**TREATING INDIVIDUALS WITH ANGER-CONTROL PROBLEMS AND AGGRESSIVE BEHAVIORS**

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**BY WAY OF INTRODUCTION:  MELISSA INSTITUTE RESOURCES**

Don Meichenbaum's Books

Treatment of individuals with anger-control problems and aggressive behaviors: A clinical handbook (Available on Amazon)

Treating individuals with addictive disorders: A strengths-based workbook for patients and clinicians (Routledge Publishers)

Evolution of Cognitive behavior therapy: A personal and professional journey with Don Meichenbaum (Routledge Publishers)

Roadmap to resilience Available for FREE roadmaptoresilience.wordpress.com

**FOR ADDTIONAL PAPERS VISIT** www.melissainstitute.org CLICK Resilience Resources SCROLL TO:

How to make an aggressive and violent youth: Implications for interventions

Comparison of aggression in boys versus girls

Family violence: Treatment of perpetrators and victims

How to identify a potential mass shooter

Ways to implement interventions in schools to make them safer: A Toolkit for School safety

  Stress inoculation training

Anger management and Bystander Intervention course

**ALSO SEE PRESENTATIONS BY**

Leena Augimeri / Collen Cicchetti  /Jim Larson /  Deb Peplar / Ron Slaby/ Erv Staub

**CONFINED BY VIOLENCE**

10 year Old Chicago Boy

I want to go outside and play, but I can't

Not because it is a rainy day

It is to avoid the gunshots that may come my way

I want to go outside and play, but I can't

Not because I have no bike to ride

It's because my mom fears

I'll be another victim of a senseless homicide

I want to go outside and play, but I can't

Not because it's after hours, or even that it 's way too dark

It's because of the gunshots that occur in my neighborhood park

I want to go outside and play, but I can't

Not because I have no friends

It's because of the violence that never ends

I want to go outside and play, but I can't

Not because I don't deserve it

There this thing called life and I am just trying to preserve it

**FACE SHEET ABOUT ANGER AND AGGRESSION: IMPLICATIONS FOR INTERVENTIONS**

The experience of feeling and becoming angry is quite common in the normal population (22 x a week).  What distinguishes high and low angry individuals is NOT the types or number of particular events that they are exposed to, but the beliefs and emotional meanings that the individual holds.

 To what degree does the emotional part of the brain (amygdala and related areas) HIJACK the Frontal lobe (Executive self-regulatory part of the brain). It is not that someone becomes angry, it is what one does with the anger that is critical.

Anger can have both positive and negative consequences, such as contributing to social change or to negative physiological, behavioral and social consequences.

To get from anger to aggression usually requires an attribution of intentionality (an accusatory response) and a sense that one's reactions are justified.

There are two major types of aggression, namely reactive and instrumental and sometimes the combination of both. One can draw distinction between State anger and Trait anger.

Aggressive behavior is relatively stable from early childhood through adolescence into adulthood. (About as stable as your IQ). Thus, aggressive behaviors are fairly predictable which has major implications for the prevention of partner abuse.

Both a Social information processing and a cognitive behavioral constructive narrative perspective have been offered to explain the development of aggressive behaviors.

Boys and girls differ in the factors that contribute to the development of aggression that has important implications for gender-specific interventions.

A variety of factors contribute to and can exacerbate the development and the intensity of aggressive and violent behaviors including the use of substances like alcohol , stress, neighborhood and cultural factors, the ready availability of guns, developmental factors like prior victimization, and co-occurring disorders like depression, substance abuse, anti-social personality disorders and Traumatic brain injuries.

There is a complex relationship between Mental health disorders and the use of aggressive violent behaviors.

Cognitive behavior therapy procedures such as Stress inoculation training have proven effective in treating aggressive children, adolescents and adults. The quality of the Therapeutic alliance is the best predictor of treatment outcomes. When employing Group therapy, the level of group coherence is the best predictor of the treatment outcomes.

**DEVELOPMENTAL PATHWAYS TO AGGRESSION: A CASCADING MODEL**

1. A high-risk intrauterine environment

2. Born with a difficult temperament that challenges parents, that can be exacerbated by the presence of a depressed mother and a substance abusing father

3.   Recipient of Adverse Childhood Experiences and the absence of compensatory protective buffering factors

4   Poor school readiness skills, especially language deficits (low vocabulary ability)

5   Development of ADHD, Conduct Disorders, Oppositional and callous behaviors

6 Discipline problems in school (engage in bullying behaviors) and peer association with similar youth

7. Harsh parenting and low parent monitoring and inadequate parent involvement with academic performance

8. Early use of substances and living in a High -risk environment

9 Recipient of interventions that increase the likelihood of aggressive behavior

10 Involvement with juvenile justice system

**A CASE CONCEPTUALIZATION MODEL (CCM)**

 A well-formulated CCM should:

1. identify developmental, precipitating and maintaining factors that contribute to maladaptive, mental health and substance-abusing behaviors and adjustment difficulties and that reduce the quality of life;

2.  provide direction to both assessment and treatment decision-making;

3. provide information about developmental, familial, contextual risk and protective factors;

4. highlight cultural, racial, religious and gender-specific risk and protective factors;

5. identify individual, social and cultural strengths that can be incorporated into treatment decision-making;

6. provide a means to collaboratively establish the short-term, intermediate and long-term goals and the means by which to achieve them;

7. identify, anticipate and address potential individual, social and systemic barriers that may interfere with and undermine treatment long-term effectiveness;

8. provide a means to assess on a session-by-session basis the patient's progress and the quality of the therapeutic alliance on a regular basis;

9.  consider how each of these treatment objectives need to be altered in a culturally, racially and gender sensitive fashion;

10.engender and bolster a high empathy therapeutic alliance, and one that nurtures hope in both the patient and the treatment team.

**GENERIC CASE CONCEPTUALIZATION MODEL**

**1A. Background**

**Information**

**1B. Reasons for Referral**

**2A. Presenting Problems**

**(Symptomatic functioning)**

**2B. Level of Functioning**

**(Interpersonal problems,**

**Social role performance)**

**9. Barriers**

**9A. Individual**

**9B. Social**

**9C. Systemic**

**8. Outcomes (GAS)**

**8A. Short-term**

**8B. Intermediate**

**8C. Long term**

**3. Comorbidity**

**3A. Axis I**

**3B. Axis II**

**3C. Axis III**

**3D. Impact**

**4. Stressors  
(Present / Past)**

**4A. Current**

**4B. Ecological**

**4C. Developmental**

**4D. Familial**

**7. Summary of Risk and Protective Factors**

**5. Treatments Received**

**(Current / Past)**

**5A. Efficacy**

**5B. Adherence**

**5C. Satisfaction**

**6. Strengths**

**6A. Individual**

**6B. Social**

**6C. Systemic**

**FEEDBACK SHEET ON CASE CONCEPTUALIZATION**

Let me see **if I understand:**

**BOXES 1& 2: REFERRAL SOURCES AND BOX 7: SUMMARY OF RISK AND**

**PRESENTING PROBLEMS PROTECTIVE FACTORS**

**“What brings you here...? (distress, symptoms, “Have I captured what you were saying?”**

**present and in the past) (Summarize risk and protective factors)**

**“And is it particularly bad when...” “But it tends “Of these different areas, where do you think we**

**to improve when you...” should begin?” (Collaborate and negotiate with**

**“And how is it affecting you (in terms of the patient a treatment plan. Do not become a**

**relationship, work, etc.)” “surrogate frontal lobe” for the patient)**

**BOX 3: COMORBIDITY BOX 8: OUTCOMES (GOAL ATTAINMENT**

**SCALING PROCEDURES)**

**“In addition, you are also experiencing (struggling**

**with)...” “Let's consider what are your expectations about the**

**“And the impact of this in terms of your day-to-day treatment. As a result of our working together,**

**experience is...” what would you like to see change (in the short-**

**term)?**

**BOX 4: STRESSORS “How are things now in your life? How would you**

**like them to be? How can we work together to**

**“Some of the factors (stresses) that you are currently help you achieve these short-term, intermediate**

**experiencing that seem to maintain your problems and long-term goals?”**

**are...or that seem to exacerbate (make worse) “What has worked for you in the past?”**

**are... (Current/ecological stressors) “How can our current efforts be informed by your**

**“And it's not only now, but this has been going on for past experience?”**

**some time, as evident by...” (Developmental “Moreover, if you achieve your goals, what would**

**stressors) you see changed?”**

**“And it's not only something you have experienced, “Who else would notice these changes?”  
 but your family members have also been**

**experiencing (struggling with)...” “And the BOX 9: POSSIBLE BARRIERS**

**impact on you has been...” (Familial stressors**

**and familial psychopathology) “Let me raise one last question, if I may. Can you  
 envision, can you foresee, anything that might**

**BOX 5: TREATMENT RECEIVED get in the way- any possible obstacles or**

**barriers to your achieving your treatment**

**“For these problems the treatments that you have goals?”**

**received were-note type, time, by whom” (Consider with the patient possible individual, social**

**“And what was most effective (worked best) was... and systemic barriers Do not address the**

**as evident by... potential barriers until some hope and resources**

**“But you had difficulty following through with the have been addressed and documented.)**

**treatment as evident by...” (Obtain an “Let's consider how we can anticipate, plan for, and**

**adherence history) address these potential barriers.”**

**“And some of the difficulties (barriers) in following “Let us review once again...” (Go back over the**

**the treatment were...” Case Conceptualization and have the patient put**

**“But you were specifically satisfied with...and would the treatment plan in his/her own words.**

**recommend or consider...” Involve significant others in the Case**

**Conceptualization Model and treatment**

**BOX 6: STRENGTHS plan. Solicit their input and feedback.**

**Reassess with the patient the treatment plan**

**“But in spite of...you have been able to...” throughout treatment. Keep track of your**

**“Some of the strengths (signs of resilience) that you treatment interventions using the coded**

**have evidenced or that you bring to the present activities (2A, 3B, 5B, 4C, 6B, etc.) Maintain**

**situation are...” progress notes and share these with the patient**

**“Moreover, some of the people (resources) you can and with other members of the treatment team.**

**call upon (access)are...” “And they can be**

**helpful by doing...” (Social supports)**

**“And some of the services you can access are...”**

**(Systemic resources)**

**GENERAL QUESTIONS**

***How are things now and how would you like them to be?***

***What can we do to help you achieve what you want to have happen?***

***What have you tried in the past? I want our current efforts to be informed by what you have already tried? What has worked? What has not worked?***

***How could you tell if it was working?***

***What difficulties, if any, did you have in trying to change? (Get what you wanted?) How did you handle these difficulties (obstacles, barriers)?***

***If we work together, and I hope we do, how could we tell whether you are making progress? What specific changes should we expect to see? Who else would notice that you are changing? What would they see?***

***What obstacles or difficulties might you encounter (or likely experience) in seeking your goals? How might you anticipate or handle these obstacles should they arise?***

***What will you need to do or have happen in order for you to maintain these changes?***

**QUESTIONS DESIGNED TO ELICIT STRENGTHS**

***What do you see as your own personal strengths or abilities?***

***What things about yourself are you most proud of?***

***What do other people say are your positive qualities?***

***What do they say are the positive qualities of your community?***

***How have you used your personal strengths and abilities to achieve goals or deal with challenges in the past?***

***How do you think you could use your strengths to help you achieve your current goals?***

***What are things that give you hope that things can change for the better?***

***Where does this leave you in terms of your X (drinking)? What is your plan?***

***How do you think you might be able to do X? What else can you try? What might get in the way of your doing X?***

***You would have to be pretty creative (strong, clever, resourceful) to find a way around that. I wonder how you could do it?***

***Let me see if I understand where you are…***

***Let me see if I understand what you are committing yourself to doing?***

***So, some benefits of making a change are…and some of the consequences of inaction are…Is that the way you see it?***

***Does this make sense to you?***

***So, you are telling me, and telling yourself, that you will be (were) able to… That’s impressive. How did you handle it this time compared to how you handled it in the past? Where else did you do X (resist social pressure to drink)? How did that make you feel? Are you saying to me, saying to yourself, that you were able to “notice, catch, interrupt, use your game plan, resist” etc. (therapist/trainer should use active transitive verbs)? What does this tell you about yourself and about your ability to achieve your goals?***

**"DANGER SIGNS" OF VIOLENCE POTENTIAL IN PROSPECTIVE PARTNER (VPPP)**

**I. Characteristics of Prospective Partner**

* Evidences aggressive behavior
* Current trouble with the law
* Evidences substance abusing behaviors (e.g. binge drinking)
* Poor response to high stress. Attacks others or withdraws
* Is depressed (feels helpless, hopeless)
* Has difficulty using words to express concerns / needs and difficulty resolving conflicts
* Availability of a weapon and preoccupied with violent media

**II. Developmental Indicators**

* History of aggressive behavior toward others or toward self
* Poor academic achievement
* History of substance abuse
* History of psychiatric disorders
* Exposed to harsh discipline, father absent, mother inconsistent and demanding
* Exposed to harsh discipline
* Absence of positive ethnic identification

**III. Relationship Behaviors**

* Demanding, controlling, jealous, suspicious, dependent
* Uses “put downs” and is argumentative. Adversarial negative reciprocal interactions
* Holds rigid gender stereotypes
* Wants things his way – exaggerated self-entitlement
* Poor current relationships with family members, peers, coworkers, authority figures

**IV. Family indicators**

* Countless family conflict and violence
* Recipient of harsh punishment
* Absence or loss of family support

**V. Community Indicators**

* Aggression and violence condoned in both the past and the present
* Exposed to community violence
* Lack of resources to stop violence, nor support for victims of violence

**CHECKLIST OF THERAPY BEHAVIORS DESIGNED TO FACILITATE THE THERAPEUTIC ALLIANCE**

**TAKE AWAYS**

The quality of the therapeutic alliance is the most robust predictor of treatment outcomes. It is the therapist and NOT the specific treatment that influences the amount of therapeutic change that occurs. The interpersonal clinical skills of the therapist is 3 to 4 X more significant in predicting treatment outcomes.

 An effective therapeutic Alliance (TA) consists of three elements:

a)  a positive affective bond between the therapist and the client

b)  a mutually agreed upon set of treatment goals between the client and the therapist

c)  a mutually agreed upon ways of achieving the client's goals ("pathways thinking" that are realistically optimistic)

An effective therapeutic alliance may develop as early as the first session, but an effective TA must be firmly in place by the third session if treatment is to be successful.  For example, consider the treatment effectiveness of Single Session Therapy (Hoyt, 2021).

Evidence-based treatments are protocol driven. The most effective therapists adapt the treatment to their client's needs and preferences.

1.  Accurate empathy is a foundational skill, whereby the therapist tunes into the inner

experiences of his/her client in an emotionally attuned manner (Miller & Moyers, 2021). Carl Rogers noted, and his students Truax and Carkhuff (1976),  demonstrated ,that an accepting, warm, genuine, compassionate positive regard  fosters behavior change.

1. Convey respect, warmth, compassion, support, empathy, a caring attitude and interest in helping. Be non-judgmental. Listen actively and attentively, and let your patient know you are listening so he or she feels understood.
2. Convey a relaxed confidence that help can be provided and a sense of realistic optimism, but not false hope. Communicate a positive expectancy of the possibility of change. Use phrases like, “As yet”; “So far” and “RE” verbs such as RE-frame, RE-author, RE-engage). Emphasize that your patient can be helped, but it will require effort on both of your parts.
3. Validate and normalize the patient’s feelings. (***“Given what you have been through, I would be deeply concerned, if at times you were not feeling overwhelmed and depressed”***).
4. Use guided discovery and Socratic Questioning. Use “How” and “What” questions. Stimulate the patient’s curiosity, so he/she can become his/her own “therapist”, “emotional detective”.
5. Enter the narrative text of the patient, using his/her metaphors. Assess the “rest of the patient’s story” and collaboratively discover what the patient did and was able to achieve in spite of traumatic/victimizing experiences. ***“You have what you need to do to change and together we are going to find it.”***
6. Explore the patient’s lay explanations of his or her problems and his or her expectations concerning treatment. Collaboratively establish “SMART” therapy goals (Specific/Measurable. Achievable, Realistic, and Time-limited). Use motivational Interviewing Procedures of focusing on the client's ambivalence about changing.  The therapist should evoke and affirm the client's CHANGE TALK and work to reduce the client's status quo SUSTAIN TALK.
7. Model a style of thinking. Ask the patient, “**Do you ever find yourself in your day to day experiences, asking yourself the same kind of questions that we ask each other here in therapy?”** The therapists should convey CURIOUSITY that nurtures the client's self -reflection. The therapist needs to model a style of thinking.
8. Encourage the patient to self-monitor (collect data) so that he/she can better appreciate the interconnectedness between feelings, thoughts, behaviors and resultant consequences, and perhaps, inadvertently, unwittingly, and unknowingly behave in ways that may maintain and exacerbate presenting problems (e.g., avoidance behaviors reinforce PTSD symptoms).
9. Conduct a pros and cons analysis and help the patient to break the behavioral “vicious cycle.” (recognize behavioral patterns, collect data)
10. Address any Therapy Interfering Behaviors and potential barriers. Solicit patient commitment statements. Play “devil’s advocate.”
11. Provide intermediate summaries and a summary at the end of each session. Over the course of treatment have the patient generate this treatment summary. Highlight how the present session follows from previous sessions and is related to achieving treatment goals. Be specific. Have the patient generate the reasons why he/she should undertake behavioral changes.
12. Help patients generate alternative “healing” narratives that empower them to examine their dominant “trauma” story and develop and live personal accounts that contribute to post-traumatic growth.
13. Solicit feedback from the patient each session on how therapy is progressing and ways to improve treatment. Convey that you, the therapist, is always trying to improve and tailor treatment to the needs and strengths of each specific patient. Monitor the relationship for any alliance strains. Accept part of the responsibility for any difficulties in the relationship.
14. The client's trust and confidence that his/her therapist is competent and interested in his/her well-being predicts treatment outcomes. The degree to which the client feels accepted, respected, understood, heard, safe and hopeful also predicts treatment outcomes.

**FEEDBACK-INFORMED TREATMENT (FIT) SCALES**

***“Completing this scale is a bit like taking your temperature. In a minute or less, we can get an idea about how you think things are with you and your life. Just as your temperature tells us something about how much distress your body is in, so do the scores on this scale. And like your temperature, this scale will let us know how things have been with you during the past week up through today, - not tomorrow or in a month. Right now we are trying to understand how we can help you which is more difficult if we don’t have a good idea of how you are doing to begin with. Can you help us out? (Bertolino, 2017, p. 197).***

**OUTCOME RATING SCALE**

**This Scale should be administered at the beginning of each session.**

Looking back over the last week including today, help us understand how you have been

feeling by rating how well you have been doing in the following areas of your life, where

 marks to the left represent low levels and marks to the right indicate high levels

**INDIVIDUALLY**

                                          (Personal well-being)

                 -----------------------------------------------------------------------------------------

**INTERPERSONALLY**

                                       (Family, close relationships)

                 ------------------------------------------------------------------------------------------

**SOCIALLY**

                                         (Work, School, Friendships)

                  ------------------------------------------------------------------------------------------

**OVERALL**

                                      (General sense of well-being)

              ---------------------------------------------------------------------------------------------

**SESSION RATING SCALE**

   Please rate today's session by placing a hash mark on the line nearest to the description that fits

your experience.

**RELATIONSHIP :**

I did not feel heard,                                                                          I feel heard,

understood and                                                                                  understood and respected        ---------------------------------------------------------------- respected

**GOALS AND TOPICS:**

We did not work on                                                                             We worked on and

or talked about what                                                                             talked about what

I wanted to work on                                                                                I wanted to work

and talk about      ------------------------------------------------------------ on and talk about

**APPROACH or METHOD:**

The therapist's                                                                                        The therapist's

approach is not                                                                                        approach is a

a good fit for me --------------------------------------------------------------- is a good fit for me

**OVERALL:**

There was something                                                                               Overall, today's

missing in this session                                                                              session was right

today -----------------------------------------------------------   for me

For additional ways to solicit client feedback visit the following websites

www.centerforclinicalexcellence.com  (Feedback informed Treatment Scott Miller)

www.OQ45measures.com

https://www.prof/horvath.com/Downloads     Working Alliance Inventory

Or you can ask the client such questions as, "Is there anything, I the therapist, did or did not do, or said or did not say, that you found particularly helpful or unhelpful?

**USE CLOCK METAPHOR**

**12 o’clock** - - external and internal triggers

**3 o’clock** - - primary and secondary emotions

**6 o’clock** - - automatic thoughts, thinking processes such as ruminating,

schemas and beliefs

**9 o’clock** - - behaviors and resultant consequences

1. Place hand at 9 o’clock and move around imaginary clock and say “It sounds like a

vicious…”. Allow client to finish this sentence with “cycle” or “circle”. Explore how his/her

account fits a “vicious cycle”.

2. Treat 3 o’clock primary and secondary emotions as a “commodity”. What does the client do

with all these feelings. For example, “stuff them”, “drink them away”, “act out”.

3. If that is what he/she does with such emotions, ask, “what is the impact, toll, price he/she

and others pay, as a result? If the client answers, “I do not know”, then the therapist should

say “I do not know either, how can we go about finding out? Moreover, how will finding

out help you achieve your treatment goals of X (be specific)?”

4. Encourage the client to collect data (self-monitor) when the vicious cycle, as the client

describes, actually occurs. Explore with the client when he/she engages in such behavior

and the impact, toll, price. “If it has this impact, then what can the client do?” It is not a big

step for the client to say, “I should break the cycle or circle”. The therapist can then explore

how the client now goes about breaking the cycle - - thus view present symptoms and

behaviors as their attempt to “break the vicious cycle”. (Use dissociation, substances, avoid,

act out).

5. Explore alternative more adaptive ways “to break the cycle”.

**PROCEDURAL CHECKLIST FOR CONDUCTING SELF-**

**MONITORING AND OTHER EXTRA-THERAPY ACTIVITIES**

1. Provide opportunity for patient to come up with suggestion for self-monitoring. Use situational analysis.
2. Provide a rationale. Highlight the connection between doing “homework” and the patient achieving his/her therapy goals.
3. Keep request simple (Use behavioral tasks and “foot in door” approach and build-in reminders).
4. Ensure patient has the skills to perform the task. Give the patient a “choice” as to how best to conduct the assignment.
5. Use implementation intention statements (“When and where”, “If …then,” “Whenever” statements).
6. Clarify and check the patient’s comprehension (use role-reversal, behavioral rehearsal).
7. Use desirable rewards and peer/family supports.
8. Anticipate possible barriers and collaboratively develop coping strategies.
9. Elicit commitment statements and patient-generated “reasons”.
10. Inquire about self-monitoring (other “homework” activities).
11. Nurture patient self-attributions (“take credit” for change).
12. Reinforce effort and not just product.
13. View failures as “learning opportunities”.
14. Keep record of patient’s compliance.

**TABLE 2**

**Phases of Stress-inoculation Training**

**Phase I - - Conceptualization and Psychoeducation**

Establish, maintain and monitor the therapeutic alliance using ongoing session-by-session patient-informed feedback.

Establish a warm, nonjudgmental, respectful, trust-engendering treatment environment. Be sensitive to ethnic and racial differences.

Assess for prior history of victimization, intergeneration transmission of trauma, address safety issues from the outset and throughout treatment (e.g., suicidal behaviors, possible access to weapons, engaging in high-risk behaviors and the possibility of revictimization).

Use a Case Conceptualization Model of risk and protective factors. Tap the patient’s implicit theory of presenting problems and treatment needs.

Address any potential therapy-interfering behaviors and patient concerns around “stigma” and barriers to treatment engagement such as compensation and entitlement issues that can act as interfering “secondary gains.”

Use Motivational Interviewing and Collaborative goal-setting procedures. Establish SMART treatment goals (Specific, Measureable, Attainable, Relevant, Timely).

Conduct psycho-education in a non-didactic fashion about the nature of PTSD and treatment.

Use Timelines to solicit patient “strengths” in the past and present, namely, “in spite of” behaviors and achievements. Elicit the “rest of the story” that influence the relative retrievability of different positive memories. Journaling and writing can enhance adjustment.

Conduct psycho-education about how positive emotions and activities can change brain structure and function. Highlight ways to bolster patient resilience. Prepare the patient for Phases II and III of SIT.

Normalize symptoms and prioritize and address any presenting symptoms and maladaptive behaviors (e.g., sleep disturbance, avoidance behaviors, substance abuse, “victim” mindset).

**Phase II: Skills Acquisition and Rehearsal**

Begin with a discussion of how patients inadvertently, unwittingly, and perhaps unknowingly contribute to and can exacerbate their presenting problems. Use a CLOCK metaphor to help the patients appreciate the interconnections between their feelings, thoughts and behaviors - - a self-sustaining “vicious cycle.”

1. 12 o’clock - - appraisal of external and internal triggers
2. 3 o’clock - - primary and secondary feelings
3. 6 o’clock - - automatic thoughts, thinking style and developmental schemas and beliefs
4. 9 o’clock - - behaviors and reactions from others

Help the patient appreciate ways they can “break the cycle” by using intra- and interpersonal coping skills.

Teach emotion-regulation, mentalizing, cognitive reframing and active behavioral coping skills.

Do not “train and hope” for generalization and maintenance of coping skills, build into treatment generalization guidelines (See Meichenbaum, 2017).

Tailor interventions according to the dominant emotional needs of the patient (fear, anxiety, guilt, shame, anger, grief, moral injuries) and provide integrated treatments for the presence of any co-occurring disorders such as PTSD and substance abuse. Where indicated, use imaginal dialogue (Gestalt empty-chair procedures).

When indicated incorporate the patient’s faith, religion and spirituality. Help the patient make a “gift” of trauma experience and undertake meaning-making activities.

**Phase III: Application, Relapse Prevention and Follow-through**

Challenge, cajole and encourage the patient to practice coping skills, both in session (imaginal rehearsal, role playing), and in vivo settings as identified by means of a planful graduating (“inoculating”) hierarchal fashion.

Ensure that patients “take credit” for behavioral changes. Nurture a personal agency self-attributional style of mastery of stress (Being a “boss of PTSD”).

Focus on psychosocial rehabilitation and on improving social relationships, social reintegration vocational/educational functioning, and daily routine and leisure activities. Help patients reengage life.

Use Relapse Prevention procedures and follow-through interventions such as ongoing coaching, booster sessions and involvement of significant others in treatment.

Throughout all Phases of SIT solicit patient-informal feedback on a session-by-session basis, and adjust treatment accordingly.

**Resources on Stress Inoculation Training (SIT) and Related Interventions**

1. Google Stress Inoculation Training to read various Websites and papers that describe SIT. Also, see video application of SIT in training military personnel.
2. Visit [www.roadmaptoresilience.com](http://www.roadmaptoresilience.com) for a description of ways to bolster resilience and [www.melissainstitute,org](http://www.melissainstitute,org) for follow-up articles including treatment manuals on Prolong and Complicated Grief, Ways to integrate spirituality and psychotherapy, and Ways to bolster resilience in LGBTQ youth.
3. Monson & Schneider (2014, pp. 89-90) and Meichenbaum (2007, pp. 501-507) provide procedural treatment guidelines. Meichenbaum (1985) Stress Inoculation Training provides an initial description. (Elmsford, NY: Pergamon Press)
4. Smith, R.E. & Ascough, J.C. (2016) Promoting emotional resilience: Cognitive-affective stress management training. New York: Guilford Press overlaps with SIT.
5. Meichenbaum conducts workshops on SIT ([dhmeich@aol.com](mailto:dhmeich@aol.com)).

**TREATMENT OF ANGRY YOUTH: INTERVIEWING PROCEDURES TO HELP THEM BECOME RESPONSIBLE PROBLEM-SOLVERS**

***(See Larson, 2005 THINK FIRST Program and view a You Tube that demonstrates the interviewing procedure) http://www.youtube.com/watch?V=Lkz2Cgw0wic***

The interview procedure has three phases: Preparation, Problem-solving and Implication.

**PREPARATION PHASE**

- Focus on establishing a collaborative alliance through active listening, empathy and reframing

- Help de-escalate intense feelings

- Solicit the youth’s view of the problem through developing a timeline

***“What happened before, during and after the anger incident?***

***What did the youth and others do and say?***

***How does the youth feel about what happened?”***

- Review the story in highlights, emphasizing strengths and coping skills

- Nurture hopefulness and collaboration with positive “we” statements

**PROBLEM-SOLVING PHASE**

- Help the youth take he perspective of others

***“Why do you think he/she said that?***

***Could he/she have been thinking that you were…?***

***How does you think he/she feels about what happened?”***

- Help the youth generate as many alternative solutions as possible

- Nurture a GOAL, PLAN, DO,CHECK approach

- Help the youth identify both internal and external triggers to his/her anger

- Use a CLOCK metaphor to have the youth better appreciate the interconnections between the ways he/she appraises internal and external events (12 O’clock), their accompanying feelings 93 O’clock), their thoughts (6 O’clock), and their behaviors and the reactions of others (9 O’clock).

**IMPLEMENTATION PHASE**

- Convey to the youth that this behavior change is a “challenge”, bolster the youth’s self-confidence

***“It won’t be easy to do what we have been talking about***

***Maybe it is too early to ask you to do…***

***This is going to take courage and street smarts. How will you begin?”***

- Help the youth select an action plan to try and walk him/her through, both behaviorally and use imagery rehearsal

***“What will you have to watch out for?***

***What will you do when …?”***

- Practice the action plan with the youth

- Reinforce effort

***“I am impressed with your maturity and willingness to try a new way of handling…***

***I give you a lot of credit for being able to (use meta cognitive verbs such as notice,***

***catch, interrupt, plan, make smart choices, and so forth) Give specific examples and***

***ask the youth whether he/she agrees?”***

- Encourage the youth to explain how he/she will benefit from the new behavior

These interventions can also be used on a group basis.

**REPORT CARD ON HOW WELL YOUR TRAINING PROGRAM FOSTERS GENERALIZATION**

 (How many of these 20 activities do you include when you do training with clients, no matter what skills you are training?)

In order to foster transfer at the OUTSET OF TRAINING my intervention program:

1. Uses collaborative goal-setting and discusses with clients their treatment goals and how learning   and deliberately practicing these skills will help them achieve their treatment objectives.

2.  Elicits from clients self-generated reasons and value statements about why it is important to work on their treatment goals. ("How will the quality of their lives be different? ") Convey an EXPECTANT ATTITUDE that the clients have the ability within themselves to use these skills. Highlight time in the past where they have evidenced such abilities and survival skills.

3. Use open-ended Socratic discovery-oriented questioning. See if you can have the clients come up with what skills might be helpful. (You are at your therapeutic best, when YOUR clients are one step ahead of you, offering the suggestions that you would otherwise be offering. Be inductive, rather than deductive. DO NOT BE A SURROGATE FRONTAL LOBE FOR YOUR CLIENTS.)

4.  Solicits the clients' public commitment, and if indicated, use behavioral contracts.

5. Anticipates and addresses any possible barriers that might undermine the implementation of the skills.

6. Chooses the skills to be trained carefully, and ensure that the training setting is as similar as possible to the real life application settings.

In order to foster transfer DURING THE TRAINING my intervention:

7.  Keeps the training regimen as simple as possible--Use Acronyms and reminders.

8. Uses performance-based individualized training so the length and frequency of the training sessions are determined by some performance criteria. Not everyone will receive the same designate number of sessions. Teach to the point of mastery.

9. Accesses the clients' prior knowledge and competence in performing the skills that are to be taught.

10. Trains at the META-COGNITIVE level using active transitive verbs and the like. Such Executive Frontal lobe verbs will help clients learn to "notice, catch, interrupt, plan, use back-up plans and the like." Teach clients how to use the SNAP (STOP NOW AND PLAN) behavioral  scripts and routines, on themselves and with others.

11.  When they are with others who are in " high risk " provocative situations clients can learn

to use BYSTANDER INTERVENTION procedures to help defuse the situation.

12. Uses a variety of cognitive behavioral instructional strategies like advanced organizers and informed instruction in order for the clients to know what skills are going to be the focus of the training ahead of time.

       Other Cognitive behavioral interventions to be included in training are self-instructional training, cognitive modeling, client think aloud, coping models as evident in Recovery Voices Websites, YouTube videos, and scaffolding procedures.  Nurture a RESILIENT MINDSET and encourage a clients to become "courageous explorers and curious emotional detectives"

13. Involve significant others as part of training, wherever feasible, such as a family or group members.

14 Include relapse prevention procedures in planning for possible "high risk" situations and potential barriers to DELIBERATE PRATICE. Discuss how your clients can obtain FEEDBACK and COACHING, from others, group or family members, or from a Sponsor, as in AA groups.

15.  If possible, conduct training across settings, using multiple trainers, and environmental supports. When the skills work, ensure that the clients "take credit" for the change (Self-attributional training). The clients need to see the connections between their efforts and the resultant outcomes.

16. Provide between session coaching via Internet or by some other means

In order to foster transfer at the CONCLUSION of training

17.  Challenge clients to take ownership of the skills that they have Deliberately Practiced by putting them in a reflective CONSULTATIVE MODE.  Have them fill out Client Checklists indicating what they took away from the training and what and how they intend to use these skills. Most importantly, have them offer the REASONS why they will use these skills.

and how they can anticipate and plan for any potential obstacles or barriers to their skills implementation.

18. Have the clients share what they have learned with significant others and even engage in teaching these skills to others.  For example, visit the Website SMART RECOVERY TOOL KIT and see the SARS (Smart Recovery Activities Scales) that Meichenbaum and Myers created to increase the likelihood that Substance abuse participants would use the skills that are being taught.

19. Provide Active Aftercare and booster sessions where possible. Maintain some form of contact with the clients, leaving the door open and convey your sense of caring. REMEMBER THAT THE QUALITY OF THE THERAPEUTIC ALLIANCE IS WHAT MAKES THE SKILLS TRAINING WORK. Include Feedback Informed Feedback (FIT Scales) on a session-by-session basis throughout the training.

20. Conduct a Graduation Ceremony and have the clients take away something from the training that   indicates their participation and accomplishments.

**Know Your Anger and Be an Active Bystander\***

Donald Meichenbaum, Ph.D.

Etiony Aldarondo, Ph.D.

Recent use of lethal violence by police with George Floyd in Minneapolis and Breonna Taylor in Louisville, as well as other such incidents, highlights the need to better understand and help reduce the occurrence of violence in police activities. Whether you view such incidents as acts of self-defense, unwanted accidents or police misconduct, **the challenge is how to prevent and defuse volatile situations and prevent them from escalating** into potentially harmful and injurious actions for all involved.

The Melissa Institute for Violence Prevention and Treatment in Miami has created the *Know Your Anger and Be an Active Bystander Course* designed to reduce the likelihood of provocative angry situations escalating to the point of rage and violence. The program teaches police officers how anger affects their brain functioning and decision making processes and provides them with proven cognitive and behavioral strategies and tools to prevent the type of emotional reactions that can lead to harmful acts of aggression and violence.

After familiarizing police officers with the science and triggers of their anger, the course focuses on the use of active bystander SNAP (STOP NOW AND PLAN) skills before reacting when facing perceived provocations. Police officers are taught to use effective communication tactics to pause, calm down, stop and reflect on what actions to take.

Dr. Ervin Staub, a pioneer in the use with active bystander interventions with the police, has demonstrated that when such an approach is adopted, endorsed and deliberately practiced from the "top down" throughout a police department, it is an effective tool to defuse violent police actions. The use of bystander interventions reflects a police department’s commitment and loyalty to fellow officers to keep themselves and others safe, prevent violence, promote trust in the community, and perform their duties at the highest levels. The adoption of active bystander intervention strategies has the potential of significantly strengthening both the police culture and the police department’s relationships to the communities they serve.

The course involves teaching police officers what to say and what to do with their fellow officers in provocative and potentially violent situations in order to reduce the likelihood of escalating violence, injury and perhaps, even deaths. The goal of the course is to have all police officers involved view provocations as "problems-to-be-solved” rather than as personal threats warranting violent reactions.

Our anger and active bystander course relies on four key features to ensure that police officers do not have the lower part of the brain, the Amygdala and related areas, which is heavily involved in emotional experiences, "hijack" the executive part of the brain (i.e., prefrontal cortex and hypothalamus and related areas) that oversees and regulates behavior. When a fellow officer is becoming enraged a timely bystander intervention can act as a supportive prosthetic "surrogate frontal lobe", defusing the intensity of the emotions and creating the conditions for more planful courses of action to emerge.

The first feature of the course is for officers to be vigilant and act as "detectives" identifying both in themselves, as well as in their fellow officers, the potential for escalating violence. The anger and active bystander program calls upon the officer to adopt a mindset of "goal-plan-do-check". Is there a way for officers to achieve their goals in a nonviolent way, when feasible? Are there safer ways to act in the heat of the moment for the officer, her fellow officers, and the suspects involved?

The second key feature is for the officer to be able to say or do something that signals fellow officers that they should SNAP (STOP NOW AND PLAN) and interrupt what they are doing in order to keep everyone safe. These prearranged and practiced communication signals could actually involve snapping one's fingers, or the use of some agreed upon code words. For example, some officers may accompany the snapping of their fingers with the code word "Amygdala." The Institute’s course invites police officers to imagine what would happen if someone were to post the police officer's behavior on Facebook. Along those lines then words like "Facebook, Facebook" could also be used as signals to SNAP. No matter what form of signal communication is employed, the object is to encourage fellow officers to STOP NOW AND PLAN.

The third feature of our active bystander course is the officer's belief and expectation that their fellow officers would come to their "rescue" if they were in a provocative potentially violent situation. Moreover, they also need to have the assurance that their bystander intervention would be accepted, if not praised by their fellow officers and their superiors. Peer support and affirmation of an active bystander philosophy are important determinants of an individual officer’s choice to intentionally defuse potentially volatile situations.

Finally, the course includes an "after event analysis" or group debriefing of what transpired, what worked, and what could have been improved on how to handle future provocative situations in a less reactive, less violent, and more planful manner. For group trainings the course includes discussions of alternative non-violent ways that other violent police actions could have been handled; the ways that bystander communication signal system could have been employed; and deliberate practice with feedback could be practiced in order to support each other. Research in learning and the acquisition behavioral skills makes it clear that this form of reflection is crucial for the increased use and sustainability of new behaviors over time.

The *Know Your Anger and Be an Active Bystander Course* does not preclude the necessary police actions required when perceived immediate safety issues are present, but in those provocative potentially violent situations that arise where police feel threatened and where individuals are being repeatedly non-compliant and intentionally disrespectful of police, there is a need for police to stop and plan how to act rather than quickly opting for the use of physical force in reaction to the provocation. As we navigate through a climate of increased polarization and social unrest, knowing how to defuse volatile situations and SNAP (STOP NOW AND PLAN) ought to be part of every police officer’s toolbox.

Access the free course here:

[*https://melissainstitute.org/wp-content/uploads/2020/12/Know-your-Anger-and-Be-an-Active-Bystander-Course1.pdf*](https://melissainstitute.org/wp-content/uploads/2020/12/Know-your-Anger-and-Be-an-Active-Bystander-Course1.pdf)

Dr. Erv Staub's Bystander Intervention Program with Police

BBC Article:

[*https://www.bbc.com/news/world-us-canada-54339252*](https://www.bbc.com/news/world-us-canada-54339252)

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