TREAMENT OF INDIIVIDUALS WITH ANGER-CONTROL PROBLEMS AND AGGRESSIVE BEHAVIOURS

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FACT SHEET ON ANGER AND AGGRESSIVE BEHAVIORS

1. Aggressive behaviors are relatively STABLE over the life-span and in many ways predictable.

2. Aggressive behaviors may be of an Instrumental form (designed to achieve a set of specific goals) OR an emotionally reactive form, or a combination of both.

3. Anger-related problems co-occur with 19 different psychiatric disorders. Anger interferes with patients' processing related emotions as in the case of PTSD patients.

4. Anger and aggression may be a secondary reaction to other emotions such as fear, anxiety, sadness, depression, humiliation, embarrassment, grief and the like. Anger can vary in its intensity, frequency and duration. Individuals may dwell or ruminate on OLD ANGER and not let the anger go.

5. There has been an increase in the level of violence toward others and toward oneself during the period of the pandemic.

6. There is nothing wrong with becoming angry. It is what one does with the angry feelings that is the most critical determinant. Anger in response to perceived Social injustice and discriminatory events has led to major collective actions for social change (For example Civil and Gay rights, Me Too Movement, Black Lives Matter, Amnesty International, and the like). Emotions like anger, fear, anxiety, sadness, grief are MESSENGERS to take some actions. What individuals do with their feelings of anger distinguishes those who are high and low in becoming aggressive.

MINDSET OF ANGRY AND AGGRESSIVE INDIVIDUALS

It is being proposed that in order to go from being provoked and becoming annoyed, irritated, bothered, frustrated to becoming intensely angry, enraged, furious and aggressive, the following steps are invoked.

1. Perception of provocations (threat, injustice, interruption of one's plans and behaviors, challenge to one's Code of Honor like " Manhood ", " Racial slurs " and the like).

2. Attribution of intentionality - - perception and appraisal that this action was done " ON PURPOSE ".

3. Have a HOSTILITY BIAS -- On the lookout for possible provocations and misappraise ambiguous events as intentional provocations that elicit readily accessible, pre-programmed aggressive emotionally-scripted behavioral patterns or action plans.

4. View that one's angry and aggressive responses are JUSTIFIED -- "An eye for an eye, a tooth or a tooth " "I am ONLY hurting them back like they have hurt me"

5. Engagement in ABSOLUSTIC THINKING -- thinking processes filled with "musts" and "shoulds". What Albert Ellis called the tendency to '" MUSTurbate" and the predilection to " SHOULD on your head ".

6. Use of INFLAMMATORY STEREOTYPICAL language that DEHUMANIZES the victims of angry and aggressive behaviors

7. PAYOFFS or reinforcements for engaging in angry and aggression that WORKS, at least in the short run, in achieving one's goals. Such aggressive behaviors may be consistent with cultural or cohort norms that meet a set of expectations. For instance, to " Save face and one's reputation, " Show that one is King of one's Castle ". " That there will be payoffs in Heaven, in the next life'". In short, a set of meaning-making beliefs help to maintain and exacerbate the level of anger and aggression.

IF THERE IS ANY MERIT TO THIS ANALYSIS, WHAT DO YOU THINK ARE THE TREATMENT IMPLICATIONS?

CONSIDER DR. MEICHENBAUM'S FAMILY ANECDOTE ABOUT HIS FOUR CHILDREN AND THE THREE GARBAGE CANS, AS ANALYZED USING THE CLOCK METAPHOR

- What were the External and Internal Triggers in this anecdote? (12 O'clock)
- How did he feel when he saw the garbage cans, the bikes in the driveway, the baseball glove on the front steps? (3 O'clock)
- What lit his fuse? Was it a violation of his Expectations, his appraisal that this was history repeating itself--not the first time, a sign of disrespect and unfairness?
- Where did the thought about his own father come from in a mood-congruent fashion?
- What were the Automatic thoughts elicited in this situation" (6 O'clock)
- What did he do? And how did he respond when his son said, " Dad, these are NOT our garbage cans ." (9 O'clock)

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9'O'Clock What did he do? And how did he respond when his son said, " Dad, these are NOT our garbage cans ."

YOU KNOW WHAT YOU DO FOR A LIVING AS A THERAPIST?

YOU GET PAID TO LISTEN TO PATIENTS' GARBAGE CAN STORIES!

APPLICATION OF COGNITIVE BEHAVIORAL STRESS INOCULATION TRAINING (SIT)
THREE PHASED INTERVENTIONS

SIT Consists of Three Phases

PHASE I:	Focuses on the initial development of a therapeutic alliance, functional analysis, psychoeducation. collaborative goal setting, shared treatment rationale. The treatment rationale and psychoeducation highlight that anger consists of a period whereby individuals can prepare for a potential provocative situation OR responds in an immediate anger-engendering fashion. ● A period when one is experiencing an angry episode. ● A period of intense emotional reactivity. ● A post-event reflective analysis period. ● A treatment guide. Conduct a Behavior Chain Analysis Is the expression of anger a reflection of a skills deficit or a performance deficit, namely your patient has self-regulatory skills in his/her repertoire, but some factors undermine their use or skills training is required from the outset? Is your patient's aggression an impulsive reactive type or an instrumental form that is designed to achieve some personal goals, or a combination of both?
PHASE II OF SIT:	Skills training phase and accessing any anger management skills that the patient already possess. Learn to engage is self -instructional training--what to say to oneself during each of these different periods of experiencing anger.
PHASE III OF SIT:	Application phase whereby the patient can practice anger management skills by means of imaginal or behavior rehearsal efforts. The patient can practice in vivio in simulated provocative scenarios. A kind of inoculation.

STRESS INOCULATION TRAINING HIGHLIGHTS THE FOLLOWING ANGER MANAGEMENT SKILLS

- Learn about what triggers the patient's anger. What do these various triggers have in common?

- Learn what are the warning signs, both internal and external that the patient's anger is building.

- Develop an anger-control plan-- " If ...Then rules ". Both immediate coping strategies like
  arousal reduction procedures (tactical mindful breathing and calming self-regulating distress tolerance, self-soothing and distraction responses) and the ability to take a Time Out and cool down. Use Opposite actions.

- Check and Change Hostility beliefs. Learn to perspective take and engage in Consequential thinking Let go of OLD ANGER such as carrying a grudge.

- View the provocation events as a " problems to -be -solved " What are the patient's GOALS in this situation and can he/she consider a non-aggressive ways to achieve these goals. Remind your patient that there is nothing wrong in becoming angry, but it is what he/she does with one's anger that is critical.

- Be assertive, instead of being aggressive. Use " I " statements, instead of: “You" statements. " I feel X, in situation Y, when you do Z. "

- Talk to someone about what is getting you angry and aggressive. Imagine how someone you admire and respect might handle this provocative situation.

- Remind the patient that anger, especially if he/she tries to suppress it can affect one's physical health causing high blood pressure, and cardiovascular health problems especially when accompanied by clinical depression.

- Engage in Bystander Intervention when the patient perceives others about to SNAP. Help others put their Frontal Lobe Executive back online and not allow the Lower part of the emotional brain to HIJACK their self-regulation skills.

Do NOT merely train and hope for transfer, build in generalization guidelines.

SEE THE ATTACHED MELISSA INSTITUTE ANGER MANAGEMENT AND BYSTANDER INTERVENTION COURSE

TO ADD THIS AS A RESOURCES FILE ON KAJABI
LINK HERE https://drive.google.com/file/d/1DrQLDpn4LZrHbiiElBSX6-ScdMqii_x0/view?usp=sharing

https://drive.google.com/drive/folders/1h609eyarpbiuD_Wjjowub93o_az0CTnO?usp=sharing

HOW TO PREVENT THE DEVELOPMENT OF AGRESSIVE INDIVIDUALS

1. A CASCADE MODEL OF THE DEVELOPMENTAL TRAJECTORY

2. IMPLICATIONS FOR PREVENTATIVE INTERVENTIONS

3. WHAT INTERVENTIONS MAKE THE SITUATION WORSE AND INADVERTENTLY CONTRIBUTES TO THE DEVELOPMENT OF AGGRESSIVE BEHAVIORS?

4. WHAT EVIDENCED-BASED INTERVENTIONS HAVE BEEN FOUND TO REDUCE AGGRESSIVE BEHAVIOR?

5, HOW TO INCREASE THE LIKELIHOOD OF GENRALIZATION AND MAINTENANCE OF PRATICED SKILLS BY INCOPORATING GENERALIZATION GUIDELINES ?

DEVELOPMENT OF AGGRESSIVE BEHAVIORS IN STUDENTS
INTERVENTION IMPLICATIONS

TABLE 1

A DYNAMIC CASCADE MODEL of the DEVELOPMENT of AGGRESSIVE BEHAVIOR

(As Dodge et al. 2008 observe, each domain in the developmental sequence operates in concert to lead to violent behavior)

Genetic Vulnerability Contributions

↓

Adverse Social Context

↓

Early Developmental Risk Factors

↓

Cumulative Exposure to Victimizing Experiences

↓

Lack of School Readiness

↓

Development of Early Behavior Problems

↓

Academic and Social Failures

↓

Coercive Parenting: Lack of supervision, monitoring and academic support

↓

Deviant Peer Association

↓

School-based Policies and Involvement with Juvenile Justice System
That Aggregates Deviant Youth

TABLE 2

IMPLICATIONS FOR PREVENTION and TREATMENT INTERVENTION

What could you do to:

1. Help reduce teenage pregnancy, in the first place
2. Provide services to pregnant teenagers
3. Provide home-visiting nursing programs to high-risk families
4. Offer services to reduce the likelihood of victimization and provide treatment to victimized families
5. Nurture school readiness, especially in the area of reading, provide empathy training early in development
6. Provide parent-child training programs
7. Implement school-based early screening procedures to identify high-risk students and high-risk families
8. Create safe, inviting schools designed to reduce bullying and cyber-bullying; improve academic performance and nurture a future orientation - - offer career counselling
9. Bolster resilience, provide mentoring programs that will build on the youth's strengths that lead to contact with prosocial peers and a bond with prosocial mentors, activities and institutions
10. Work with parents to improve supervision, monitoring, conflict resolution, and positive affective bonds, address family dysfunction and familial psychopathology.
11. Provide school-based interventions that are designed to reduce high-risk deviant behaviors such as dating violence, offer school-based mental health programs with "high-risk" students, provide media literacy courses.
12. Provide evidence-based skills intervention in the area of anger and impulse control, empathy training and social problem-solving. (See Tables 5 and 6) Incorporate generalization guidelines in order to promote skills maintenance. (See Tables 7 and 8).
13. Eliminate or minimize practices that aggregate deviant youth.
14. Build in evaluation procedures
15. Convince others that implementing such interventions need to be prevention

-oriented, administered early in the developmental cycle, comprehensive addressing multiple risk factors. Moreover, there is a need to convince supporters of these intervention program that doing so will not only be effective and have salutary consequences, but it will result in significant financial savings.

What do we know "works" and what has been found to inadvertently increase violence (make things worse)?

A number of well-intentioned intervention programs, not only do not work but they actually backfired and made things "worse". The following list of programs should be avoided, if possible. What is common is that they bring together or aggregate deviant peers where these youth can mutually reinforce and model aggressive behaviors. How many of these programs are in place in your community?

I have also included a list of viable alternative programs that should be tried.

TABLE 3

PROGRAMS AND POLICIES THAT AGGREGATE DEVIANT PEERS AND THAT SHOULD BE AVOIDED, IF POSSIBLE
(*From Dodge et al. 2006 and www.teachsafeschools.org*)

Education

1. Tracking of low-performing students
2. Forced grade retention for disruptive youth
3. Self-contained classrooms for unruly students in special education
4. Group counselling of homogeneously deviant youth
5. Zero tolerance policies for deviant behavior
6. Aggregation of deviant youth through in-school suspension
7. Expulsion practices
8. Alternative schools that aggregate deviant youth
9. Individuals with Disabilities Education Act (IDEA) reforms that allow disruptive special education students to be excluded from mainstream classrooms
10. School-choice policies that leave low-performing students in homogeneous low-performing schools

Juvenile Justice and Child Welfare

1. Group incarceration
2. Military-style boot camps and wilderness challenges (“brat camps”)
3. Incarceration placement with other offenders who committed the same crime
4. Custodial residential placement in training schools
5. Three strikes-mandated long prison terms
6. Scared Straight
7. Group counselling by probation officer
8. Institutional or group foster care
9. Bringing younger delinquents together in groups

10. Vocational training

Mental Health

1. Any group therapy in which the ratio of deviant to non-deviant youth is high
2. Group therapies with poorly trained leaders and lack of supervision
3. Group therapies offering opportunities for unstructured time with deviant peers
4. Group homes or residential facilities that provide inadequate staff training and supervision

Community programming

1. Midnight basketball
2. Unstructured settings that are unsupervised by authority figures (e.g., youth recreation centers designed as places for teens to “hang out”)
3. Group programs at community and recreation centers that are restricted to deviant youth
4. After-school programs that serve only or primarily high-risk youth

TABLE 4

EFFECTIVE PROGRAMS THAT REPRESENT VIABLE ALTERNATIVES TO AGGREGATING DEVIANT PEERS

(*From Dodge et al. 2006 and www.teachsafeschools.org*)

Education

1. Universal, environment-centered programs that focus on school-wide reform, including:

   a. clearly explicated expectations for student and staff behavior
   b. consistent use of proactive school discipline strategies
   c. active monitoring of "hot spots" for behavior problems
   d. improved systems to monitor student achievement and behavior

2. Universal classroom programs to build social competence (e.g., Responding in Peaceful and Positive Ways, PATHS, school-wide bullying prevention programs)
3. School-wide positive behavior support
4. Individual behavior support plan for each student
5. Improved training in behavior management practices for classroom teachers, especially:

   a. group contingencies
   b. self-management techniques
   c. differential reinforcement

6. Incredible Years Teacher Training
7. Good Behavior Game
8. Consultation and support for classroom teachers
9. Family-based Adolescent Transitions Program
10. Matching deviant youth with well-adjusted peers (e.g., Coaching, Brain Power, Peer Coping Skills Training, the Montreal Longitudinal Project)
11. Multimodal programs (e.g., LIFT-Linking Interest of Families and Teachers, Fast Track, Seattle Social Development Project)
12. Proactive prevention programs that shape student "morals" and encourage responsible decision-making
13. Cognitive-behavioral Intervention for Trauma in Schools (CBITS)

Juvenile justice and child welfare

1. Functional family therapy
2. Intensive protective supervision
3. Teaching Family Home Model
4. Sending delinquent youth to programs that serve the general population of youth in their neighborhoods (e.g., Boys and Girls Clubs)
5. Community rather than custodial settings
6. Interpersonal skills training
7. Individual counselling
8. Treatment administered by mental health professionals
9. Early diversion programs
10. Victim-offender mediation
11. Teen court programs
12. Therapeutic jurisprudence programs
13. Community commitment orders
14. Psychiatric consultation

Mental Health

1. Individually administered treatment
2. Family-based interventions
3. Triple P Program (Positive Parenting Program)
4. Adolescent Transitions Program
5. Linking the Interests of Families and Teachers (LIFT)
6. Iowa Strengthening Families Program
7. Family Unidas Program
8. Mentoring programs such as Big Brothers/Big Sisters

Community programming

1. Public or private organizations that are open to all youth, regardless of risk status, and that provide structure and adult involvement (e.g., religious groups, service clubs, Scouts, Boys and Girls Clubs)
2. School-based extracurricular activities that include pro-social peers
3. Encouragement of commitments outside of gangs (e.g., to jobs, family roles, military service, mentors)
4. Early childhood interventions such as the Perry Preschool Program, school readiness programs like Head Start, and programs that highlight reading comprehension skills
5. Job Corps
6. Policing programs that target high-crime neighborhoods where high-risk youth congregate
7. Community efforts to reduce marginalization of specific groups of youth

4. What are the lessons to be learned from previous attempts to replace aggressive and delinquent behaviors?

Attempts to treat aggressive children and youth and their families has been going on for some time. It is worth taking stock and asking what has the field of prevention and treatment learned? Consider the following summaries for work with children and youth who evidence Disruptive Behavior Disorders (DBD) and those who have adjudicated as juvenile delinquents.

We should develop an evaluative critically-minded stance and require those who conduct intervention programs to demonstrate how they have considered these lessons in their treatment planning.

ILLUSTRATIVE INTERVENTION PROGRAMS

SNAP (STOP NOW AND PLAN) PROGRAM

THINK FIRST PROGRAM

PARENT TRAINING PROGRAM

II CE HOPE

I --- INTERRUPTION OF PLANS

I --- IMPLICATIONS FOR THE FUTURE

C ---CONCERNS FOR WELL-BEING

E ---VIOLATION OF EXPECTATIONS

H ---HISTORY REPEATS ITSELF

O ---PARENT OVERLOAD

P ---VIOLATION OF PERSONAL ISSUES

E ---EMBARESTMENT

REFERENCES

Averill, R. Anger and aggression New York: Springer Verlag

Fields, D. (2018) Why we snap: Understanding the rage circuit in our brain.

Meichenbaum. D. (2001). Treatment of Individuals with anger-control problems and aggressive behaviors.

VISIT the Melissa Institute Website for the following resources

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

Stress Inoculation training

ALSO see presentations by Alex Piquero on Spouse abuse, Leena Augimeri on the SNAP (STOP NOW AND PLAN program). James Larson on the THINK FIRST program. Deb Pepler on BULLY PREVENTION program, Ron Slaby on the EYES ON BULLYING program and the Melissa Institute website www.teachsafeschools.org)