Cycle Model and more for Problematic Anger and Related Behaviors

The following sequence is specifically recommended for trauma-informed EMDR treatment for problematic anger and related behaviors. Steps 1-14 should be adequately addressed before moving to trauma reprocessing.

1. Identify and assess the issue of problematic anger, hostility and related behaviors.
2. Take appropriate general history.
3. Use Cycle Model for further understanding of problem dynamics.
4. Use Truck Check List to assess and guide early treatment issue identification.
5. Build client motivation to change patterns of problematic anger/behavior.
6. Use the window of optimal activation diagram to understand dysregulation.
7. Use the cycle model to identify patterns of angry and violent behavior.
8. Acknowledge that effective skills can be learned during the "life as usual" phase of the cycle however the first priority for change is to stop escalating angry and violent behaviors.
9. Ongoing review of skills needed.
10. Identify client triggers with the aid of "Red Flag High Risk Challenges."
11. Identify with client "Red Flag Warning Signs."
12. Discuss Time-Out/ Time-In procedure.
13. Complete the Time-Out/ Time-In Rehearsal Protocol.
14. In future sessions, review the occurrence of triggering situations and the use of the Time-Out/ Time-In procedure.
15. Strategically identify targets for reprocessing.
16. Reprocesses targets.
17. Reevaluate treatment progress and modify as needed.

The Cycle Model:
A Guide for History Taking and Treatment Planning for Treating Problem Behaviors
(Mark Nickerson revised © 2015)

Step 1: Establish the problem behavior of concern to the client (e.g. compulsive/addictive behaviors, angry/destructive behaviors, relational reenactments, avoidance, etc.)

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

Use the Cycle Model diagram and the following questions as a guide to help the client identify and reflect upon their past experiences as related to the recurrent problematic behavior. The goal is to help the client safely recall and reflect upon past experiences. The client can review a recent or highly significant incident/episode of the problem behavior or discuss more general patterns, or a mixture of both. Open-ended questions allow the clinician to implement this flexibly. This assessment can be implemented slowly allowing plenty of time for related discussions. It can also be used as a quick means to gain initial information to be explored in subsequent sessions.

Indentifying the problem behavior

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

Using this Cycle diagram, I am going to describe the common phases of a recurrent problem behavior. The Cycle Model can help you better understanding your experience. After I explain the cycle, I'll ask questions about your experience at various phases in the cycle. We'll be looking to gain insight into this problem so that we can plan strategies to break the cycle and help you change the problem behavior. (Explain cycle using diagram.)

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 were 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?* (With direct questioning or the float back technique, this question is designed to help the client make links from current triggers to past events.)

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. At those times: What have you done? What have you thought? What emotions have you experienced? What physiological reactions have you had?*

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 reinforcement 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?*

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 (as in DeTUR protocol)

Now that we better understand the problem behavior, let's establish a 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 (e.g., three months, six months, one year) and describe what would be different. Be as specific as possible. Install Positive Treatment Goal (multiple sets of BLS to reach maximum strength)

The time frame should be far enough away that the client can accomplish the desired change but not so far as to seem too remote. The Positive Treatment Goal (PTG) goal should be a significant and meaningful stretch from how the client's life is currently but not unrealistic. The PTG should increase the clarity of their vision of change and have a magnetic appeal so as to increase motivation to make the necessary changes. The specifics of the goal provide direction and focus. The PTG is the light at the end of the tunnel and illuminates the gaps between how the client is doing now and how they would like to be in the future. This awareness can be used to create a pathway to the goal including to identify the obstacles to be addressed.

Step 4: Identifying Pathways and Obstacles

Next, collaborate with the client to determine treatment strategies:

Case formulation should combine information from the Cycle Model assessment with a more broad clinical assessment including other treatment goals.

To determine treatment priorities including the sequence of intervention steps, the clinician should think flexibly and balance factors such as:

Orienting with the PTG, clinician and client:

- review information from Cycle Assessment
- identify gaps between current state and PTG
- assess client strengths/ resources/ motivation
- formulate and prioritize treatment priorities and sequences
- reevaluate and revise treatment plan as needed

Decisions about sequencing of interventions and 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 stabilizing/destabilizing the client
- "bang for the buck"-what might bring the biggest gain

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

Options: The following are strategies that can address problems at each particular phase of the cycle. They are listed in order of sequence on the cycle model chart, not the order that may be the best clinical strategy.

Incident aftermath

- **Target and reprocess** memories from the aftermath. Reprocessing the aftermath can reduce the phobic denial or minimization of the incident and therefore increase client awareness, support learning and increase motivation for change. Ask, *What were the worst consequences of the incident?* (reprocess)

Recovery

- Identify ways client recovers after an episode. **Support effective coping and build skills as needed.** Use reinforcing, rescripting and rehearsing protocols.

Moving forward

- Identify and **strengthen core resources**. Develop additional resources as needed to increase capacity to face and resolve difficulties (personal qualities, positive beliefs about self, etc.)
- **Identify unmet needs** that have been dysfunctionally coped with through the problem behavior. **Build skills and develop ways to adaptively meet unmet needs**. Use reinforcing, rescripting and rehearsing protocols.

Tension Building Phase: Preexisting Conditions, Triggers, Warning Signs, Urges and Past Trauma

- Identify **Preexisting Conditions** such as emotional moods, mindsets, or physiological conditions that create a vulnerability to being triggered. (Use Red Flag Trigger worksheet for times and topics)
- Identify **Triggers** that ignite the tension building phase
- Identify **Warning Signs** that client has been triggered. Use Red Flag warnings worksheet Increase client awareness.
- Develop an **Alternative Action Plan** to more adaptively cope with **Warning Signs**. Rehearse alternative strategies with BLS. Develop resources as needed to increase strength of the alternative plan (personal qualities, positive beliefs about self, new skills, etc.)
- Target and desensitize **Triggers and Urges/Yearnings/Cravings** with EMD (such as DeTUR) or EMDR

Positive attraction of the problem behavior

- Target the apparently rewarding aspect of the problem behavior to uncouple the link between a genuine need and the currently dysfunctional behavior. Use "What's good

about the behavior?" with BLS to dislodge. Or, as needed use Feeling State Addiction Protocol.

Reprocess trauma:

- Identify past **Traumatic or Disturbing Life Experiences** that are linked to triggers and preexisting conditions. Strategically prioritize targets for reprocessing. Standard EMDR with managed processing considerations.
- Reprocess traumatic memories from incidents related to problem behavior

Ongoing:

Monitor Behavior

- Treatment should continue to review progress toward PTG even if other treatment issues emerge.
- Continue progression through most appropriate intervention strategies

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Summary Sheet

Assessment information (gather from Cycle Model Interview):

1. Problem behavior

2. Past incidents

3. Consequences

4. Normal capacity/strengths

5. Resourcing needed

6. Skills needed

7. Alternative actions/solutions desired

8. Vulnerable times

9. Triggers and Warning signs

10. Past trauma

11. Maladaptively linked desired feeling-states

12. Motivation

Intervention Options (built from information in initial assessment)

Positive Treatment Goal (establish and strengthen)

Step 4: Identifying Pathways and Obstacles

Target incident aftermath

Identify adaptive and maladaptive recovery strategies. Build on adaptive.

Moving forward

- Strengthen core resources.
- Identify unmet needs
- Build skills and develop ways to adaptively meet unmet needs.
- (Truck metaphor checklist for resources needed)
- Strengthen with reinforcing, rescripting and rehearsing protocols

Tension Building Phase:

Expanded Identification of Preexisting Conditions, Triggers, Warning Signs, Urges and Past Trauma (Use Red Flag worksheets)

- Identify Preexisting Conditions
- Identify Triggers that ignite the tension building phase
- Identify Warning Signs that client has been triggered.

Develop an Alternative Action Plan to more adaptively cope with Warning Signs.

- Strengthen with reinforcing, rescripting and rehearsing protocols

Target and reprocess:

- Triggers and Urges/Yearnings/Cravings with EMD (such as DeTUR) or EMDR
- Positive attraction of the problem behavior. Use "What's good about the behavior?" to dislodge the maladaptive link, focused EMD, or FSAP
- Urges and cravings with EMDR
- Traumatic or Disturbing life experiences that are linked to triggers and preexisting conditions.

Ongoing: Monitor Behavior- review progress toward PTG

Time-Out/ Time-In Procedure

Overview: Taking a "Time-Out" is a time honored strategy to stop the escalation of “out of control” feelings and problematic behavior. Essentially, the goal of a Time-Out is for the upset person to pull back from the situation, settle down, and return to a higher level of functioning. In more psychological language, the technique is used to help manage dysregulated emotional states. Hyperaroused states often include high levels of emotion, distorted thinking, physiological agitation and behavioral reactivity. During these times, normal judgment is impaired and difficulties typically get worse. The "window of optimal activation" diagram can be a helpful aid in understanding this concept. In a state of hyperarousal the limbic system activates the production of adrenaline and cortisol which fuel a person’s escalation into a *flight* or *fight* response.

Used appropriately, a Time-Out allows a person to redirect their attention toward de-escalating their nervous system, returning them within window of effective functioning. Once in the window, a person usually gains a fresh perspective about the situation that had triggered their dysregulated state.

During a time of high reactivity, a person is at risk of acting out old patterns of problematic behavior. Typically the escalating person is externalizing the "locus of control" of the problem and believes that they will only feel better if something outside of them changes. However, changing others is often beyond their control. Although the whole situation may seem out of control, *self-control* is usually the first constructive step toward improving the situation. The Time-Out/Time-In procedure is a guide to self-control.

Taking a Time-Out/ Time-In is a two step process. The **Time-Out phase** involves retreating from the trigger. The **Time-In phase** is an added step to the traditional Time-Out model and addresses the common problem in which a person pulls away from the triggering situation yet is still preoccupied by it. During the **Time-In phase** the person turns their attention inward to a self-stabilizing strategy.

Within the field of anger management and violence prevention, the Time-Out has been a fundamental skill to master in early phases of treatment. The Cycle Model diagram and questions can helps identify the cycle phases of angry and violent acting out. Once a person understands their cyclic patterns and demonstrates motivation to change, particular skills and strategies can be learned to break the cycle.

The Time-Out/Time-In procedure should be used consistently when an individual has been triggered to a state they can't easily manage.

Time-Out/ Time-In procedure (therapist guided):

Therapist reads/paraphrases to client: *As we have discussed, it is importance to begin immediately to maintain safe behavior despite strong emotions or urges to act out with anger. Taking a Time-Out/ Time-In is a proven technique to regain personal control and restore safety to an escalating situation. Current understandings of brain and body functioning support this technique as it is now known that once a person is sufficiently triggered, hormones are activated to prepare a person for a "flight or fight" response. Once activated, the blood flow moves to our heart, lungs and muscles to protect ourselves. Unfortunately, the blood flow to the part of the brain that thinks clearly is reduced. So as your anger and adrenalin level increases, your intelligence drops! After a Time-Out/ Time-In, you regain personal control and return to your better judgment and can make better choices. You can always communicate and resolve conflict better in that recovered state.*

Because triggers can be so powerful, it is important to have planned and rehearsed your Time-Out/ Time-In procedure so that it can be remembered and executed instantly when needed.

Time-Out/ Time-In steps:

(These general instructions can be read/paraphrased to the client or modified to suit the situation)

1. *We have determined some of 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, and 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 a direction 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 and visualizations or by contacting others who can be supportive to the process of helping you come back into yourself safely.*
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 composed, you can offer to return to an activity or discussion that was interrupted by the Time-Out/ Time-In. If you or the other person are not ready, arrange for more Time-Out/ Time-In and suspend the activity/discussion for later.*

Additional considerations:

- Review this Time-Out/ Time-In procedure in advance with your partner, family members or others who will be involved. If appropriate, offer them the same option. Be sure to clarify with them the purpose of this is to build safety in the relationship so that challenging issues can be handled with less difficulty in the future. It is not a plan to permanently avoid issues.
- This procedure can be adapted to fit a variety of experiences. For example, in a workplace where a person may not feel it appropriate to request a Time-Out/ Time-In, he/she might exit appropriately. In a school setting, a student will have to gain permission from the appropriate staff. With milder irritation, a person may simply move away from a topic or situation until they are more emotionally balanced. However, if there is an established problem with anger/violence, the full Time-Out/ Time-In should be mastered first before learning to discriminate "lesser triggers".
- With couples and families: A therapist can help negotiate a Time-Out/Time-In plan with a partner or other family members. Ideally, this can be done with all parties present. A person need not be the "angriest person in the room" to ask for a Time-Out. As long as a person is triggered or perceives an escalating situation in another person that gives them credible reason for concern, a Time-Out can be called with the simple language, "I'm feeling upset, I need to take a Time-Out, and I'll get back to you in an hour (or other appropriate time frame)."
- Getting back to the other person. Often implementing a Time-Out meets resistance from a person who feels abandoned when the Time-Out is requested. They need reassurance that avoiding the issue or the relationship is not the purpose of this strategy. Quite the opposite, it is designed to maintain safety so that there can be more meaningful communication and intimacy in the relationship.
- To keep the responsibility in the hands of the person who took the Time-Out, they should make every effort to reengage a suspended topic of discussion within 24 hours. After that time, the other person, who has been patient enough, has permission to check-in with the person who took the Time-Out and ask if the topic can now be constructively discussed.

During a Time-Out/Time-In

- Don't dissipate activated angry energy by escalating anger to "get it out".
- Don't drive dangerously.
- Don't drink or use substances to manage your feelings.

Time-Out/ Time-In Rehearsal Protocol (Clinician guided- clinician instructions in italics):

1. *Is it your goal to manage triggering situations by responding safely? Why? How will it benefit you? Be as specific as possible.* (When specifics are fully accessed, install with BLS).
2. *Do you have a grounding strategy?* (Calm/safe place, relaxation strategies). If not, establish grounding strategies/resources.
3. *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).
4. *I want you to imagine a potential upcoming triggering situation.* (If difficult, use a past triggering situation)
5. *Silently, closing your eyes can be helpful, visualize every step of your Time-Out/Time-In plan including all the steps mentioned in the Time-Out/Time-In description. 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.*
6. *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)
7. (Continue to modify and perfect the plan until solid) (BLS)
8. I'd like you to hold the image of your successful plan, and pinch the knuckles of one hand with the fingers from the other to create a "body anchor" sensation to remind you of your plan. (Install with BLS).
9. It is important that you use this plan consistently between sessions. The first time will likely be the hardest. You can use the T body anchor sensation to remind you of the plan.
10. 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.

(Follow up session: Review practice Time-Out/ Time-Ins. Review any actual Time-Out/ Time-Ins. Make modifications as needed).

Scripted EMDR Protocol for Targeting Prejudice and Hostile Externalized Beliefs

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Phase 2: Preparation (if needed)

- Normal preparation as needed.
- Consider reprocessing prior memories of being the target of discrimination. This builds adaptive empathy and realizations that can assist the prejudice reprocessing.
- *What is a personal quality of yours that will help you address this prejudice (e.g. open-mindedness, sense of fairness, curiosity)? Can you think of a time in your life where you had this quality?* Access memory and enhance with bilateral stimulation (BLS).

Target selection: Identify prejudice. *What is the prejudice (stereotype, hostile belief) you would like to reprocess today?*

What prejudice would you like to address?

_____

_____

Phase 3: Assessment

Picture/ image: *What memory/thought related to the subject of the prejudice evokes the strongest reaction? What specific picture comes to mind?*

_____

_____

Externalized Negative Cognition (ENC): Negative Cognition: *What words go with that picture that best describe your negative belief about the subject of the prejudice <u>now</u>?*

_____

Negative cognition (about self): *What words go with that picture and that belief (repeat ENC) about the subject of the ENC that best describe your negative belief about yourself now?*

_____

Positive Cognition: *When you bring up that picture, what would you prefer to believe about yourself instead?*

VoC: *When you think of at that picture/image/incident, how true do those words (Repeat PC about the other from above) feel to you now on a scale from 1 to 7 where I feels totally false and 7 feels totally true?*

1 2 3 4 5 6 7

Emotions: *When you bring up that picture and those words (Repeat the NC), what emotion(s) do you feel now?*

SUDs: *On a scale of 0-1 0, where 0 is no disturbance or neutral, and 10 is the highest disturbance you can imagine, how disturbing does the incident feel to you now?*

1 2 3 4 5 6 7 8 9 10

Body: *Where do you feel it in your body?*

Phase 4: Desensitization and Reprocessing

Proceed to reprocess with normal procedures. If a recent memory, consider a float back to earlier memories.

If SUDS moves to zero or one, proceed to installation.

Installation:

Positive Cognition: *When you bring up the original subject of the prejudice, do the words "repeat the original PC" still fit, or is there another positive statement you feel would be more suitable?*

Assess VoC (1-7), *Hold the PC and the subject together*. Sets of BLS to strengthen.

1 2 3 4 5 6 7

Administer BLS to strengthen PC to most adaptive resolution

Do not complete Body Scan yet.

Evaluate Externalized Negative Cognition: *From 0 (completely false) to 5 (completely true), how true do the negative words about the subject of the disturbance (repeat original ENC) feel now?*

0 1 2 3 4 5

If 1 or 2, apply BLS to see if negativity comes to zero or ecologically correct. The clinician should look for generalized or exaggerated nature of the negativity to dissipate. Sometimes there is some truth to a belief. Proceed to installation of a positive cognition related to the original subject.

If over 2, look for another memory target that is linked to the continued externalized negative belief.

Externalized Positive Cognition (EPC): *When you bring up the original subject of the prejudice, what positive or neutral words describe a revised belief that you now hold about the subject of the original prejudice?*

VoC: *Think about the subject, and those words (Repeat PC from above). From 1 (completely false) to 7 (completely true), how true do they feel?*

1 2 3 4 5 6 7

Hold them together. Administer BLS. Continue to strengthen to most adaptive resolution.

Perform Body Scan

Closure: If session is incomplete, get SUDS of original and current target.

1 2 3 4 5 6 7 8 9 10

Whether desensitization was complete or not, consider returning to the original target and identify a temporary fitting self- related PC and externally- related PC. Install. The purpose of this is to assure an improved belief toward the targeted issue as the session ends in the event that the client will be interacting with the target of the negative belief.

Create closure and containment.

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