



PTSD 101 Course

Transcript for: Anger, Aggression and PTSD

Welcome to PTSD 101. These PTSD 101 podcasts were extracted from online multimedia courses and may refer to tables, charts, or videos. To view the complete courses, which include all these elements, and to find out about earning free continuing education credits, please go to ptsd.va.gov.

All right, thank you for watching this presentation. I'm going to be talking about anger, aggression, and PTSD as part of the VA/DoD clinical practice guidelines for PTSD.

My name is Dr. Casey Taft, I'm from the National Center for PTSD (NCPTSD) and VA Boston Healthcare system and I'm an associate professor at Boston University School of Medicine.

Okay, so let's talk about the objectives. The first one is to understand the association between PTSD and anger and aggression. The second objective is to review the 2010 VA/DoD clinical practice guideline recommendations, and the last is to describe a clinical application, and specifically I'm going to be talking about the Strength at Home program which is a program that I helped develop which focuses on treating Veterans who have difficulties with anger and aggression in intimate relationships.

So, objective one, understanding the association between PTSD and anger and aggression.

So, first I'll talk a bit about the link between PTSD and anger. Before I get started it is probably important to define what we are talking about when we are talking about anger. So, one of the best definitions of anger is that, "it's an emotional state that comprises feelings that vary in intensity from mild annoyance or aggravation to fury and rage." So, sometimes people get the constructs of anger and aggression confused so it is important to make the point that they are related but they are distinct constructs. One can have difficulties with anger and it may not necessarily translate into aggressive behavior. The literature shows that anger is higher among Veterans who have PTSD relative to those without PTSD. And, also this relationship between PTSD and anger tends to be stronger in Veterans than it is in civilian populations. Clinically, Veterans with PTSD often report that anger is the problem that interferes the most with their functioning. So, often Veterans come in for help with problems with anger and they describe it as really their primary clinical concern for coming into treatment. Research also shows that when an individual has high levels of anger, it can hinder the effectiveness of other treatments for PTSD so it's really important to kind of focus on targeting the anger and treating anger and aggression in Veterans who come in for treatment for PTSD.

One interesting finding that's been shown in the literature is that Veterans with PTSD, when they are reminded of their traumas, are more likely to report anger than other negative emotions such as anxiety or depressive kinds of emotions, depressive affect, which is really interesting given that we think of PTSD

as an anxiety disorder, but Veterans tend to report a severe anger response when they are reminded of their traumas. The figure that we have depicted here is from another relatively recent study that my colleagues and I published, and the main finding from this study was that Veterans with PTSD, when they were exposed to trauma cues, when they were reminded of their trauma, their anger went up considerably. So, they showed a very strong anger response when they were reminded of traumas, and we didn't find this same increase in anxiety when they were reminded of their traumas. So, it's really interesting that they showed an elevated anger response but not an elevated anxiety response when reminded of traumatic events.

So, now shifting gears a little bit and talking about how PTSD is related to aggression, it's really important to point out that research shows that military service members tend not to be more violent than civilians in the absence of significant stress and/or PTSD. So, PTSD really seems to be a central and primary risk factor for aggression among military Veterans and when you take PTSD out of the equation, Veterans aren't necessarily more violent than civilians. Some evidence also suggests that the relationship between PTSD and aggression is higher in men as well as those who are exposed to military trauma. So, these are some findings that we obtained in a recent meta-analysis that we published in the *Journal of Consulting and Clinical Psychology*. A lot of the data on PTSD and aggression comes from samples of Vietnam Veterans and in a large-scale representative survey of Vietnam Veterans, The National Vietnam Veterans Readjustment Study, they found that Veterans with PTSD had much higher rates of partner violence than Veterans without PTSD. So, Veterans with PTSD had a 33% partner violence prevalence rate, and Veterans without PTSD, their rate was only 13.5%. When I am talking about partner violence rates, I am referring to any physical aggression toward, or perpetrated toward, a partner in a previous year. So, these behaviors can range from pushing, grabbing or shoving to more severe acts of aggression such as punching, kicking or using a weapon. So, basically the take home message from this study was that when Veterans have PTSD, it places them at much greater risk for partner violence relative to Veterans who don't have PTSD.

So, again, this just illustrates that PTSD is a strong predictor of partner aggression and that combat exposure leads to higher partner aggression through its impact on PTSD symptoms.

These are some research findings from a study that showed that once you take out the effects of PTSD, once you take PTSD out of the equation, combat exposure isn't necessarily related to higher levels of partner violence.

The take home message from this slide is that combat exposure does not necessarily lead to higher levels of partner violence if you don't take PTSD into account."

This table here is taken from a study that we recently published in the *American Journal of Orthopsychiatry*. This study focused on examining rates of different forms of aggression among Veterans who were seeking help in a PTSD clinic. These data were obtained from the clinic where I work, the PTSD clinic at the Boston VA. The two different columns here depict partner aggression that were perpetrated by these Veterans seeking assessments in our PTSD clinic, aggression perpetrated towards relationship partners or perpetrated against non-relationship partners. So, the partner aggression focuses on the aggression perpetrated towards their partners, general aggression focuses on aggression towards individuals other than relationship partners. You can see the different items that made up this scale of physical aggression that we looked at that referred to specific behaviors the individual may have engaged in such as throwing something, twisting the partner's arm, her hair or another person's arm or hair, all the way up to using a knife or a gun. And, you can see endorsements of each of these types of behaviors. In the bottom row, you can see endorsement of overall rates of aggression towards a partner and aggression towards somebody other than a partner. So, kind of focusing on the bottom row first, Veterans reported an overall rate of almost 33% of engaging in aggression towards a relationship partner

over the previous year. In terms of aggression towards a non-relationship partner, a very similar rate of about 32% was found suggesting that approximately one third of all Veterans coming through our clinic reported engaging in physical aggression towards a relationship partner or towards a non-relationship partner. Looking at the individual item endorsements, you can see that pushed or shoved or grabbed tended to be the most highly endorsed physically aggressive behavior by these Veterans.

Similarly, we also looked at rates of psychological aggression in this same sample, and here we found a very high rate of psychological aggression perpetration of about 91.3% up towards their relationship partners and about 81% towards non-relationship partners. The rates that you might find in the community for psychological aggression are probably closer to about 60 to 70% so a fairly high psychological aggression was reported in this sample. And, I should say, in terms of physical aggression, the rate that's typically reported in the community is about 13% so the rates that we found were about three times higher than those rates

Most of the studies that have been done that have looked at aggression that's been perpetrated by military Veterans has focused on Vietnam Veterans. There are a handful of studies that are being done that look at aggression perpetrated by more recent cohorts of Veterans and these studies are just starting to come out now. One of these studies was conducted by Teten and her colleagues, and this was published in 2010. They looked at overall rates of partner violence perpetration over the previous year in groups of Iraq and Afghanistan Veterans with PTSD, Iraq and Afghanistan Veterans without PTSD and Vietnam Veterans with PTSD. So, they looked at these three groups who were seeking help in a PTSD clinic. And, basically what they found was that Iraq and Afghanistan Veterans with PTSD reported the highest rates of physical partner violence perpetrated against their partners. Iraq and Afghanistan Veterans with PTSD reported there was a 56% rate of partner violence. 40% of Iraq and Afghanistan Veterans without PTSD reported engaging in partner aggression and only 32% of Vietnam Veterans with PTSD reported partner aggression over the previous year. So, these are relatively high rates of physical partner aggression that are perpetrated by returning Veterans with PTSD, in particular, and even Veterans without PTSD reported fairly elevated rates of partner aggression. Interestingly, Iraq and Afghanistan Veterans with PTSD also reported that they were six times more likely to sustain an injury than those without PTSD. So, those with PTSD were much more at risk for sustaining an injury in an intimate partner dispute. There were also very high levels of mutual violence that were reported in this study indicating that not only the Veteran was engaging in partner aggression but their partner was engaging in partner aggression as well. And, this is something that sort of mirrors the domestic violence literature in non-Veterans as well and some other studies that have shown that the partners of Veterans may also engage in high levels of relationship aggression.

All right, so now I am going to shift gears a little bit and talk about some explanatory models and risk factors for aggression. So, we've talked a lot about rates of aggression among Veterans, but now we are going to talk about why Veterans may have more difficulties with anger and aggression than civilians, and why Veterans with PTSD, in particular, may have higher rates of anger and aggression.

One of the models that have been used to help explain why Veterans may be at risk for anger and aggression is referred to as the survival mode model. This is a model that is similar to the battlemind model that you may be familiar with. The idea here is that military members, when they are in the warzone, need to be constantly on guard and vigilant to any potential threat in their environment. So, they'll notice small changes in their environment such as a rock formation that is placed in a different way than it was previously. They'll pay attention to people's facial expressions to try to determine if that person might represent a threat, and they really need to be trained and they need to be very alert to any potential threats in their environment so they can respond to those threats possibly with aggression in order to stay alive and in order to keep their buddies alive when they are in the warzone. So, this heightened sense of threat perception is something that's very adaptive when they are in the warzone.

However, often when they return stateside, they still have this heightened sense of threat perception and they may be more likely to misread situations as overly threatening when the situation does not truly represent a significant threat. For example, they may misread one's facial expression as threatening when the other person really doesn't present any kind of threat to them at all or doesn't have any harmful intentions. So, as you might expect, for Veterans coming back who have this heightened sense of threat perception, and often faulty sense of threat perception, it can get them into trouble, because they start to view social situations through an overly negative or an overly hostile, or threatening, kind of lens and they misread these situations in a faulty way, and they may be more likely to respond to these situations with anger and with aggression. So, they may perceive unrealistic threats, exhibit an overly hostile appraisal of events, over-value aggressive responses to these threats and also exhibit a lower threshold for responding to these threats.

This survival mode model also tends to coincide with other models that have been developed to explain domestic violence perpetration not only in Veterans but in civilians as well. One well known and influential model for domestic violence is called the Information Processing Model for domestic violence that was developed by Amy Holtzworth-Munroe in 1992. This is a model that borrows from Ken Dodge's model that talks about social skills development and talks about information processing at different stages. And, this model really emphasizes that domestic violence perpetrators exhibit deficits in terms of how they take in and interpret their social world. So, there are various stages of information processing, and it has been shown that domestic violence perpetrators exhibit deficits at each of these stages. And, a lot of the emphasis has focused on the decoding stage, and this is the stage of information processing where people take in information and they interpret social information. There is a fair amount of research that supports the idea that men who exhibit violence exhibit these cognitive deficits at the decoding stage in particular. For example, they make faulty attributions about social situations and display irrational beliefs such as an overly hostile interpretation of events. So, again, this coincides well with the survival mode model of aggression among those who have PTSD, because it really emphasizes how people interpret their social world and that individuals who may have trauma, and may have PTSD, are maybe more likely to exhibit more of these information processes deficits, which may contribute to their violence perpetration. Also, importantly, these information processing deficits can be influenced by a number of other transitory factors that I'll be talking about next such as alcohol use and traumatic brain injury.

Some of the research findings that are out there that look at the impact of PTSD on aggressive behavior really seem to highlight the hyper-arousal symptoms of PTSD. So, these hyper-arousal symptoms reflect an overactive fight or flight response, and they involve symptoms such as increased anger and irritability, an increased startle response, difficulty sleeping. Basically hyper-arousal symptoms reflect increased physiological arousal and physiological reactivity, which, if we are thinking about the information processing models of domestic violence, it makes sense that these hyper-arousal symptoms would be most strongly related to aggression since, when one has this increased hyper-vigilance, increased sense of physiological arousal, it can have a strong influence on their information processing abilities and their executive functioning abilities.

So, we've talked about how PTSD is a contributing factor, it's a strong risk factor for aggression. There are also a number of other contributing risk factors that tend to go together with PTSD. They tend to be comorbid with PTSD, and they represent risk factors for aggression in their own right. All of these risk factors can influence social information processing. The three that I am going to be focusing on are depression, alcohol use problems and traumatic brain injury.

First, with respect to depression, evidence suggests that when a Veteran has PTSD, and then they have depression on top of that PTSD, it's a very strong risk factor for partner violence. So, there's an interactive effect between PTSD and depression on partner violence. There's been a number of theories that have helped explain why depression may be related to aggressive behavior. One of the best known

models was developed by Berkowitz, who is really one of the leading aggression theorists. His Cognitive Neoassociationistic Model of aggression highlights the role of dysphoric, or negative, affect in leading to aggression. So, this model states that negative affect is connected to anger networks, that include anger related feelings, thoughts, memories and aggressive inclinations, and when individuals experience negative affect more of the time, this is likely to trigger their anger networks and lead to a higher likelihood for aggressive behavior.

Alcohol use problems also tend to be highly comorbid with PTSD. In fact alcohol abuse and dependence is, in fact, the most highly comorbid psychiatric problem with PTSD. Models explaining why alcohol use tends to go along with PTSD really emphasize the role of self-medication. So, especially when an individual with PTSD has high hyper-arousal symptoms, they have this increased physiological arousal and reactivity, they are likely to use alcohol to try to damp down this heightened physiological reactivity, again as a way of self-medicating. We know that alcohol use, in and of itself, is a strong risk factor for aggression perpetration and research shows that alcohol leads to aggression, in part, through its impact on executive functioning. So, again, alcohol use can impact information processing which may place an individual at higher risks for aggression. Research also shows that alcohol use disinhibits violence among those who are high in hyper-arousal and those who are high in terms of anger problems. So, we are beginning to see a picture that emerges that, when an individual has PTSD, and then they have some of these other comorbid problems on top of that PTSD, such as depression, or such as alcohol use, it can increase risks for aggression in a multiplicative fashion. Often when Veterans seek care, or seek help for their PTSD, they often present with multiple problems in addition to PTSD such as depression or alcohol use, and when an individual has multiple of these risk factors, it can increase aggression, again, in an exponential fashion. So, it's important to consider all of these risk factors together when an individual comes in with PTSD and problems with anger and aggression.

Traumatic brain injury is also an important consideration when we are talking about PTSD and risk for aggressive behavior. One fairly recent study showed that 19% of Iraq and Afghanistan Soldiers, who have recently returned, screened positive for probable TBI during their deployment. And, we know that traumatic brain injury can lead to higher risks for aggressive behavior because it contributes to difficulties inhibiting behavior and regulating emotions and especially among those with PTSD. So, you may have an individual with PTSD who's at higher risk for aggression. So, you can think of PTSD as sort of an impelling factor for aggressive behavior. Then they have a disinhibiting brain injury on top of that PTSD which makes the expression of aggressive behavior more likely. There's also a relatively small literature among domestic abuse perpetrators in the civilian literature, and research shows that approximately half of all domestic abuse perpetrators report some brain injury over the course of their lives. So, traumatic brain injury seems to be very highly linked with partner aggression and aggressive behavior in general, not just among Veterans but among civilians as well.

It is also important to consider core themes when we are talking about the impact of trauma and PTSD on anger and aggression. So, as I am sure you are aware, when one experiences a deployment, or when one is exposed to trauma, it can really influence their views on the world and affect certain schemas that may impact how they act in intimate relationships. In particular, themes that may be impacted by trauma, that may be especially linked with relationship problems and aggression in relationships, are themes related to trust, self- and other-esteem, and power conflicts, and I am going to touch on each one of these briefly.

With respect to trust, we often hear from Veterans, who are returning, that they have difficulties trusting other people after they have experienced some form of trauma. Perhaps the service member did not know who they could trust when they were in the warzone and thus they find it difficult to trust people when they come home, or maybe they feel that somebody let them down during their deployment – maybe one of the other service members, or a commander that they feel let them down during a difficult

situation. And, so, they may have found it difficult to trust others in their unit, and then, when they come home, these feelings of mistrust can carry over to other people, including their intimate relationship partners. Sometimes service members feel that they can't trust anyone or that they feel that everybody is out to hurt or betray them, and this can result in controlling behavior with respect to their families. If they feel that they can't trust relationship partners, and others in their family, they may engage in more attempts to control these individuals' behavior.

Self- and other-esteem may also be impacted by trauma and PTSD. Sometimes Veterans may unfairly blame themselves for the trauma they experienced, or they may feel guilt over behaviors that they engaged in while they were deployed, and we know that low self-esteem can contribute to problems with depression, insecurity in relationships, and it's also a strong risk factor for relationship abuse. In addition to low self-esteem, traumas can also lead to the belief that other people aren't good and cannot be respected, and this is often referred to as other-esteem. And, when one develops low other-esteem, following exposure to trauma, it can lead to problems with social withdrawal and anger, which, again, can contribute to difficulties, interpersonally in relationships and ultimately lead to aggression down the road.

It's also very important to consider conflicts related to power and control in relationships. When Veterans are deployed, they may experience very profound feelings of powerlessness in the warzone. They may feel powerless to control the trauma that they're being exposed to, or the various conditions that they face, when they are deployed. And, sometimes these feelings of powerlessness can be profound and contribute to conflicts regarding power in relationships. So, sometimes when the Veteran feels powerless when they are in the warzone, when they come home, they continue to have this sense of powerlessness. They may try to exhibit more control over others in their family when they come home. What often happens is that when the service member is deployed, their family members, or relationship partners back home, take on additional roles around the house. Then, when the service member returns and the service member tries to kind of take on their former household roles, this can lead to conflict with their partners who may have taken on some of these different roles in the household, which, again, can contribute to these conflicts related to power and control in relationships. This is very relevant for domestic violence perpetration because a lot of the main, particularly feminist, theories to explain domestic violence perpetration highlight issues related to power and control.

Okay, so let's talk about objective two, which is describing the 2010 VA/DoD clinical practice guideline recommendations.

The first clinical practice guideline recommendation is to assess the nature of symptoms, severity and dangerousness. Consider using standardized anger scales such as Spielberger's State-Trait Anger Expression Inventory, to quantify. The second practice guideline is to explore for the cause of symptoms and follow up to monitor change.

So, both of these guidelines refer to the assessment of anger and aggression, and I just have a few more tips for assessing problems with anger and aggression when you are working with a Veteran with PTSD who may report difficulties with anger and aggression. First, it is very important to ask direct, specific and non-judgmental questions. So, don't be shy about asking directly about aggression. Ask about specific behaviors such as, "Did you push your partner? Did you shove your partner? Did you push or shove anybody other than your partner?" If you ask these kinds of questions in a more general way such as, "Is there any aggression going on? Is there any violence or abuse going on in the relationship?" people will often just flat out deny it. But if you are very specific and you ask it in way that shows that you really want to know the answer, and that you are not going to judge them for whatever answer they give, people are much more likely to openly report that they have engaged in some sort of aggression towards another individual. There's some research evidence showing that higher rates of aggression tend to be reported in interviews versus when you give somebody an intake, such as a paper and pencil measure, asking about

these things. So, again it really makes a difference how you ask these questions, and it's really important to be direct, specific and non-judgmental when you are asking these kinds of questions.

Secondly, avoid pressuring the patient. So, don't try to push them to try and get them to talk about it. Really let them talk to you about the aggression and don't try to pressure them into disclosing abuse. It's important to be aware of referral options and hotline numbers because if the Veteran reports that they are engaging in aggression, you want to give them very specific referrals. Tell them where they can get help to work on problems with anger and aggression. And, in a little while, I will be talking about some of the treatments that are out there to help with problems with anger and aggression that are related to PTSD. It's also important to assess aggression and abuse in as private an environment as possible. So, don't ask about these questions when the person is presenting with a relationship partner, or with other family members, because they are less likely to disclose the abuse when other people are present. And, you also don't want to put an individual at risk for reprisal if you're asking them about abuse victimization in front of others who may actually be the ones who are perpetrating that abuse. It is also important to assess how imminent the danger is, so ask the Veteran if they feel safe. Ask them if they have a support system to talk about issues related to anger, and aggression and ask if they have an emergency plan to use, both if they feel that they are going to engage in aggression, but also if they are perhaps being victimized themselves.

The third clinical practice guideline recommendation is to consider referral to specialty care for counseling or for marital or family counseling as indicated. Offer referrals for anger management therapy or training and exercise and relaxation techniques.

So, there have been a handful of studies that have looked at how effective anger management is for military Veterans, and pretty much all of this research shows that anger management is effective in reducing different forms of anger in military Veterans. For example, Chemtob and his colleagues showed reductions in anger expression and self-reported anger during anger-provoking situations using their cognitive behavioral anger management intervention. Marshall and her colleagues also showed reductions in state and trait anger, and physical aggression, in those participating in anger management intervention at a VA hospital. It's interesting that they found that anti-social characteristics predicted treatment response. So, those who had more anti-social personality characteristics tended to benefit less from anger management intervention. Morland and her colleagues, in a more recent study, showed that group anger management therapy delivered by video teleconferencing was as effective as anger management therapy delivered in person. So, this was a ground breaking study to show that you can deliver anger management therapy by video teleconferencing and this is also a very highly effective intervention. So, anger management intervention does not necessarily have to be delivered in a face to face format.

Okay, the remaining clinical practice guidelines are: number four, to promote participation in enjoyable activities, especially with family and loved ones. Number five, promote sleep and relaxation. Number six, avoid stimulants and other substances such as caffeine and alcohol. Number seven, address pain because pain is highly linked with problems with anger and aggression. Number eight, avoid benzodiazepines. Number nine, consider Selective Serotonin Reuptake Inhibitors (SSRIs), Serotonin Norepinephrine Reuptake Inhibitors (SNRIs). If not responding to SSRIs or SNRIs, and other non-pharmacological interventions, consider low-dose anti-adrenergics, and if not responding, or worsening, refer to specialty care.

And, lastly, in terms of clinical practice guidelines, it is important to be aware of other treatments for PTSD that also show that, in addition to their effectiveness with PTSD symptoms, they do have effectiveness for reducing anger. And, this is important because anger and irritability represents a component of PTSD. It's essentially one of the hyper-arousal symptoms. So, some evidence suggests

that Prolonged Exposure and Stress Inoculation Training lead to more reductions in state anger levels than those in a waitlist condition. And, this was a study conducted among women with chronic PTSD. Evidence also suggests that different versions of Cognitive Processing Therapy showed decreased levels of anger suppression, but they didn't find that anger expression was reduced by Cognitive Processing Therapy. Again, this was a study in women with PTSD.

Objective three is to describe a clinical application, and, specifically, I'm going to talk about the Strength at Home program which is a program that my colleagues and I developed to treat aggression perpetration, and, specifically, intimate partner aggression perpetration among military Veterans and active duty service members.

So, to give you a sense of background structure and format, again, this is an anger management intervention that's focused on those who have recently engaged in some type of partner aggression in the previous 6 months to a year. This is a program that was funded through the Department of Defense as well as the Department of Veterans Affairs. So, for this project, we have recently completed phase 1 of the program, which involve developing this intervention, and now we are in phase 2, which involves conducting a large scale controlled clinical trial. For this program, it is conducted in closed psychoeducation groups that consists of 12 weekly two-hour sessions with 3 to 5 Veterans per group and is co-led by male and female co-therapists.

There are different stages for the Strength at Home intervention. The first stage can be thought of as a psychoeducation phase, and then the next stage focuses on conflict management, where we're trying to help Veterans develop ways of reducing conflict to diffusing situations before situations escalate to problems with aggression. We provide coping strategies, that I'll talk about a little while, such as reducing stress and developing kind of cognitive strategies, or ways of thinking about situations differently to kind of prevent the aggression from escalating. And, lastly, we focus very heavily on communication skills to try to help the Veteran in expressing their feelings better, showing their partner that they're listening to them better, and to help to give them skills to resolve disagreements in situations with their partner, or with other people, that may present risk for conflict and aggression. Overall, the intervention strategies that I'll be talking about are very consistent with the number of other anger management interventions that are out there that have been designed to treat anger and aggression among Veterans with PTSD.

So, there are really four main stages of the Strength at Home program, and I'm going to walk you through each one of them. The first stage can be thought as, again, the psychoeducation phase. During this phase, the main focus here is to increase awareness about trauma and PTSD; how trauma and PTSD can impact relationships. We talk about different forms of abuse, so we provide definitions for what is physical abuse, what is psychological abuse, and what is sexual abuse. There's a heavy focus on different forms of psychological abuse, because, often, people don't have a great sense what psychological abuse actually is, or they often don't recognize that they're either engaging in psychological abuse, or they're experiencing psychological abuse. So, psychological abuse refers to behaviors that may include things such as: denigrating behaviors, or put down behaviors, where one calls their partner names or tries to make them look kind of foolish in front of other friends or family members. There are hostile withdrawal behaviors which may involve kind of withdrawing from situations, or not listening to one's partner when the partner is trying to tell them something. There are more dominating and kind of controlling behaviors that may involve direct threats or put downs. They may involve things such as driving recklessly to scare one's partner. So, there are a number of different forms a psychological abuse, and it's important to educate group members about these different forms of abuse.

We also, during the very first session with Veterans, use a motivational interviewing strategy where we talk about the pros and cons of aggressive behavior. Here, we're asking the Veterans to talk about what

they actually get out of their aggression, which is often, seems like a funny way to think about it, but, it's really important to have people develop an understanding of what is it that keeps these behaviors going. So, in a way Veterans learn to be aggressive because that aggression has some kind of desired effect for them. For example, often they will talk about how acting aggressively is the only way that they feel that can get their point across to their partner. Or maybe they more kind of powerful, or in control, when they respond aggressively. Or maybe they feel temporarily relieved; they may relieve their stress temporarily when engage in some kind of aggressive behavior, either verbal or physical kinds of aggression. Then we go to the other side, and we ask them what are the cons of aggression? What are all the negative things that their aggression has caused them? And, often, they come up with a really long list of all kinds of problems that their aggressive behavior has caused them, such as losing friends or family members, or a stigma that has been caused by them being identified as domestically violent. Often they talk about financial problems that have occurred as result of their anger and aggression. Maybe they've lost jobs. Maybe they've lost their military status or their military rank. There's all kinds of negative consequences that people talk about. Not to mention things such as jail time. They'll generally go through a laundry list of negative consequences that have come from their anger and aggression, and what the group leaders do is that they write down all of these pros and cons that the group member generates. And, invariably, there is a much longer list of cons for aggression than there is of pros. And, what the therapist will pose to the group members is, what we often ask is, "so given that you only get a few things out of your aggression, such as communicating better and temporary relief of stress, and considering all these cons that have come as a result of your aggression, do you see any other ways of meeting the needs of the pros without having all these cons associated with it?" And, Veterans, they pretty much always say yes, that they would like to find other ways to communicate with their partners without being aggressive. They would like to find ways of relieving stress without being aggressive. So, this could be a really useful strategy to try to increase their sense of motivation for working on issues of anger, aggression and abuse.

During this first stage, we also talk about some of the core themes that I have talked about, such as trust and self-esteem, power and control. We are really working with the Veterans to try to help them establish what their goals for group are. Obviously, an important goal is to cease any aggression and domestic violence, so that is something that all Veterans really agree on that goal. But other goals are important too, such as improving communication skills, finding better ways to take a break from a situation before it escalates too far. So, really during this early stage we're working on trying to motivate the Veterans for group and have them come up with treatment goals for themselves.

The second stage of the Strength at Home Program focuses on conflict management. So, here, the main goal is to help give them skills to diffuse situations before it escalates too far into anger and aggression. An important part of this conflict management phase is to give them education on the anger response. So, we talk about the fight or flight response and how in Veterans with PTSD they may be more likely have an overactive fight or flight response which may contribute to problems with anger and aggression. We also talk about how anger consists of thoughts, feelings, and physiological responses, and each one of these different responses can contribute to anger. So, we have Veterans begin to self monitor their thoughts, feelings, and physiological responses in practice assignments we give them, because we really want to know what it is that contributes to their own anger episodes and their aggressive behavior. So, we give them a self monitoring form where they check-off different thoughts feelings of physiological responses. Often what we hear from Veterans, when they first come into our program, is they talk about problems with aggression as something that is really beyond their control, and they often say that they don't see the aggression coming, that they just explode into aggressive behavior. And, invariably, in our groups we have Veterans who say that and they say they would never be able to diffuse the situation because it just happens instantaneously. And, what we find is that, even among these Veterans, when they begin to monitor what their thoughts feelings, and physiological responses are, when they are really paying close attention to their anger response, they are able to notice certain warning signs for their anger and aggression. They may start to notice that their heart is beating a little bit faster, or they might

start to get red or start to sweat, so those are some of the physiological responses. They might start to notice that they feel hurt or betrayed and their thoughts are starting to race, so these are feelings that often contribute to anger and aggression. With respect to their thoughts, they may begin to feel again their thoughts may race. They may begin to think that the other person is trying to betray them or the other person isn't on their side. Often what we see in Veterans with PTSD who have problems with anger and aggression is that they are more likely to think about situations in an overly negative or overly hostile way, which goes back to the survival mode model that I talked about earlier; that Veterans who experience trauma and have PTSD may experience faulty thoughts, negative thoughts, that can fuel their anger. So, an important goal of treatment in working on anger and aggression is to have them recognize it for themselves when they're having these negative thoughts and to try to replace the thoughts with more positive thoughts.

During this second stage we also do assertiveness training, because what we often see in Veterans who have problems with anger and aggression is they often vacillate between being overly passive in situations to being overly aggressive in situations. Veterans often talk about how growing up as children they were taught that to be a man you didn't talk about your feelings, and that, often, military training reinforces those ideas where they are taught to keep in their feelings, to not talk to others about their feelings such as feelings sad, afraid, hurt or anxious, and instead to turn those feelings into anger and aggression. So, often, we have veterans come into our group who talk about going back and forth between either keeping in all of their feelings and then often, when they stuff their anger, and the stuff all these other feelings, they go to the other extreme and they explode into more aggressive ways of expressing their anger. So, we really work with Veterans to try and find that middle ground and to try and teach them how to be more assertive and express how they feel when situations come up; to express their angry feelings but also the feelings underneath the anger such as feeling hurt or feeling betrayed in different situations. And, once they find they are able to express their feelings in different situations, they are not stuffing their feelings, then they're not kind of walking around with all this kind of pent up anger and frustration, which makes them less likely kind of blow up into aggression down the road.

Also during this stage we teach the Veterans timeouts to de-escalate difficult situations. And, by timeouts, I'm not referring to simply just kind of walking away from a situation when the Veteran gets angry, but, rather, for the Veteran to come up with a very specific, detailed written plan for how they're going to take a break from a situation before it escalates to aggression. So, we have them write out a specific plan in which they write about how they'll call a time out in a situation, where they'll go, what they'll do, how long the time out will last for, and what they'll do when the timeout is ended. And, then we give them practice assignments where they practice taking a time out in different situations and they come back to the group and they talk to the group about what worked well, what didn't work well, what they might need to tweak for their time out plan, and how they are going to overcome any barriers that they experience to taking a time out in anger provoking situations.

Alright, the third stage of Strength at Home focuses on coping strategy and kind of building on some of the work in recognizing a negative thought processes, that I talked in some of the earlier stages. Here we're making it even more explicit where we're working with Veterans to identify negative ways of thinking, and to develop more realistic appraisals of threat and other people's intentions. So, at this point, they've been monitoring themselves in terms of their negative thinking. And, during sessions five and six we also give them handouts which talk about the survival mode that I described earlier. During this phase we also talk about coping with stress and the importance of matching coping strategies with the nature of the stressor. So, we talk about how some situations that are changeable, it can be very useful to use problem-focused coping strategies to work on changing that situation. For example, leaving more time to drive to work in the morning is a good example of problem-focused coping which can reduce stress. And, then there's emotion-focused coping that is used when there's nothing you can do to change the nature of the stressor. For example, coping with the loss of a loved one. So, we talk about coping, emotion-

focused coping strategies, such as finding better ways to relax or to exercise, whatever it is for them that reduces their stress. We also cover relaxation training for anger during this phase.

During the last phase of Strength at Home, we focus on communication skills. So, one of the sessions focuses on what we call roots of your communication style, and here we have Veterans reflect on how they learned how to express their anger and express their other emotions over the course of their lives. We also focus, very heavily, on improving listening skills. Research shows that improving listening is really the best way to improve communication and to enhance relationships. So, we have the Veterans practice things such as paraphrasing; where they're reflecting back what their partner is saying to them by using slightly different words to convey that they understood the meaning behind what their partner was trying to convey. We also try to teach them to work on validating their partners more, to clarify things through questions more, these are some of the main elements of active listening. We also teach the Veteran how to give an assertive message. So, we provide tips such as to be very specific about whatever it is that's bothering you that you want to convey to the other person; to talk about the emotions, or how that situation makes them feel, and to talk about what they would like to see in that situation, what would be the desired effect that they would like from that situation. We also emphasize expressing feelings during this phase. Veterans, especially Veterans with PTSD, often have problems with emotional numbing where they have difficulties understanding what it is that they're feeling or they don't have any feelings at all. So, it's very important to have them identify what it is their feeling during different situations; what some of the feelings might be underneath that anger because anger is really the easiest emotion for them to express, oftentimes, but it's really important to express, and be in touch with, what are those feelings that are contributing to their anger. Because usually when Veterans get angry, it's not just that they're angry, but it's they feel hurt or they feel sad. They feel betrayed. There's always other emotions that are underneath the anger, and those are the emotions that they really need to convey to other people to let them know how they feel about the situation. During this fourth stage, we also go over communication traps. These are traps that, really, all couples can fall into, but Veterans with PTSD maybe at higher risk for falling into these traps. An example of one of these traps is mind reading, where the Veteran assumes they know what the other person is thinking and often they assume in the most negative direction possible. So, we try to help Veterans to avoid these different communication traps or pitfalls that people often fall into when it comes to communicating with others.

OK, just shifting gears a little bit, I'm just going to present some of the pilot data that we have from the Strength at Home Program. These are data that were collected during the treatment development phase, when we were first developing the program. We only have a handful of people in this pilot sample, so it's not a tremendous amount of data. But, it does help give us a sense of how effective the group, the program, is. It, at least, provides us some initial effect sizes for some idea of reductions in aggression in the program.

So, this is a table that shows overall physical aggression scores from pretreatment; so when the individual first comes into Strength at Home Program, to six months after they complete the Strength at Home Program, using what is called the Conflict Tactics Scale. So, this is the most widely used measure of relationship aggression that has been used. And, we looked at physical aggression variety scores. Variety scores really refer to the number of forms of aggression that the individual has engaged in. So, what we see in the total row, we see that Veterans reduced their aggression from 4.5 different forms of aggression to approximately one form of aggression at six-month follow-up, and these reductions in overall physical aggression were statistically significant with a very large effect size suggesting that these were substantial reductions in aggression. We also found reductions in both mild and severe forms of physical aggression.

Similarly, we looked at reductions in psychological aggression frequency from baseline, or pretreatment, to six-month follow up. And, these numbers refer to the actual frequency of aggressive behaviors. So,

again, looking at the total row, we see that Veterans reported in engaging in approximately ninety-three acts of psychological aggression in the six months prior to baseline, and this was reduced to approximately 43 acts of psychological aggression in the 6 months after treatment. Again, these were statistically significant reductions in psychological aggression. We also found substantial reductions in mild and severe psychological aggression. And, I should also note that these reports of physical and psychological aggression were obtained from both the Veteran and also from their relationship partner, so they're combined scores of psychological aggression. So, that was just kind of a brief summary of some of the pilot data suggesting efficacy for the Strength at Home Program.

And, finally, to summarize this program, PTSD is associated with heightened anger and greater risk of aggression in Veterans. There is very consistent research evidence that shows this. Also, anger and aggression represent significant clinical concerns among Veterans with PTSD. So, Veterans who are presenting for help with PTSD often described anger and aggression as one of their primary concerns. And, one thing that's important to point out is that not all Veterans with PTSD have problems with anger and aggression. In fact, most Veterans of PTSD don't have problems with aggression, although they may be at higher risk for anger and aggression. And, finally, there are promising anger management interventions that are out there that may be delivered in different formats.

And, I'll close with providing a slide showing that if people are interested in the Strength at Home program we have a web site www.strengthathome.com.