Tri-County Batterer Intervention Provider Network Meeting
Minutes--11/13/01

Present:Gustavo Picaso, Lee Parker, Michael Davis (Changepoint); Chris Huffine (Men's Resource Center); Devarshi Bajpai (ASAP); Paula Manley; Christine Crowe (Choices DVIP); Stacey Womack (ARMS); Marc Hess (Mult. Co. Corrections), Songcha Bowman.

Minutes by Paula Manley

Topic: When are Medications Warranted in treating abusive men, featuring Barbara J. Limandri, DNSc, PMHNP

This is a follow-up to a presentation made last winter on the effects medication can have on aggressive behaviors. We see many abusive men, but want to focus on those who might benefit from medications specifically related to their aggressive behavior. Some may benefit from this.

Further information is available from Chris Huffine.

What medications can help are anything that is biologically mediated. Most mental disorders are brain disorders with behavioral consequences. We need to have a body, mind and society unification. Medications can help, but only with one piece. People often get over-invested in the medication piece. But I need to have the rest. Medication should be used only when someone is also working on his behavior.

Symptoms that indicate medications might help include poor concentration and thought disorganization. Emotional leakings—someone who is spontaneously tearful or angry—when genuinely don't know where it comes from. Impulsivity has a brain component. Confusion may be biologically mediated. It may also have to do with general physiology as well as the brain.

Episodic violence – almost like a seizure-invoked violence. They suddenly become angry, irritated, almost have a spontaneous violence where they throw things, hit things, perhaps themselves. There is usually not an external events stimulus. These are often called temporal lobe seizures. There is no obvious gain from the violence. This person genuinely doesn't understand their behavior and genuinely wants something done about it. It is mediated by the limbic node. There is usually an aura associated with it—see something over their left shoulder, or smell something. They are not psychotic. It is identified-via ct scan.

The brain and our lives are both complex. When someone has a minor concussion, we worry that it might start a "kindling effect". This is where some nerves may start firing at a low rate. This may activate some other neurons, and perhaps a year later, the person may have a seizure. Depending

on where this occurs in the brain, it may also cause intermittent explosive disorder. In the midst of it, the person may feel they were not there, were in another realm. This can be treated with the same drugs as a person with a seizure disorder. If you can get the nerves to work on a regular basis and interrupt the kindling, this will stop the behavior in these cases, using anticonvulsants. The same thing happens with people who have manic episodes.

The limbic system of the brain is the emotional system. Emotional learning and memory involve facts and problem-solving types of facts. If someone is jerked back in an emotional traumatic memory, they may be right back to the age they were when an event occurred. You have to get the limbic system and the frontal cortex connected. The behavior approach helps learn to recognize and to intervene. It can't if it's blocked.

For a human to store a memory we have to process it and make sense of the event. If you can't process it, it is only stored, ready to be evoked when there is another opportunity to process it. The limbic system mediates between the external and internal.

The olfactory nerve is hooked right into the limbic system. A smell can evoke a flashback. The frontal cortex is what helps us recognize that something is a memory, not something happening now. It gives us social consciousness telling us when it's not the time to react in a certain way.

Perpetrators react out of shame and denial. One of the reasons for talking about their past abuse is to process it. When it is traumatic, we get tunnel vision and only process what is in front of us. We remember it, but often just store it without processing. As you go through it, you can sort it out and add options. This goes into the learning piece that the hippocampus can process.

Reprocessing has some dangers, because they are feeling the experience that they had as a child (or whenever). They have the fear and the sense of powerlessness, along with the adult strength. As you process, you bring the thought into feeling. But before they do that, they have to have stress management skills to be able to deal with their own stress as they deal with their feelings. As they go through that, remind them to do their deep breathing, bring them back into the present.

The more the neural pathways are used, the more active they are. When an infant's brain is active, the norepinephrine pathway, it gets everything going and gets to the frontal cortex and gets your attention. The muscles are ready to go because the autonomic system is activated. If you don't have the nurturing of parental soothing, with the serotonin pathway, you will probably have someone who is hyper-aroused. This is the guy who is over-sensitive to himself and under-sensitive to others. Medications can be used. You can accentuate the serotonin—medication or exercise when this person is activated. Serotonin dopamine antagonist. When you have someone

who doesn't think clearly under stress, you can use serotonin dopamine blocking, which blocks the receptors.

Sense of lack of remorse is a frontal cortex reaction. Lack of remorse is due to an underutilization of the frontal cortex. Hypofrontality when you don't have the balance between serotonin and norepinephrine. Between the limbic system and frontal cortex is if someone may have a blunt emotional system—they don't feel. This is also true with chronic post-traumatic stress as well as antisocial. Men who are antisocial have a low level of cortisol at all times. Serotonin reuptake inhibitors are good. Many people can't tolerate Serzone.

GABA drugs (benzodiazepines) put the frontal cortex to sleep and reduce conscience, etc. These aren't a good idea for aggressiveness.

For BIPs, look at the guy who actually is taking advantage of the therapy, but isn't getting the full effect. The other situation is when the individual is depressed. They may have irritability, depression. They have emotional leaking, but deny it. These men would benefit from medication.

Barbara won't start someone on medication unless they are in therapy. The cognitive behavioral approach gives them tools to manage.

Symptoms that would give concrete indication for medication referral: Anyone with nuero-vegetative signs (sleep, appetite), anyone with poor concentration on a regular basis, someone who is impulsive despite behavioral controls—acts before they think even though they have the skills, someone with emotional leaking who suddenly becomes tearful, irritated and the irritation grows, someone who becomes isolative, dissociates. Anxiety that they can't disrupt with cognitive approaches. Six weeks into it is the important variable, because that is when the brain starts downloading receptors.

Carbohydrate craving along with irritability and over-sensitivity. That probably is a serotonin balance thing. Craving for chocolate. Some guys with antisocial personality have a rewards center that is totally nonfunctional. They need a lot of chemicals that stimulate their reward center—caffeine, drugs (not alcohol), chocolate, Wellbutrin. Wellbutrin acts on the reward center.

Usually when they get clean, the reward center is just aching. They may start smoking or drinking coffee. Are vulnerable to relapse when they have an episode that causes guilt. Women will go to chocolate when feeling guilty.

Hypothalamus –reward center (Fs).

THC long term destroys the dopamine receptors, which causes the amotivational system. It also affects the hypothalamus.

For some men, the stalking behavior goes away with teaching self-care, but not al. Socialization and developing a support network is an appropriate intervention. Often the guys won't have the social skills to develop that. Usually, obsessed stalkers may need serotonin dopamine antagonists (anti-psychotics).

Shame drives a lot of violence. Medications don't help that—information does.
A lot of times, understanding what the brain is doing will help the client

When referring for medical, give a sense of what you have observed and what clients has done, where he is in process, etc. Nurses are trained to teach; physicians are trained to order people. Nurse practitioners of Oregon: Oregon Nurses Association website or can call them for a directory. On each person, the specialties will be listed.

Bottom line summary (by Chris Huffine)

Symptoms present at intake or shortly thereafter that may indicate that a referral for a psychiatric/medication evaluation might be appropriate:

- -generalized anxiety (i.e., not focused on any one thing)
- -emotional leakage (sudden, intense emotions)
- -poor thinking/decision-making under stress
- -episodic violence (i.e., without a clear pattern of control)
- -intense rumination/obsessive thoughts/jealousy/stalking behaviors
- -depression with vegitative signs of greater than 6 weeks in duration
    - -impaired sleep (or excessive sleeping)
    - -reduced appetite (or excessive eating)
    - -poor concentration
    - -social isolation
    - -mood swings/labile mood
    - -anhedonia (disinterest in normally pleasurable activities)
    - -depressed and/or irritable mood

Symptoms present after a man has been enrolled in the program for some time and appears committed to being nonabusive, but struggling to do so (in spite of appearing to have the skills to do so) that may indicate that a referral for a psychiatric/medication evaluation might be appropriate:

- -intense emotional outbursts
- -impulsivity
- -unresponsive rumination/paranoia