Breaking the Cycle:

EMDR Therapy Solutions for Problematic Anger and Related Behaviors

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Mark Nickerson, LICSW
markinickerson@gmail.com
markinickerson.com

Anger and Violence is an Underaddressed Clinical Issue

1. Huge cost to individuals and society
2. Clinicians are generally under trained
3. Offenders often avoid and resist treatment
4. Current treatments are of limited effectiveness
5. Clinicians often carry trauma related to anger/violence

"When anger arises, think of the consequences."

Confucius (c. 551 – c. 479 BC)

"When one becomes angry while standing, he should sit down. If the anger leaves him, well and good; otherwise he should lie down."

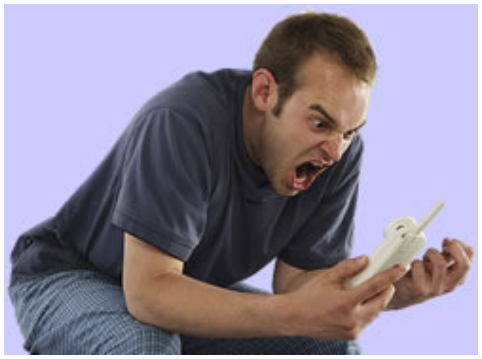
Muhammad (570-632)

"Anger is never without reason, but seldom a good one."

Ben Franklin

"Anger and intolerance are the enemies of correct understanding."

Gandhi (1869-1948)



Definitions

- Anger (reactive emotion)
- Problematic Anger (unmanageable state manifested internally or externally)
- Hostility (trait)
- Angry or Violence Behavior (a behavioral direction of the state or trait)
- Abusive Behavior (behavior designed to demean the target or otherwise gain power or control over the target)

Understanding Anger (Review With Client)

1. **Anger is a normal emotion.**
2. **Anger is a signal we can use.**
3. **Anger does not justify destruction/violence.**
4. **Anger is elicited by a perception of harm.**
5. **Perceptions and interpretations can be distorted.**
6. **Anger is influenced by our past.**
7. **Victim and aggressor identifications are common.**
8. **Anger is often a secondary emotion.**
9. **Anger reactions are learned and can be unlearned.**

Understanding Anger (Review With Client)

1. **Anger is a normal emotion.** (Everyone experiences anger.)
2. **Anger is a signal we can use.** (There is a problem to be solved.)
3. **Anger does not justify destruction/violence.** (Anger is an emotion, violence is a behavior.)
4. **Anger is elicited by a perception of harm.** (When we feel threatened, we may become aroused physically and this can be interpreted by us as anger.)
5. **Perceptions and interpretations can be distorted.** (A perception of harm may or may not mean there really is a threat to one's physical or psychological well being.)
6. **Anger is influenced by our past.** (An angry reaction greater than would be normally expected is usually connected to a negative past experience that influences thoughts and behavior in the present.)

Understanding Anger (Review With Client)

7. **Victim or aggressor identifications.** (Allowing your feelings to let you act like a victim or aggressive violent person can easily lead to passive acceptance of abuse or violent behavior that destroys relationships.)

8. **Anger is often a secondary emotion.** (It can often cover up more vulnerable feelings such as sadness and loss. It is important to search for times that anger is a secondary emotion and acknowledge these more vulnerable feelings.)

9. **Anger reactions are learned and can be unlearned.** (They can be unlearned. Through heightened awareness, practice and desensitization each person can free himself from automatic reactions to anger triggers.)

Possible Benefits of Anger

- Natural survival mechanism
- Signal that something is (or appears) wrong
- A powerful assertion of the self
- Mobilizes, fuels perseverance
- Can focus energy in a clear and effective manner
- Moral anger an impetus to fight for justice and fairness
- May be last emotion to resist numbness or despair
- Can get people's attention when nothing else works

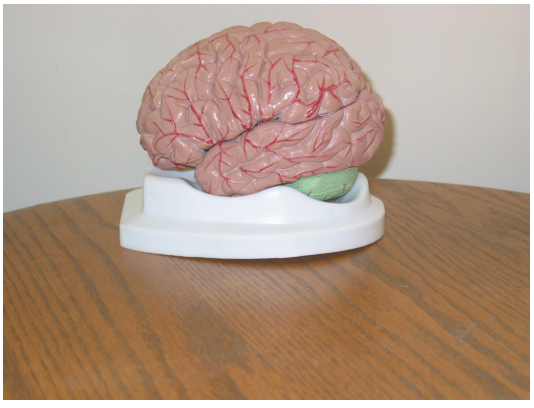
Secondary Gain

For the client, anger and aggression (emotion/behavior) may have had an instrumental value in coping with life.

- Gets peoples attention
- Reduces Stress (short term)
- Accomplishes a goal in best way seemingly possible
- Hurts or controls others
- Avoids other feelings
- Avoids traumatic memories/ pain
- Keeps personality intact- ego syntonic

Core Premise

Problematic behaviors are often both symptomatic manifestations of unresolved trauma *and* ongoing reinforcers of trauma templates that compromise the quality of a person's life.

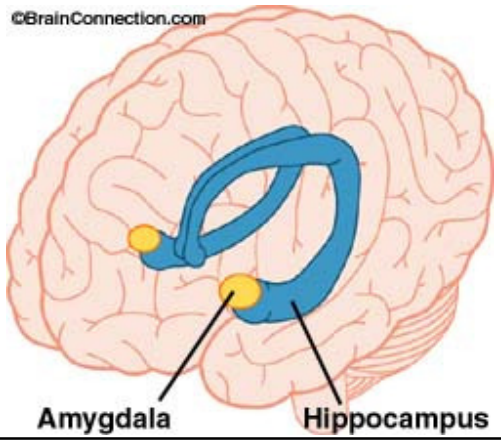


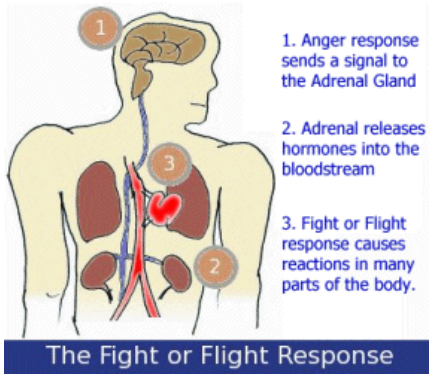
Triune Brain

- "Human Brain" (Neocortex): Cognitive
- "Paleo mammalian Brain" (Limbic Region): Emotional
- "Reptilian Brain" (Brain Stem): Sensorimotor

Executive Functions of the Prefrontal Cortex

- Selective attention-focus on what's important
- Working memory
- Self observation: emotions and behaviors
- Inhibition of automatic and habitual responses (thoughts, emotions, motives, impulses and behaviors)
- Access to core values and conscious motivations
- Capacity for reason and imagination
- Makes choices to think and act
- Bias toward constructive over destructive





When hyperaroused defensively..

- Deeper respiration
- Increased blood flow to muscles
- Decreased blood flow to cortex
- Increased vigilance to environment
- Suppression of systems not needed for defense

Physiology of Anger Response

- Adrenalin/ cortisol releases (to energize body)
- Heart rate and blood pressure increase
- Vascular changes: blood vessels constrict or dilate to improve blood flow
- Blood chemistry changes: blood more sticky to increase ability to clot
- Gastrointestinal change- digestion slows, urge to eliminate
- Senses more acute
- Muscles tighten

"Anger: an acid that can do more harm to the vessel in which it is stored that to anything on which it is poured."

Seneca (4 BC- 65 AD)

Health Impact of Anger & Hostility

- High blood pressure
- Risk of cardiac arrest
- Prolonged chronic pain
- High cholesterol
- Weakened immune system
- At risk for substance abuse

Human Response to Trauma

- The experience of Trauma can be seen as a violation of one's sense of self
- It overpowers the normal abilities to process the information of the situation and to cope flexibly
- Reactions include:
  - Flight
  - Fight
  - Freeze
  - Fog (dissociation)
- These reactions are instinctive survival reactions

Stored Trauma

All that went into the traumatic episode is stored in a memory node:

- Sensory impressions
- Affective states
- Cognitions
- Physiological reactions
- Action tendencies

Trauma Templates

- What was an adaptive coping response becomes a template for future behavior.
- This response template is activated when the individual perceives enough information that resonates with the original trauma unless it is regulated by other action in the brain (conscious or unconscious)
- It is stored as it was experienced until processed (like a coiled spring)
- This template becomes maladaptive when it governs a response that is inappropriate to the actual situation

Trauma Templates

- Trauma templates are the blueprints of a reactive system of response
- Psychological "sore spots"
- Any association to the trauma can trigger the trauma reaction
- When triggered, "the past becomes the present"
- Externalized impulse: "Do unto others what was done unto you"

Trauma produces maladaptive orienting tendencies

Hypersensitivity to minor environmental or internal changes

- A tendency to over orient to archaic trauma-related stimuli
- An inability to discriminate and evaluate the context of stimuli, especially regarding cues that may indicate danger in certain contexts but not in others (MacFarlane and many others)

Desensitivity: Reduced or normal sensitivity to stimuli

- Habituation: numbed response to stimuli (problematic for important stimuli)

Resensitization: attention to appropriate/ adaptive stimuli- Involves dishabituating

State Based Learning

Clients often present with symptoms, not coherent verbal stories. Traumatic memory consists largely of reactivated, nonverbal memories, sometimes combined with incomplete narrative accounts that are split off from conscious awareness and stored a sensory perceptions, obsessive thoughts and behavioral reenactment.

The individual seems to "remember" what happened through reliving these nonverbal iterations of the historical traumata event or thoughts mysterious physical symptoms that seem to have no organic basis.

These self-contained forms of memory do not necessarily interact with general autobiographical knowledge. Inaccessible to verbal recall, they typically remain unintegrated and unaltered by the course of time.

Van der Hart, 1991 and others.

Tendencies stem from procedural memory of processes and functions, reflected in habitual responses and conditioned behavior (Shackter, 1996) they do not require conscious or unconscious mental representations, images motivations or ideas to operate. They have the character of urges or impulses. They lie waiting a call to action, a trigger

They are stored in the brainstem, cerebellum, basal ganglia and lower brain. More complex actions are stored more toward the frontal context.

Ogden, et al

Top- Down/Bottom- Up Processing

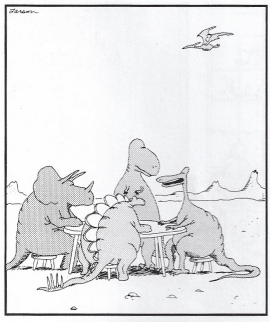
Triune Brain

Top-Down Processing ("Adult" functioning)

- Reason dominates emotions and sensations

Bottom-Up Processing ("Child" or "trauma introject" driven functioning)

- Bottom-Up Hijacking
- Processing impaired by trauma



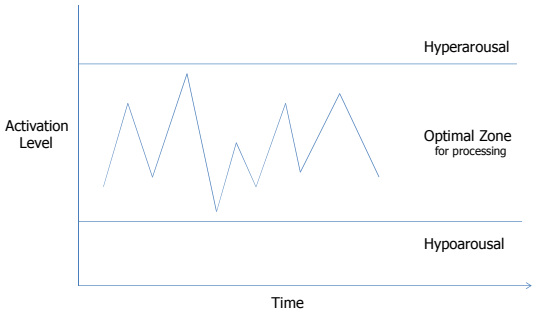
"Well, time for our weekly brain-stem-storming session."

- Physiological arousal, localized in the brainstem and exemplified by HRV, drives continued dysregulation, intrusions and behavioral reenactment
- Training in affect regulation and retraining automatic motor attitudes are the key to regaining locus of control (rather than understanding or inhibiting with drugs)
- A key to arousal modulation is "befriending" internal sensations, and gaining awareness of transitory nature of all sensory experience

Van der Kolk

Window of Tolerance

learning to self-regulate



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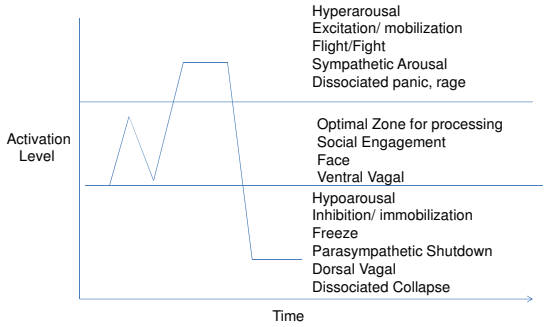

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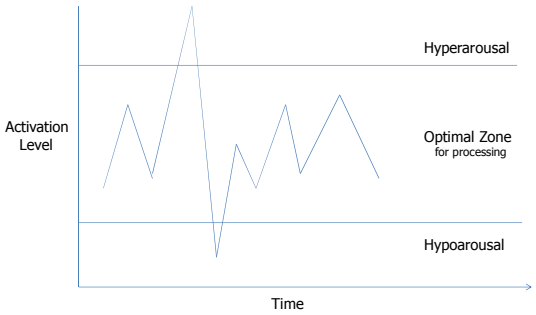
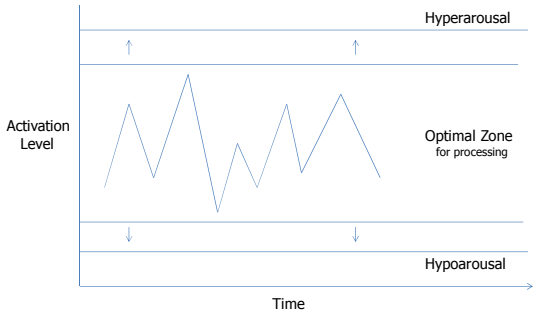


Window of Tolerance

learning to self-regulate



Polyvagal Theory

Steven Porges

1. Ventral parasympathetic branch of vagas nerve (social engagement)
2. Sympathetic system (excitation, mobilization) fight/ flight
3. Parasympathetic system (inhibition, immobilization) freeze

- Accelerator/ Soft Brake/ Emergency Brake
- Impairment of coping when over or under aroused

Window of Tolerance:
The Capacity for Modulating Arousal

- Oscillation between hyper/hypo arousal interferes with top down management/ regulation. Loss of flexibility of response, lower emotional tolerance
- Each person has a habitual width and range that varies by circumstances.
- A wide window allows for better functioning

***Acting Out*:**

Behavior tells a story that has not been otherwise understood.

Interpersonal Violence Triangle

Perpetrator

Ineffective
Observing other

Victim

Historic DV Critique of other Therapies:

- **Supportive Therapies:**

"I'm here for you…" (Affirms unconditionally)

- **Non-directive:**

"What would you like to talk about?" (Inadequate structure)

- **Insight oriented:**

"Well, you know, it probably happens because" (May help rationalize)

- **Cathartic or expressive:**

"Just get it out"(activates trauma, reinforces response patterns)

- **Gender/ Culture blind:**

"That's just the way men are sometimes" (denies)

Hotzworth- Monroe and Stuart (1995) Review of Typologies of Male Batterers

- Family Only (53%)
- Dysphoric/ Borderline (32%)
- Generally Violent/ Antisocial (15%)

Family Only (53%)

- Relatively low rates of violence in Family of Origin
- Low to moderate impulsivity
- Somewhat dependent on spouse
- Adequate social skills in non-marital relationships
- No/low generalized hostility toward women
- Remorseful/ more empathic
- Lower level/ frequency of violence

"I'm sorry. It was my fault. I don't want to do that again."

Dysphoric/ Borderline (32%)

- History of more parental rejection/ abuse
- More positive attitudes toward use of violence
- More history of deviant activity as a youth
- More hostile attitudes toward women
- High level of dependency on wife
- Low/ moderate capacity for empathy
- Low/ moderate extra family violence

"I'm sorry it happened. I really couldn't help it. I hope it doesn't happen again."

Generally Violent/ Antisocial (15%)

- Most severely abused as a child
- Higher rates of exposure to violence to parental violence
- Mod/ severe level of violence including psychological/ sexual
- More likely to have substance dependency
- Higher level of violence outside the family
- Most extensive criminal history
- Moderate level of anger

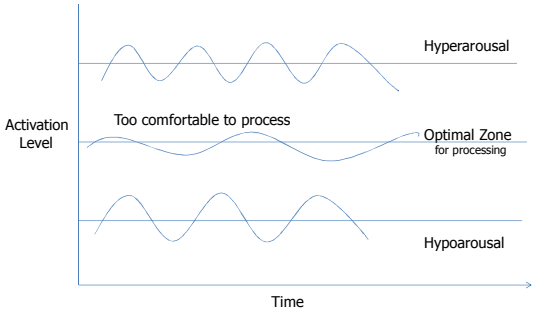
"You may think it was wrong but I don't really care. I did what I needed to do."

We Matter: Key Role of the Therapeutic Relationship

- Maintaining the therapist attachment is central to feeling safe and managing defenses
- Managing emotions in a relationship allows a sense of mastery
- Therapeutic relationship creates a corrective model for staying within the window of tolerance (the ventral vagal "soft break")
- And sometimes, we "make the disturbed comfortable and the comfortable disturbed" - Anonymous AA participant

Window of Tolerance

Therapeutic relationship can happen on the edges of hyper and hypo



AIP Trauma-Informed Understanding of Client "Resistance"

Client:

- Doesn't feel safe/secure enough
- Traumatized but being confronted
- Avoids reminders of trauma
- Fears not being able to contain trauma (uncoiling)
- Emotionally constricted

AIP Trauma-Informed Understanding of Client "Resistance"

Client:

- Avoids close relationships (attachment issues)
- Feels shame and blame
- Tends to create reactivity in others (e.g. feel scared but are treated as scary)
- Hasn't been believed or trusted in past

AIP Trauma-Informed Understanding of Client "Resistance"

Client:

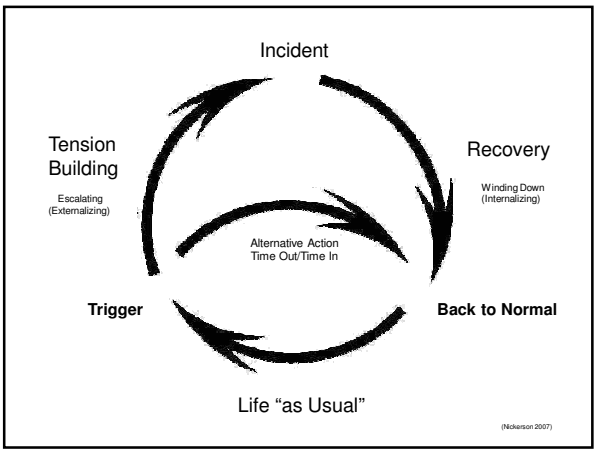
- Distrusts authority
- Blocking beliefs due to trauma reinforced gender/ cultural socialization
- Disclosure risks negative consequences (honesty is dangerous)
- If mandated counseling or externally motivated, may feel alienated from purpose of therapy

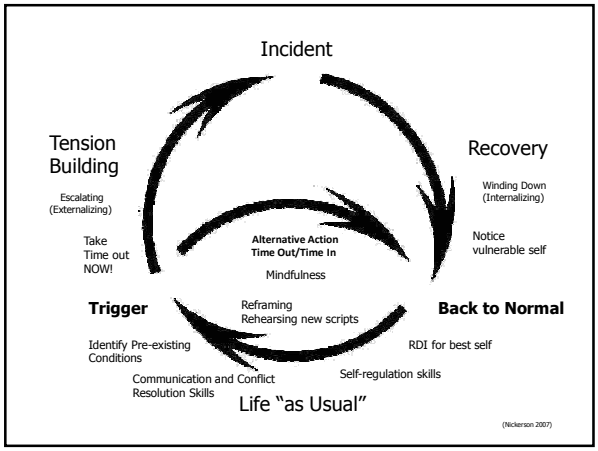
EMDR Approach can Minimize Transference and Countertransference Issues

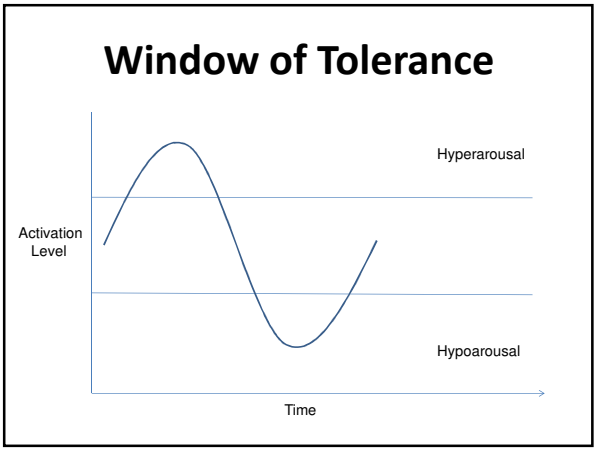
- Respects and (appropriately) empowers client
- Structured Approach
- Goals and pace of therapy are driven by client goals, realities, needs
- Symptom focused (stays relevant to client needs)

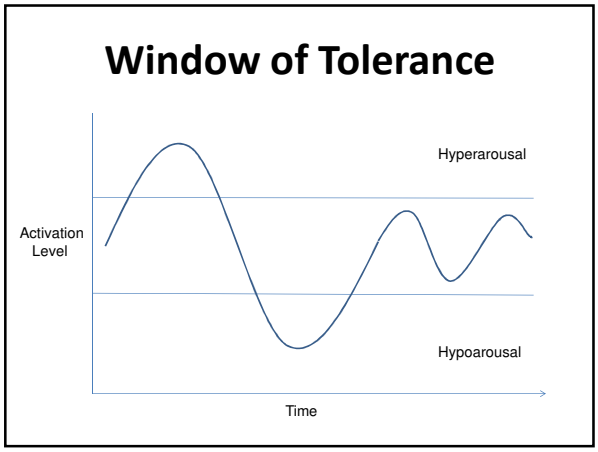
EMDR Approach can Minimize Transference and Countertransference Issues

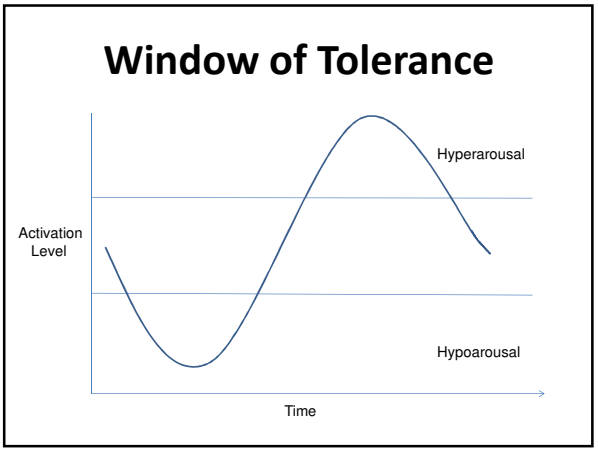
- Competency based (indicates trust in client)
- Clinician is collaborator and consultant
- Client takes the credit, measures the progress
- Client doesn't have to always "talk"



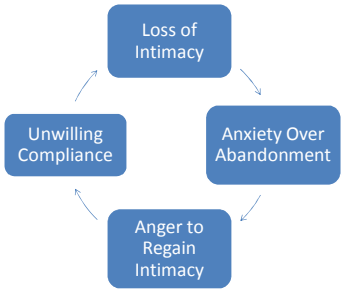




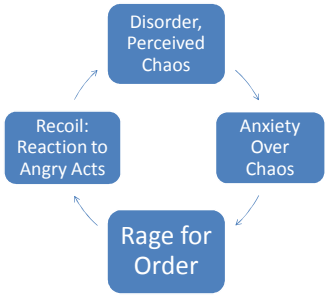




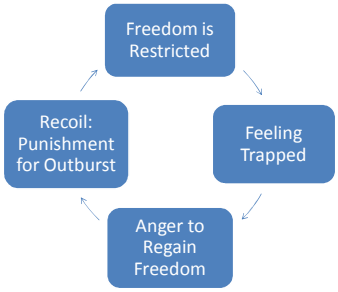
Mad About You!



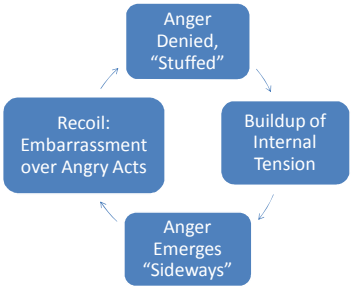
Rage for Order!



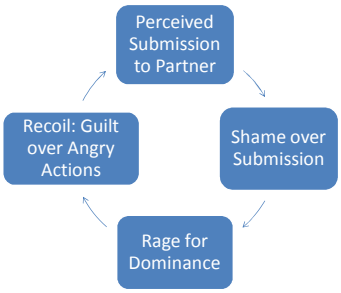
Breaking Out!



Angrily Avoiding Anger



Shame-Guilt Pendulum



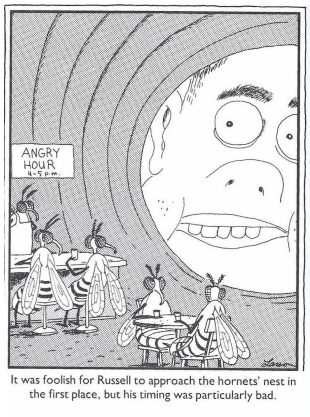
Externalization

"At the moment you become angry, you tend to believe that your misery has been created by another person. You blame him or her for all of your suffering. By looking deeply, you may realized that the seed of anger in you is the main cause of your suffering."

Tich Nhat Hanh

"The repetition compulsion amazes us way too little"

Sigmund Freud



It was foolish for Russell to approach the hornets' nest in the first place, but his timing was particularly bad.

The Cycle Model:

A Guide for History Taking and Treatment Planning for Treating Problem Behaviors

Additional details in handout

(Mark Nickerson © 2014)

Common Dynamics and Considerations when Treating Problem Behaviors

- Locus of control issues
- Target of behavior: Externalized /Internalized
- Conscious/ Unconscious
- If conscious, is it "owned" as a problem by the client or "denied"
- Ego syntonic/ ego dystonic
- Dissociated ego states likely

Common Dynamics and Considerations with Treating Problem Behaviors

- Trauma enhanced
- Stress Enhanced
- Emotional funneling- poor affect literacy and tolerance
- Situational Risk Factors
- Behaviors and action tendencies become part of the trauma memory

Common Dynamics of Problematic Behaviors

Cyclic pattern

- External or internal factors trigger impulsive/ compulsive behavior
- Compulsions are self-stimulating
- Fulfilling compulsions provides temporary relief
- Potential for negative consequences ignored
- Pattern of behavior reinforced over time

Common Dynamics of Problematic Behaviors

- Defensive behaviors built around the problem (denial, minimization)
- Preoccupation
- Secondary gain
- Co-morbidity with other problem behaviors
- Entangled with real needs
- Skill deficits

Cycle Model Protocol

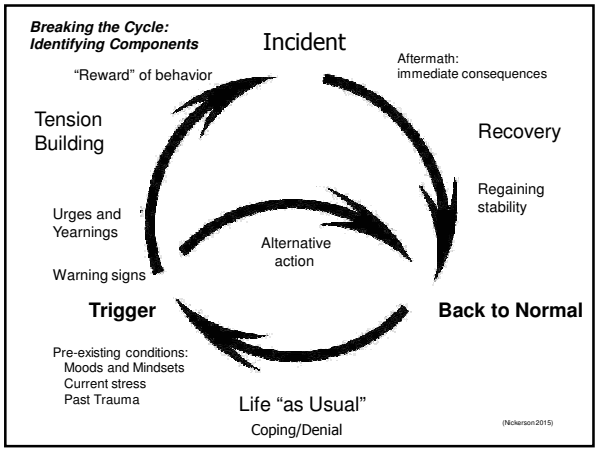
A tool for assessment and intervention for problematic behaviors including trauma "acting out" and addictions.

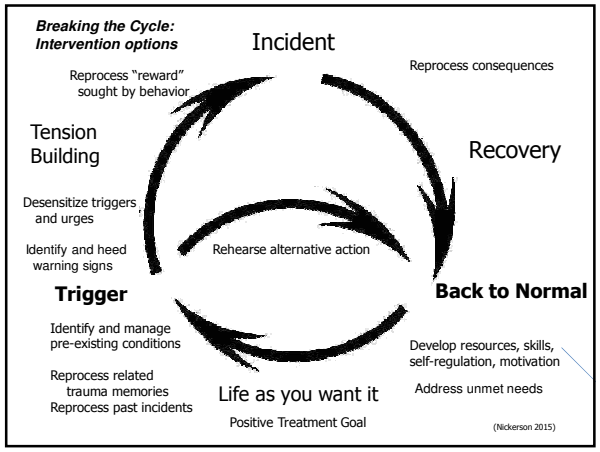
- quickly builds client awareness and motivation
- guides case formulation and treatment planning
- informs strategies to stabilize, manage and resolve
- identifies appropriate EMDR protocols
- illuminates targets for reprocessing

Motivational Interviewing

Key Principles:

1. **Express empathy** to share with clients your understanding of their perspective.
2. **Explore discrepancy** to help clients appreciate the value of change by exploring the discrepancy between how clients want their lives to be vs. how they currently are (or between their deeply-held values and their day-to-day behavior).
3. **Avoid argumentation** to prevent conflict and power imbalances
4. **Roll with resistance** to accept client reluctance to change as natural rather than pathological.
5. **Support self-efficacy** to explicitly embrace client autonomy (even when clients choose to not change) and help clients move toward change successfully and with confidence.





Worksheet for Practicum

Step 1: Establish the problematic behavior of concern to the client

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Worksheet for Practicum

Step 2: Establish dynamics of the problem behavior using the Cycle Model

Using this Cycle diagram, I am going to describe the commonly experienced phases of a recurrent problematic behavior….

Problematic Behavior

1. What is the recurrent problematic behavior you are concerned about?

Incident/Episode

2. Please describe what has happened in the past during an incident or episode of _____ (the problem behavior)?

Aftermath

3. *In the past, what has happened immediately after an incident/ episode of _____ (the problem behavior)? What have you typically done after an incident? If others were involved, what have others done?*

4. How have you felt afterwards? If others are involved, what have others felt?

Recovery

5. How have you recovered and gotten yourself back to normal?

Moving Forward

6. When you got back to normal, what have you done or tried to do about the problem? How has this worked for you? What has helped and what hasn't helped?

7. Do you have new thoughts about what might help? What skills do you think you need?

Triggers and Pre-existing Conditions

8. In the past, what triggers have activated you toward _____ (the problem behavior)? (External triggers can include certain people, places or topics. Internal triggers can include certain emotions, thoughts, and bodily feelings.)

9. Under what pre-existing conditions unrelated to the triggering event have you tended to get more easily triggered? That is, what conditions make you vulnerable to being triggered? (This may include emotional moods such as irritable, mindsets like in a hurry, or physiological conditions such as being tired)

10. What experiences from your past do you think may link to these triggers and make them so powerful?

Warning Signs and Urges

11. *When you recall past times when you have been triggered and the tension was building, where there warning signs that could have told you that you had been triggered and might be headed toward engaging in _____ (the problem behavior)? Warning signs can include things you certain behaviors, thoughts, emotions, or physiological reactions.*

12. *In the past, what urges, yearnings, or cravings have you had during the tension building phase that may have compelled you toward _____ (the problem behavior)?*

Solutions: Alternative Actions and Attempted Solutions

13. *When triggered and the tension was building, what efforts have you made in the past to cope with the triggered reaction and divert from a tension building phase to get back to normal? How has that worked for you? When that has worked, why do you think it worked? When that hasn't worked, why do you think it hasn't worked?*

"Positive" Reward of the Problem Behavior

14. Even though it may not be good for them in certain ways, there is often some learned reward that a person may be getting or seeking from a problem behavior. Sometimes the reward is obvious and sometimes it's more unconscious. Although you have identified _____ (the problem behavior) as a problem behavior, can you think of a positive aspect of the behavior? What reward do you currently or did you once get from the behavior?

"Positive" Reward of the Problematic Behavior

15. *When you think of a time in your life when that behavior was most rewarding, what positive sensations, feelings and thoughts did you have about yourself at that time?*

16. Are there other healthier and less problematic ways you can pursue similar rewards and better meet your needs?

Meta-Concerns and Motivation

17. If this cycle pattern continues, what do you think will be the consequences?

18. If you could believe right now that you are capable of change, how motivated are you now to break this cycle on a 0-10 scale?

Step 3: Establish Positive Treatment Goal

- *What would your life look like it you got a handle on this problem and were able to change this behavior? Choose a time in the future and describe what would be different.*

(PTG as defined by Popky, DeTUR protocol)

Step 3: Establish Positive Treatment Goal

Positive Treatment Goal (PTG) should be:

- clarifying of goals
- client generated
- a meaningful stretch, but not unrealistic
- far enough away in time to accomplish goal but close enough to appeal
- magnetic in its appeal and thus motivating
- the light at the end of the tunnel

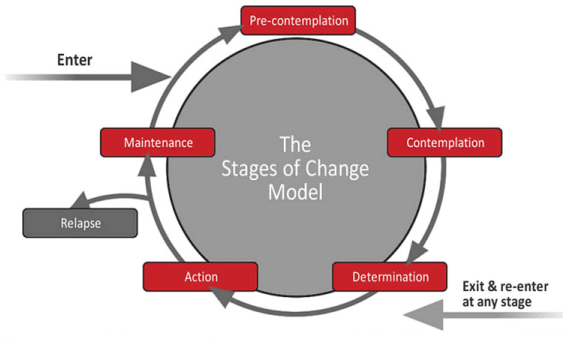
Step 4: Identifying Pathways and Obstacles

Orienting with the PTG, clinician and client:

- Identify gaps between current state and PTG
- Review information from Cycle Assessment
- Assess client strengths/ resources/ motivation
- Formulate and prioritize treatment priorities and sequences
- Reevaluate and revise treatment plan as needed

Decisions about where to start first should be based upon factors such as:

- client willingness and motivation
- stability/resources of the client
- acute needs and short term goals
- obstacles that are most problematic
- risk/benefit of destabilizing the client
- "bang for the buck"- biggest gains possible



Stages of Change

- Precontemplation (Not yet acknowledging that there is a problem behavior that needs to be changed)
- Contemplation (Acknowledging that there is a problem but not yet ready or sure of wanting to make a change)
- Preparation/Determination (Getting ready to change)
- Action/Willpower (Changing behavior)
- Maintenance (Maintaining the behavior change) and
- Relapse (Returning to older behaviors and abandoning the new changes)

DiClemente and Prochaska

Questions to Develop a Treatment Plan

As you consider your Positive Treatment Goal and what we learned as we went through the phases of the cycle, let's consider where we should focus our work together. Where can we strengthen your capacity for change and how can we overcome the obstacles that have interfered with change in the past?

Step 5: Determine Treatment Intervention and Begin Treatment

Treatment possibilities
at each phase of the Cycle

Red Flags: High Risk Challenges and Triggers

Times/ Situations

Topics

(Nickerson 2007)

Red Flags: Warning Signs

Verbalizations/Actions Neg. Thoughts Emotions Body Sensations

External (toward other)/ Internal (self)

(Nickerson 2007)

Early phases of Treatment for Anger Management and Violence Prevention

1. Use the cycle model to identify patterns of angry and violent behavior
2. Build client motivation to change patterns of behavior and reactivity
3. Prioritize stopping escalating angry and violent behaviors
4. Identify client triggers with the aid of *Red Flag High Risk Challenges and Triggers*
5. Help client identify *Red Flag Warning Signs*
6. Discuss and rehearse Time-out/ Time-in procedure
7. In future sessions, review the occurrence of triggering situations and the use of a Time-out/ Time-in procedure

Time-Out/ Time-In Procedure

1. It is important to **know your warning signs** that tell you your anger is escalating (for example: voice getting louder, thoughts getting hostile, adrenalin increasing).
2. **Time-Out Phase**: When your warning signs have been activated, say to anyone present: "I'm feeling angry (upset), I need to take a Time-out, I'll get back to you in an hour". Say this as calmly and respectfully as possible. Leave the triggering situation safely.
3. **Time-In Phase**: Once removed from the triggering situation, it is important to make every effort to move your attention away from the trigger and in directions that will allow you to settle down and return back to your "normal self". This might involve some dissipation of energy through exercise. It can also be accomplished by using grounding exercises, self-affirmations, visualizations and contacting others who can be supportive to the process of coming back into yourself.
4. **Return**: If there is another person involved, get back to them in person or by phone at the end of the hour. Assure them that you have been taking a Time-out/ Time-in. If you feel adequately settled, you can offer to return to a discussion that was interrupted by the Time-out/ Time-in. If you or the other person is not ready, arrange for more Time-out/ Time-in or defer the discussion.

Time-out/ Time-in Protocol (Therapist Guided)

1. Is it your **goal to manage triggering situations** by responding safely?
2. Is there a **personal quality** that can assist you in accomplishing this goal such as courage, level headedness, discipline, or caring? Can you identify a time in your life when you had that quality. (*When fully accessed, install with BLS*).
3. I want you to **imagine a potential upcoming triggering situation**. (*If difficult, use a past triggering situation*)
4. Silently (*closing eyes can be helpful*), **visualize every step of your Time-out/Time-in plan including all the steps mentioned** (*above*). Be as specific as possible. First imagine telling your partner or others that need to know that you will be using this plan if needed. As you imagine the plan, be sure to imagine realizing your warning signs, saying the exact words you will use in the best possible way, how you will exit, and where you will go. Picture what you will do to take your Time-in, and how you will return appropriately to any others that are involved.

Time-out/ Time-in Protocol (Therapist Guided)

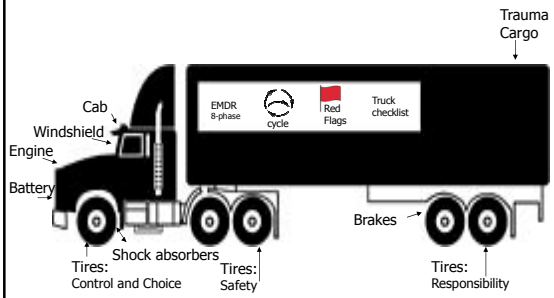
5. When you are done, **let me know what you imagined**. (Therapist discusses plan and asks questions or makes recommendations as needed to further develop any parts of the plan to make it realistically doable and effective). (*BLS*)
6. (**Continue to modify and perfect the plan until solid)** (*BLS*)
7. **Link to "body anchor"** such as holding finger and thumb tips together. (*Install with BLS*).
8. It is important that you **use this plan consistently between sessions**. The first time will likely be the hardest.
9. To be ready for the real thing and before our next session, I want you to take a **"practice" Time-out/ Time-in**, including, if appropriate, with the cooperation of your partner, a family member, etc.
10. (**Follow up session**: Review practice Time-out/ Time-ins. Review any actual Time-out/ Time-ins. Make modifications as needed).

Eight Phases of EMDR

(Shapiro, 2001)

1. Client History and Treatment Planning
2. Preparation
3. Assessment
4. Desensitization
5. Installation of Positive Cognition
6. Body Scan
7. Closure
8. Reevaluation

Truck Metaphor for Problem Behavior



- Accident Report
- Driving Lessons
- Road Maps

(Nickerson 2007)

Truck Metaphor: Clinical Checklist

- ❑ **Accident Report:** Reviewing Past Behavior and Its Consequences
- ❑ **Cab**: Secure Self/ Resource Development
- ❑ **Clean Windshield:** Sense of Vision and Mindfulness
- ❑ **Engine maintenance**: Health and Self Care Skills
- ❑ **Tires**: Appropriate Thinking/ Positive Beliefs
- ❑ **Brakes:** Self Control
- ❑ **Battery**: Managing Arousal/ Energy Levels
- ❑ **Shock Absorbers:** Affect Management/ Tolerance
- ❑ **Driving Lessons I**: Skill Development: Self Control
- ❑ **Driving Lessons II:** Being aware of other drivers: Empathy
- ❑ **Co-Driver**: Developing Co-Conscious Mindfulness
- ❑ **Who's Driving?:** Moods and Ego States
- ❑ **Road Map:** Goals/ Sense of Purpose and Direction
- ❑ **Support:** Others who understand and can support me
- ❑ **Tighten the Load**: Trauma Awareness
- ❑ **Unload the Packages**: Trauma Processing

Phase I: Client History and Treatment Planning (Be sure to assess)

- Trauma history
- Violence history
- Entire clinical picture, co-morbidity
- Behavioral difficulties (past and current)
- Personality disorders
- Substance abuse
- Medical Issues
- Medication
- Lifestyle habits- Exercise, Sleep, Nutrition
- Organic conditions (TBI, impulsivity, cognitive impairments)

Phase I: Considerations in Risk Assessment for Client and Others

- Employment status/ Legal status
- Social identity/ stigmatization
- Impact of problem
- Violence history
- Secondary gain issues
- Assess treatment "resistance"
- Motivation for change- Explicit/implicit reasons, internal/external reasons, degree of motivation
- Past experiences of receiving "help" for problems

Phase I: Considerations in Risk Assessment for Client and Others

- Current circumstances in all psycho-social stressors
- Contextual risk factors (e.g. recent separation, pregnancy)
- Other lifestyle challenges
- Attachment style
- Where appropriate or mandatory, make collateral contacts
- Personal strengths
- Ability to contract for safety

Phase 2: Preparation Special Tools and Considerations

- Cycle Model and Truck Metaphor for identification of treatment priorities and preparation
- Maintain ongoing risk assessment
- Attend to risks of treatment failure
- Attend to therapeutic relationship

Protocols for Preparation Phase

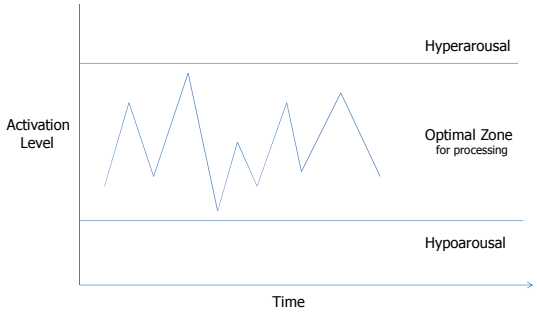
- RDI (Grounding, Containment , Strength building)
- Affect Tolerance: Leeds, Kiessling, others
- Affect Tolerance (emotional reset): Katie O'Shea
- Two-hand interweave for motivation and decision making
- Reinforcing/ Rescripting/ Rehearsing
- Skill Enhancement/Installation
- Scripts: Time out/ Time in
- Mapping the Problem: Ricky Greenwald
- Urge Reduction: DeTUR- A.J. Popky

Resource Development

- Safe (calm) place
- Container
- Physiological grounding
- Install (as resources) personal qualities needed to do the work. Redefine power with constructive qualities (e.g.):
  - Courage
  - Patience
  - Persistence
  - Love

Window of Tolerance:

learning to self-regulate



Emotional Funneling

Other emotions are channeled into anger.

- Fear
- Sadness
- Joy
- Disgust
- Surprise
- Anger
- Love
- Shame

Phase II preparation technique
"Emotional Clearing" developed by Katie O'Shea
Goal: Clear "Affective Circuits" for more genuine emotional processing

Steps:
1. Establish Container
2. Establish Safe Place
3. Identify and Emotion-
   - What picture goes with that emotion
   - Recommended order- shame, fear, anger, grief, seeking, enjoyment
   - Stay with image until "negative" feelings are faded or neutral or "positive" feelings have plateaued
   - If feelings about the feeling arise put in container for later reprocessing

Katie O'Shea
Solutions II

Creating Change
Visioning the Future
Shaping Behavior

Protocols for Immediate Behavioral Change

3 R's

- Reinforcing
- Rescripting
- Rehearsing

Two- Hand Interweave (R. Shapiro)

Mapping the Problem (Greenwald)

Reinforcing: Enhancing Progress and Shaping Behavior

- Corrective experiences/behaviors/ feelings can be noticed, highlighted and enhanced with BLS.
- "*Notice how you handled that situation. What choices did you make? What do you notice now as you remember handling those situations?" (BLS)*

Re-Scripting

Bad experiences can be rescripted with corrective "redos."

1. *"Imagine how you would have liked to have handled that situation if you could do it over."*
2. *Or "Imagine how you would have handled that situation knowing what you now know."*
3. Enhance with multiple sets of BLS until fully strengthened.

Rehearsing for the Future

Future Templates:

Anticipatory Anxiety (third prong of Standard EMDR Protocol).

1. Use established Positive cognition that comes after reprocessing all memories connected to a negative cognition or…
2. Use a temporary positive cognition based upon the most positive belief the client can hold to with a VOC of 6 or 7. What positive belief would you like to have about yourself as you leave here today?

Rehearsing for the Future

Skills Building with Imaginal Rehearsal

1. Establish and access a positive cognition, a personal quality, a skill and/or another resource
2. "Holding _____ in mind, I would like you to imagine coping effectively with_____"
3. Sets of BLS to refine and enhance.

Enhance with multiple sets of BLS until fully strengthened. Add in new skills and resources as needed.

If significant distress continues, target and reprocess memories linked to the distress.

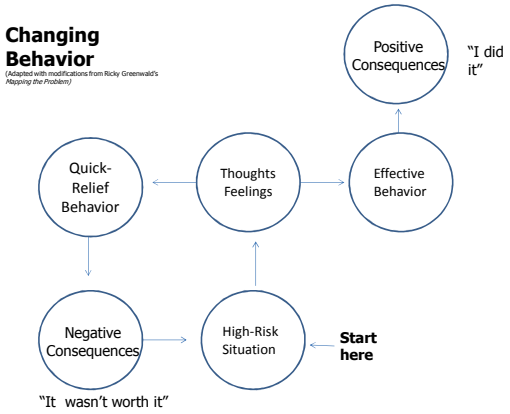
Two-Hand Technique

Robin Shapiro *Solutions II*

one hand	other hand
motivated to face issues	not motivated
preferred behavior	problem behavior
true self	internalized self
I am a bully	I am a person... who bullied
safe/in control	not safe, out of control

Changing Behavior

(Adapted with modifications from Ricky Greenwald's Mapping the Problem)



Map Out a Problem - For Behaviors to be Improved

Modified from: Greenwald, R. (2009). Treating Problem Behaviors. New York: Haworth.

Part 1: Review of problem and possible solutions

1. What do you do that seems to create problems for you? Does it happen a lot, or just in certain situations? What's a recent example, the last time this happened? When's the next time this could happen?

2. When you're in this kind of situation, what are the thoughts, the words in your head? Your emotional reaction? The signals in your body?

3. If you let the feelings take you over, what do you do next? How does this lead to the problems you get into?

4. If this tendency continues, and the problem gets even worse, how bad could things get? What picture could represent that? When you think of that, does "it's not worth it" feel true?

5. If you were in that (challenging) situation and had those thoughts and feelings and got yourself under control, what would you be doing instead (of the problem behavior)?

6. So if this effective behavior got to be a habit, what good things would that lead to? What picture could represent that?

Part 2: Processing the options

1. Imagine the challenging situation including going with the quick-relief tendency. Picture it until you get to the point where you see the negative consequences. Then say out loud, "It wasn't worth it". (BLS)

2. What did you imagine? What did you think, feel and do? Why in the end was it not worth it?

3. Now imagine the situation and, this time, go with a more effective way to handle it. Picture it until you get to the point where you see the positive consequences. Then say out loud, "I did it". (BLS)

4. What did you imagine? What did you think, feel and do? Why in the end was positive?

5. Now imagine the situation and this time it will be a surprise ending. Just let your mind go in either direction. I'll know which one you went with when you say out loud either "it wasn't worth it" or "I did it". (BLS)

6. What did you imagine? What did you learn from imaging that?

7. (Discuss and integrate new learning, consider new strategies. Repeat surprise ending until there are two positive choices.)

Protocols for Immediate Behavioral Change

- Skill Building
- Detailed Scripts:
  - Assertiveness and Empathy Scripts
  - Time-Out/Time-In Procedure
  - Apology Scripting
- Targeting Upcoming Challenges

Conflict Management/ Resolution

	Resolves Conflict/ De-Escalates Tension	Escalates Conflict
1.	"I" Statements	"You" Statements
2.	Listen	Interrupt
3.	Paraphrase	Ignore other
4.	Receptive Body Language	Rejecting Body Lang.
5.	Respect	Disrespect
6.	Open-Ended ?'s	Accusatory ?'s
7.	Be constructive	Be destructive

Conflict Management/ Resolution

	Resolves Conflict/ De-Escalates Tension	Escalates Conflict
1.	Be Specific	Generalize
2.	Be Concise	Be wordy
3.	Focus on Present & Future	Focus on the Past
4.	Focus on Issue	Focus on People
5.	Focus on Possibilities	Focus on Positions
6.	Open up	Dig in
7.	Find Answers	Find Fault

Conflict Management/ Resolution Skills

Assertiveness (Raising a concern and a request)

1. When this happened…. (Describe what happened as objectively as possible)
   _____
2. I felt…. (Describe personal feelings)
   _____
3. Because I am needing…. (Describe an underlying personal need)
   _____
4. So, in the future, would you be willing to ….. (Describe a specific behavior)
   _____

(adapted from Conscious Communication Institute Course Manual)

Conflict Management/ Resolution Skills

Empathy (Showing understanding and concern)

1. After this happened …. (Describe what happened as objectively as possible)
   _____
2. You may have felt (and still be feeling)…. (Describe possible personal feelings the other may have)
   _____
3. Because you are needing…. (Describe an underlying personal need the other may have)
   _____
4. So, I would like to …. (Acknowledge that feeling/need…,Invite you to tell me more about how you feel or what you need about what happened…,Offer to ….. (perform a specific action now or in the future)_____

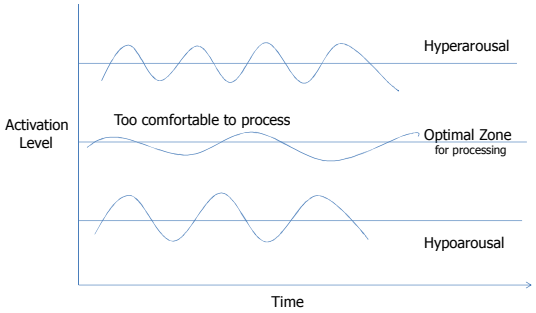
(adapted from Conscious Communication Institute Course Manual)

Time to Reprocess?

- Risk/ Benefit
- Client stable "enough"
- Demonstrated capacity for state change
- Sufficient resources
- Sufficient mastery of Truck Checklist items
- Client able to take responsibility for behavior
- Informed consent
- Capacity for dual attention (present safety and trauma activation)
- Contract for safety with credible strategies

Window of Tolerance:

Breakthrough processing happens on the edges of hyper and hypo



Three Pronged Protocol

Identify Presenting Issue

- Past—What memories set the foundation?
- Present—What situations trigger disturbance?
- Future Templates—What skills, behaviors, information are necessary for optimal functioning in the future?

Float Forward/ Float Backward

1. *As you imagine an upcoming challenge, what's the worst thing that could happen?*
2. *What image represents the worst part?*
3. *What negative beliefs/ emotions/ body sensations go with that image?*
4. *Holding the felt sense that goes with that worst part image, allow yourself to float back in your life to memories that are linked to these feelings. What do you notice?*
5. Target for desensitization.

Phase I Target Selection: Common Need for Symptom-Focused Work

Current issues have

- high relevance and
- high activation levels

whereas old trauma may be initially denied and well buried

- Use cycle of violence model to generate targets
- Use Float Back Technique whenever appropriate and proceed with standard protocol

Interweaves

"The strategies I developed are strategies to "jump-start" blocked processing by introducing certain material rather than depending on the client to provide all of it".

Shapiro (2001)

Interweaves

"By using the cognitive interweave the clinician attempts to change the client's perspectives, somatic responses, and person referents to the adult or adaptive perspective."

Shapiro (2001)

Phase 4: Reprocessing
Special Considerations and Interweaves

Watch for looping, abreaction

Track for externalization of problem and disconnection from self, guide client to identify healthier aspects self

Keep NC connected to self

Keep client "in body" by checking in about body reactions

Corrective Movie

Be sure client can feel vulnerable emotions "under" anger

Engage with client that creates a corrective experience.

Phases 7: Closure

Key component for these clinical issues:

- Assess and plan for safety and effective coping
- Review safety plan as needed
- Install temporary positive cognition as appropriate:

  What have you learned today that will be useful?

  What positive belief about yourself can you take with you from this session? (Install with BLS)

Phase 8: Reevaluation
Special Considerations

- Install corrective life experiences life experiences that occur between sessions
- Treatment often needs skill building before processing stage, during, and after a target has been fully processed
- After reduction in state distress, important to explore trait difficulties

EMDR Protocol for Anger, Resentment And Revenge
Veerbeek, Herman (2014)
EMDR Europe Conference

- externalization problems
- maladaptive reactions for angry clients
- distancing
- judgmental
- lack of empathy and interest

restorative justice- the challenge with injustice is to forgive and forget

Internalization	Externalization
Helpless	Bitter
Panic	Explosion-"posttraumatic anger"
Self blame – feel like a victim	Blame others, hostility, urge to avenge
Anxiety, avoidance and submission	Anger, impulsiveness and aggression
Paralyzing	Energizing

Veerbeek, 2014

EMDR Protocol for Anger, Resentment, and Revenge
Veerbeek, Herman (2014)
EMDR Europe Conference

assumptions of the anger protocol

- anger, urges to revenge, revenge fantasies are normal symptoms of damaging experiences
- split generalized anger to those who were responsible- "focus on the person who has treated you wrongly"

EMDR Protocol for Anger, Resentment, And Revenge
Veerbeek, Herman (2014)
EMDR Europe Conference

The patient vents in an imaginary film all the bodily energy towards the person he/she is angry with.

The preliminary instructions to the client are:

- You are in the lead
- You are allowed to do everything your body wants to do
- You have to do it yourself
- You have to feel safe all the time

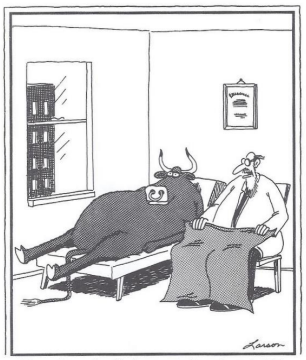
EMDR Protocol for Anger, Resentment, and Revenge
Veerbeek, Herman (2014)
EMDR Europe Conference

Procedure:

- Look in the eyes of the person,
- feel what your body wants to do, and
- do it (imagine doing it).

Continue with sets of BLS until reprocessed to adaptive resolution.

Old School Desensitization



"Now relax. ... Just like last week, I'm going to hold the cape up for the count of 10. ... When you start getting angry, I'll put it down."

Reasons for Managed Processing

- Time restraints
- Symptom reduction focus
- Triggers/Urges reduction
- Contracted agreement
- Limited affect management
- Complex trauma (bit by bit)
- Staying within the window

Contained Reprocessing

- Symptom Focused Targeting
  - Acute present stress
  - Present focus
  - Unwilling to address past
- History
  - Informed decision
- Preparation
  - Container, firewall, reprocessing resource
- Reprocessing
  - Hierarchy
    - Normal
    - Managed
    - Contained (Restricted)

Processing Management Range

- **Normal (EMDR):** free association- client attention goes wherever "the brain goes" and is encouraged by "*go with that*"
- **Contained/Managed (EMDr):** client attention is kept within clinically determine parameters
- **Restricted** (**EMD**): client attention is kept to original target

graphics by ©Roy Kiessling 2011

Normal (EMDR)

- Free association- client attention goes wherever "the brain goes" and is encouraged by "*go with that*"
- Standard 8 Phases and 3 Prong Processing
- Phase 4 Desensitization:

"Take a breath, let it go, what do you get now?"
"Go with that"

Restricted (EMD)

- Client attention is kept to original target
- Phase 4 Desensitization: (target & SUD)
  - *"Take a breath, let it go, when you think of _____ (target), how disturbing is it now from 0-10?"*
  - Every 3-4 sets: *"What are you noticing now about the incident?"*

Repeat until SUDs no long lowers

Contained/Managed (EMDr)

- Client attention is kept within clinically determined parameters of association
- Phase 4 Desensitization:
- After set, regardless of where their attention may have gone bring them back to target before next set.
  - *"Take a breath when you think of _____(the original target), what do you notice now?" If association is off target, say, "Bring up _____ (the original target), what do you notice not?*
  - Then, *Go with that."*
  - *Allow for more range tolerance for negative and adaptive associations.*
  - *Check SUDS frequently to assure that it is descending, If not, consider broadening the scope of associative material.*

Preparation

Discuss the associative process

Create resources for client to better focus their attention within agreed upon criteria.

- Container
- Firewall, drape, screen

Once processing starts, the therapist is responsible for managing the client's focus.

Telescopic Processing

- Determine target range
- Event, episode, or everything
- Expanding/contract the focus for strategic goals- adjust the range of information processing
- Point of disturbance
- Frequent back to target
- Frequent SUDs checks

Clinical Choice Points…

Clinical decisions informed by:

- Flexibility
- Knowledge of options
- Short term and long term goals
- Attunement to client
- Collaboration with client
- Intuition in the moment

DeTUR Protocol- A.J. Popky

Desensitization of Triggers and Urge Reprocessing

1. Rapport
2. History, Assessment
3. Support Resources
4. Accessing Internal Resource State
5. **Positive Treatment Goal**
6. **Associated Positive State**
7. **Identify Urge Triggers**
8. **Desensitize Triggers**
9. Install Positive State to each Trigger
10. Test and Future Check
11. Closure and Self Work
12. Follow up

DeTUR Protocol- A.J. Popky

Desensitization of Triggers and Urge Reprocessing

Desensitize Triggers

1. Positive Treatment Goal (PTG) established, triggers identified
2. Picture of trigger + words, sensation, emotions
3. Identify Level of Urge (LOU) (0-10)
4. Contained processing (what do you get now, frequent back to target, frequent LOU checks)
5. However, some tolerance of accessed negative material then diverting the standard EMDR
6. When LOU is 0, link and install with PTG
7. Follow up

Robert Miller, Ph.D.

- Treatment of Behavioral Addictions Using the Feeling-State Protocol: A Multiple Baseline Study. Journal of EMDR Practice and Research, Vol. 6, No. 4. pp 159-169.
- The Feeling –State Theory of Impulse-Control Disorders and the Impulse-Control Disorder Protocol- Traumatology 13 (3) 2-10, 2010.
- http://www.fsaprotocol.com

Feeling-State Theory of Behavioral and Substance Addictions

Robert Miller

Feeling-State + Triggering Event
creates urge for…

Desired Feeling + Compulsive Behavior

Target the linkage of the Feeling-State and the Compulsive Behavior

Important Points

• Once a feeling-state is created, the feeling-state can be activated by either internal or external factors.

• There is no specific association between any feeling and any behavior. Any feeling can become fixated with any behavior.

How Does Feeling-State Addiction Protocol Work?

The FSAP works by reprocessing the fixated linkage between feeling and behavior.

Once this fixation is broken, the person's behavior will be released from the compulsion

"…wanting to be non-prejudiced is not the same as being non-prejudiced."

Siri Carpenter "Buried Prejudice"
Scientific American Mind

Evolutionary and Developmental Role of Social Identity: Understanding the acquisition of patterns of prejudice (AIP consistent)

- **Action Systems-** Defense and Attachment systems are designed for survival. Sociability/Affiliation system emerges later in development.
- **Evolutionary benefit-** those seen as similar or having valuable attributes can be helpful, trusted, sought after. Others to be avoided.
- **Essential for all age groups** including infants to be able to sort people quickly.
- **Developmentally**, kids show a particularly strong interest in social categories and how they fit in at ages 7-11.

Information Processing

While highly attuned to in-group information processing, the social brain can be very ineffective at accurately processing experiences with out-group members.

Information Processing

"The mind tends to categorize environmental events in the grossest manner compatible with action."

Gordon Allport (1954)

Information Processing

Ingroups and Outgroups

People process information about "other" group members in different ways and in different parts of the brain than "in" group members.

Information Processing

Toward those perceived as in-group members, people tend to:

- Retain more detailed information
- Biased toward retaining positive information
- Remember ways in-group members are similar and outgroup members are dissimilar
- Be more forgiving

Information Processing

Toward those perceived as in-group members, people tend to:

- Show preference with reward allocations and esteem.
- Display more prosocial and cooperative behavior
- When there are limited resources, show greater generosity and more personal restraint.
- Create a decreased sense of psychological distance which facilitates the arousal of empathy.

Information Processing

People tend to:

- Encode undesirable actions of out-group members at a more abstract level (e.g. she is hostile vs. she slapped the girl)
- Encode desirable actions of out-group members at more concrete levels (e.g. she walked across the street holding the old man's hand vs. she is helpful)
- Attribute positive behaviors and successful outcomes to internal stable characteristics (the personality) of in-group than out-group members

Impact

- Outgroup stereotypes containing information pertaining to traits, dispositions or intentions are not likely to be influenced by casual observing of counter stereotypic outgroup behaviors.
- The use of pronouns like “we” and “they” alone can influence reactions to the associated matters.

Impact

- Individuals have difficulties due to seeing others through the outgroup lens *and/or* by being seen though the outgroup lens
- These cognitive biases help perpetuate social biases and stereotypes even in the face of countervailing evidence.
- Because positive behaviors of outgroup members are encoded on the concrete level, they *tend not to generalize* to reduce stereotypes. People don’t remember that an outgroup member was helpful, only that they did a helpful thing.

Impact of Prejudice on Wellbeing and Mental Health (Offenders)

Research Substantiated

- Prejudice impairs thinking and decision making
- Situational cues trigger prejudiced reactions increase prejudicial/ internalized response
- Prejudiced behaviors include withdrawal, avoidance, discounting, threatening, submission and can be reflected in ways as subtle as facial expressions
- Stereotypes can fuel and “justify” aggression (active or passive)
- Self-fulfilling prophecies- prejudiced responses reinforce and enhance prejudice

Desensitization (Impacting Automatic/Implicit Response-Amygdala)

Research supported

- Trying to overcome bias can lead to overcompensation and hence discrimination
- People motivated to be non-biased tend to avoid situations that might trigger bias response- reverse by rehearsal and behavioral goals
- Address fears of being seen as prejudiced

"Perspectives, affects and sensations are not ephemeral 'learned' reactions, they are manifestations of the stored memory and the reactions to them."

"Dysfunction persists because the negative networks are unable to link up with the more adaptive information. "

Francine Shapiro (2001)

Mindful Attention

Research supported

Mindful attention to good information reduces prejudice

Divine's model (1989) for breaking the bad habit of prejudice requires:

- Sustained effort
- Motivation to respond without bias
- Awareness that the stereotype has seen activated
- Cognitive resources (attention and working memory) to inhibit biased response tendencies with an intentional non-prejudiced response
- Awareness, motivation and ability are necessary to change responses

Resource and Perspective Building and Strengthening

(addressing control/explicit response- PFC)

Research supported

Strengthening PFC awareness will decrease stereotyping and increase regulating control over amygdala based reactivity.

Research shows that low –prejudice people must consciously "choose" to say "no" to prejudice to bring significant change.

Impact

- fMRI studies indicate that prejudiced reactions are linked to amygdala reactivity, as is trauma.
- EMDR is perfectly suited to reprocess the foundations of learned prejudice and internalized stigma/oppression

Early theory developed around prejudice by Gordon Allport (1954) defines prejudice as having the following four characteristics:

1. Negativity
2. Overgeneralization
3. Inaccuracy
4. Directed at others *(or at an aspect of the self)*

These components link to the four primary criteria for a negative cognition about the self as used in Phase 3 Assessment .

Prejudice is effectively an externalized Negative Cognition

Phase 1: Assessing Social identity, Internalized Social Stigma/Oppression and Prejudice

Prejudice

- Do you have any strong prejudices toward other people or types of people?
- How did you develop these beliefs?
- Do you see problems associated with having these prejudices?
- Do you want to better understand or change them?

Strong Beliefs about Society

- Do you have any strong beliefs about culture or society that you think are extreme, inflexible or problematic?

Targeting Hostile Attitudes and Prejudice

- Identify hostile belief/prejudice or object of hostility/prejudice
- Identify trigger image
- Identify E NC (externalized NC about target)
- Identify NC (about self)
- Complete assessment and reprocess
- Install PC (about the self)
- Identify and install a E PC (about object)
- Future Template related to the target issue

Mark Nickerson

Interpersonal Violence Triangle

Perpetrator

Ineffective
Observing other

Victim

The Meeting Area

"Dissociative Table"

- Including Ego states
- Employing the imagination
- Bringing parts of self to the meeting
- Ongoing or intermittent reference to the "parts of self"
- "Part of me thinks..."

Attachment Patterns

(Ainsworth, Blehar, Waters & Wall, 1978)

1. Secure Attachment
2. Insecure Attachment- Anxious/ Ambivalent
3. Insecure Attachment-Avoidant/ Dismissive
4. Disorganized Attachment (Main and Solomon, 1990)

Encoded in procedural memory, these patterns manifest as:

1. Proximity seeking
2. Social engagement behavior (smiling, movement toward, reaching out, eye contact
3. Defensive expressions (physical withdrawal , tension patterns, and hypo or hyper arousal)

Anger and Alcoholism

- "Alcoholic's cannot afford the luxury of righteous anger"
- "Resentment is like the kiss of death for alcoholics"
- "there's a lot of mad for one little thing"

AA sayings

Assessing and Addressing the Presence of Substance Abuse and Other Addictions

- High co-morbidity between substance abuse and anger/ hostility issues
- Alcohol use frequently involved with incidents of violent behavior
- Rage is self-stimulating
- Adrenalin rush is the drug

Domestic Violence: High Comorbidities

- PTSD
- Depression
- Substance abuse
- Relationship distress
- Impaired problem-solving skills

Research has begun to distinguish the unique contribution of PTSD over and above other related factors.

DSM IV- Hyperarousal Cluster of PTSD Symptoms
"irritability and angry outbursts."

Research

- Combat veterans with PTSD display higher levels of anger than do non-PTSD combat veterans

Novaco & Chemtob (2002)

Positive correlation between the severity of PTSD symptoms and the risk for perpetrating partner violence

Orcutt, King, & King (2003)

Anger Avoidance

Problematic when one loses the element of choice or can't access normal emotions (Can lead to passive aggressive behavior)

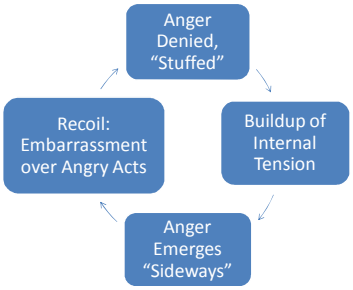
Blocking beliefs about anger (e.g.):
- Anger is bad, dangerous, immoral
- Conflict is never safe, safety means avoiding anger

If I am angry, I _____ (will hurt others, get hurt, be a bad person, be selfish, etc.)

Look for cultural messages:
- Women- Anger is not ladylike
- Men- If angry, I will hurt someone, misuse my power

Look for beliefs of different ego states

Angrily Avoiding Anger



Self- Directed Anger and Violence

- Ego state understanding of self directed anger and violence
- Internalized stigma/oppression
- Self- harm
- Considerations in assessing suicidal risk

Other Issues and Populations

- Road Rage and short-fused blow-ups
- Parent to child anger, abuse
- Bullying (e.g. Workplace)
- Teenagers
- High conflict divorce