater, you will receive a link to the course evaluation. , which is the final step in the process. Once you submit the evaluation, you will receive a link to the Certificate of Completion. This is the final step in the process, and you may save and / or print your Certificate of Completion.

   If, however, you do not achieve a passing score of at least 80%, you will need to review the course material and return to the Student Center to resubmit your answers.

   OR

2. *Submit your test by mail using the answer sheet found at the end of this package.* First, complete the cover page that will identify the course and provide us with the information that will be included in your Certificate of Completion. Then, answer each of the questions by selecting the best response available and marking your answers on the sheet. The final step is to complete the course evaluation (most certifying bodies require a course evaluation before certificates of completion can be issued). Once completed, mail the information, answer and evaluation sheets to this address:

   CEU Matrix - The Institute for Addiction and Criminal Justice Studies
   P.O. Box 2000
   Georgetown, TX 78627

   Once we receive your exam and evaluation sheets, we will grade your test and notify you of the results.

   If successful, you will be able to access your Certificate of Completion and print it. Access your browser and go to the Student Center located at:

   http://www.ceumatrix.com/studentcenter

   Once there, log in as a Returning Customer using your Email Address and Password. Then click on 'Certificate' and you will be presented with a download of your Certificate of Completion that you may save / and or print. If you would rather have your Certificate of Completion mailed to you, please let us know when you mail your exam and evaluation sheets; or contact us at ceumatrix@ceumatrix.com or 800.421.4609.

   If you do not obtain the required 80% score, we will provide you with feedback and instructions for retesting.

   OR

3. *Submit your test by fax.* Simply follow the instructions above, but rather than mailing your sheets, fax them to us at **(512) 863-2231**.

If you have any difficulty with this process, or need assistance, please e-mail us at **ceumatrix@ceumatrix.com** and ask for help.

Answer the following questions by selecting the most appropriate response.

1. The number one cause of death for those addicted to stimulant drugs is:

    a. car accidents.
    b. violence.
    c. heart attacks.
    d. strokes.
    e. gun shot wounds.

2. Anything that _____ higher brain function often leads to acting out.

    a. increases
    b. promotes
    c. inhibits
    d. stimulates
    e. intensifies

3. Research from the University of Chicago, suggests that for people who are very impulsively aggressive, the use of which of the following chemicals can be helpful to them?

    a. Valium
    b. Iron
    c. Salt
    d. Lithium
    e. Alcohol

4. “Elaboration therapy” seeks to get the client to function from this part of the brain.

    a. Cognitive
    b. Emotive
    c. Lower
    d. Middle
    e. Auditory

5. Anger sometimes can be looked at as a part of the grief process.

    a. True
    b. False

6. Which of the following techniques does Nuckols suggest should be avoided until the counselor really knows the client?

    a. Relaxation training
    b. Assigning homework
    c. Mental imagery
    d. Role playing
    e. Expressing strong emotions

7. When a person uses marijuana, it seems to reduce:

    a. automatic thoughts.
    b. blood sugar levels.
    c. irrational spending.
    d. sexual expression.
    e. anxiety and anger.

8. Behavioral therapy is based on the simple phenomenon of:

    a. stimulus response.
    b. anticipatory response.
    c. automatic response.
    d. reward and punishment response.
    e. delayed response.

9. During the later stages of dependence, alcohol can cause a decrease in this neurotransmitter.

    a. Dopamine
    b. Norepinephrine
    c. Anabolic steroids
    d. Lithium
    e. Serotonin

10. If you are a cognitive therapist you would call “stinking thinking:”

    a. irrational.
    b. dysfunctional thought.
    c. self-defeating.
    d. childlike behavior.
    e. of no importance in therapy.

11. Controlled breathing, voice tone and tempo are techniques commonly used in:

    a. Gestalt Therapy.
    b. Regression Therapy.
    c. Psychodrama Therapy.
    d. Family Therapy.
    e. Relaxation Therapy.

12. According to some of the literature about _____ of people on death row have a history of violence and drug use:

    a. 50%
    b. 60%
    c. 70%
    d. 80%
    e. 90%

13. Research indicates that the brain is developed from:

    a. the bottom up.
    b. the top down.
    c. the middle upward.
    d. the middle downward.
    e. trial and error.

14. In order to use the cognitive and behavioral recovery strategies taught in treatment, Nuckols suggests we help the client increase:

    a. excitation over inhibition.
    b. inhibition over excitement.
    c. stabilization of the frontal cortex.
    d. stabilization of the mid brain.
    e. emotion over intelligence.

15. Most violence against children is committed by

    a. men.
    b. children.
    c. adults.
    d. women.
    e. All of the above

16. One of the main principles Nuckols suggests in this course is that violence is:

    a. encouraged in contact sports.
    b. learned with video games.
    c. learned early in school.
    d. learned at home.
    e. often disregarded by legal authorities.

17. The highest predictor of a positive outcome in therapy is:

    a. for the counselor to be in recovery.
    b. for the counselor to be the same sex as the client.
    c. a strong therapeutic relationship.
    d. a long term counseling relationship.
    e. consistent use of behavioral therapy techniques.

18. Which of the following dynamics is characteristic of Cognitive Therapy?

    a. Situation; automatic thought; behaviors
    b. Emotions; thoughts; behaviors
    c. Thoughts; behaviors, situation
    d. Situation; emotions; thoughts
    e. Thoughts; behaviors; emotions

19. In the case history example with Lyle, Nuckols contracted for how many counseling sessions?

    a. 12
    b. 3
    c. 18
    d. 10
    e. 6

20. When excitation takes over inhibition we lose:

    a. control.
    b. stabilization.
    c. intensity.
    d. personal power.
    e. sobriety.

21. Nuckols asserts that beneath most anger is:

    a. anxiety.
    b. hate.
    c. sadness.
    d. mental illness.
    e. fear.

22. The majority of stress response related systems are located in this area of the brain.

    a. Locus ceruleus
    b. Frontal cortex
    c. Midbrain
    d. Limbic system
    e. Hypothalamus

23. Which of the following techniques is NOT a common practice in cognitive-behavioral therapy?

    a. Reframing
    b. Setting limits
    c. Homework assignments
    d. Practice expressing strong emotions
    e. Developing a safety plan

24. Which of these terms refers to the escalation of the dose of steroids?

    a. Ranking
    b. Plastering
    c. Pyramiding
    d. Pouring
    e. Peeling

25. Most violence against men is committed by:

    a. women.
    b. law enforcement officers.
    c. men.
    d. adolescents.
    e. older adults.

26. In research conducted by Maine and George, toddlers without an abuse history responded to the crying of the child in which of the following ways?

    a. Ignored the child
    b. Hurt the child
    c. Asked an adult to help stop the child from crying
    d. Continued to play with their toys
    e. Tried to console the child

27. In Father Martin's "Chalk Talk", "I over E" refers to:

    a. instinct over extroversion.
    b. introverts over extroverts.
    c. intelligence over emotion.
    d. intelligence over extroversion.
    e. introversion over emotion.

28. The frontal cortex is typically fully developed in women by age:

    a. 20.
    b. 17.
    c. 24.
    d. 12.
    e. 28.

29. A child growing up in a traumatic environment will develop an exceedingly active:

    a. frontal lobe.
    b. brainstem and midbrain.
    c. intelligence.
    d. motor skills.
    e. need for risk taking behaviors.

30. In the case history example of James, the primary reason for his inappropriate behavior with his 7 year old step-daughter was:

    a. alcohol intoxication.
    b. drug addiction.
    c. stimulant abuse.
    d. frontal cortical surgery.
    e. delayed sexual addiction.

31. In order to be an effective clinician, Nuckols recommends lifelong:

    a. self denial.
    b. self discovery.
    c. self promotion.
    d. therapy.
    e. self discipline.

32. Nuckols suggests that relapse is most often associated with:

    a. anger and frustration.
    b. anger and drug use.
    c. anger and broken relationships.
    d. anger and depression.
    e. anger and isolation.

33. In the case history of Monique, Monique had a history of:

    a. simple alcohol dependency.
    b. sexual abuse.
    c. alcohol and benzodiazepine addiction.
    d. stimulant abuse.
    e. None of the above

34. “Various areas of the brain can grow new cells.”

    a. True
    b. False

35. Nuckols explains that at the present time there are three empirically proven psychotherapeutic approaches to managing anger and aggressive behavior. Which of the following three combinations does he suggest?

    a. Cognitive, emotive, psychodrama
    b. Cognitive, behavioral, relaxation
    c. Relaxation, bibliotherapy, journaling
    d. Psychodrama, relaxation, behavioral
    e. Stress reduction, behavioral, relaxation

36. One of Nuckols primary beliefs is that anger is:
    a. often not treated effectively.
    b. a secondary emotion.
    c. often misunderstood in society.
    d. a threat to clinicians.
    e. a learned coping survival skill.

37. The case study of Marcus illustrates the common decision of physically abused children:

    a. to never to let anyone hurt them again.
    b. to get even with the source of their abuse.
    c. to withdraw and protect themselves.
    d. to never let their emotions control their lives.
    e. to always be in control.

38. There is a greater chance for anger and acting out behaviors when:

    a. individuals believe they have no control of their lives.
    b. offenders are cornered by police authorities.
    c. there is increased excitation in the lower parts of the brain.
    d. there is decreased excitation in the lower parts of the brain.
    e. there is increased functioning of the upper parts of the brain.

39. Which of the following medications works well as a long-acting form of injectable medication used to manage agitation?

    a. Geodon
    b. Zyresxa
    c. Risperdal Consta
    d. Lorazepam
    e. Diazepam

40. A safety plan is a cognitive intervention designed to limit “in vivo” exposure to life problems.

    a. True
    b. False

Fax/Mail Answer Sheet

CEU Matrix - The Institute for Addiction and Criminal Justice Studies

Test results for the course "Treatment of Anger and Aggression in Early Recovery"

If you submit your test results online, you do not need to return this form.

Name*:_____

(* Please print your name as you want it to appear on your certificate)

Address: _____

City: _____

State: _____

Zip Code: _____

Social Security #*: _____

(*Most certifying bodies require a personal identification number of some sort – last 4 digits or License is perfect.)

Phone Number: _____

Fax Number: _____

E-mail Address: _____

On the following sheet, mark your answers clearly. Once you have completed the test, please return this sheet and the answer sheet in ***one*** of the following ways:

1. Fax your answer sheets to the following phone number: **(512) 863-2231**. This fax machine is available 24 hours per day. **OR**

2. Send the answer sheet to:
   CEU Matrix - The Institute for Addiction and Criminal Justice Studies
   P.O. Box 2000
   Georgetown, TX 78627

You will receive notification of your score within 48 business hours of our receipt of the answer sheet. If you do not pass the exam, you will receive instructions at that time.

Name: _____

Course: Treatment of Anger and Aggression in Early Recovery"

1. [A] [B] [C] [D] [E]
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40. . [A] [B] [C] [D] [E]

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Course Evaluation – Hard Copy Format

The final step in the process required to obtain your course certificate is to complete this course evaluation. These evaluations are used to assist us in making sure that the course content meets the needs and expectations of our students. Please fill in the information completely and include any comments in the spaces provided. Then, if mailing or faxing your test results, return this form along with your answer sheet for processing. **If you submit your evaluation online, you do not need to return this form.**

NAME:_____

COURSE TITLE: "Treatment of Anger and Aggression in Early Recovery"

DATE:_____

COURSE CONTENT		
Information presented met the goals and objectives stated for this course	☐ Start Over ☐ Good ☐ Excellent	☐ Needs work ☐ Very Good
Information was relevant	☐ Start Over ☐ Good ☐ Excellent	☐ Needs work ☐ Very Good
Information was interesting	☐ Start Over ☐ Good ☐ Excellent	☐ Needs work ☐ Very Good
Information will be useful in my work	☐ Start Over ☐ Good ☐ Excellent	☐ Needs work ☐ Very Good
Format of course was clear	☐ Start Over ☐ Good ☐ Excellent	☐ Needs work ☐ Very Good
POST TEST		
Questions covered course materials	☐ Start Over ☐ Good ☐ Excellent	☐ Needs work ☐ Very Good
Questions were clear	☐ Start Over ☐ Good ☐ Excellent	☐ Needs work ☐ Very Good
Answer sheet was easy to use	☐ Start Over ☐ Good ☐ Excellent	☐ Needs work ☐ Very Good

_____

COURSE MECHANICS		
Course materials were well organized	☐ Start Over ☐ Good ☐ Excellent	☐ Needs work ☐ Very Good
Materials were received in a timely manner	☐ Start Over ☐ Good ☐ Excellent	☐ Needs work ☐ Very Good
Cost of course was reasonable	☐ Start Over ☐ Good ☐ Excellent	☐ Needs work ☐ Very Good
OVERALL RATING		
I give this distance learning course an overall rating of:	☐ Start Over ☐ Good ☐ Excellent	☐ Needs work ☐ Very Good
FEEDBACK		
How did you hear about CEU Matrix?	☐ Web Search Engine ☐ Mailing ☐ Telephone Contact ☐ E-mail posting ☐ Other Linkage ☐ FMS Advertisement ☐ Other: _____	
What I liked BEST about this course:		
I would suggest the following IMPROVEMENTS:		
Please tell us how long it took you to complete the course, post-test and evaluation:	_____ minutes were spent on this course.	
Other COMMENTS:		