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A Solution-Focused Group Treatment Approach for Individuals Maladaptively Expressing Anger

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A SOLUTION-FOCUSED GROUP TREATMENT APPROACH FOR INDIVIDUALS MALADAPTIVELY EXPRESSING ANGER

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I HEREBY RECOMMEND THAT THE DISSERTATION PREPARED UNDER MY SUPERVISION BY **KIMBERLY MARIE BRZEZOWSKI** ENTITLED **A SOLUTION-FOCUSED GROUP TREATMENT APPROACH FOR INDIVIDUALS MALADAPTIVELY EXPRESSING ANGER** BE ACCEPTED IN PARTIAL FULFILLMENT OF THE REQUIREMENTS FOR THE DEGREE OF DOCTOR OF PSYCHOLOGY.

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Abstract

This dissertation describes a proposed protocol for a brief solution-focused group treatment model for treating "expressed externalized anger". Such an approach postulates that positive and lasting change can come about in a relatively brief period of time by using a solution-focused rather than a deficits-focused approach. Without minimizing or diminishing the negative and detrimental consequences of maladaptive anger expression, a solution-focused approach aims at using an empowering approach to hold group members responsible for recognizing and utilizing solutions to their difficulties in appropriately managing their anger. This proposed protocol includes a complete solution-focused treatment approach with a stage by stage description of the group process as well as the interventions and techniques specific to each of these stages.

Chapter One

Introduction to the Study

Aim and Purpose

Anger, like other feelings and emotional states at times has utility, however; when anger is expressed maladaptively through acts of aggression and abuse it is a problem. Literature suggests that counseling and psychotherapy are effective for anger reduction (Deffenbacher, Oetting, & Digiuseppe, 2002). Digiuseppe (1999) notes that anger has been a long neglected area of study among mental health professions. The lack of diagnostic categories for anger disorders results in researchers and clinicians applying one intervention across the domain of all angry clients (Digiuseppe & Tafrate, 2003). It also suggests that nearly all the research done on anger has come from one general perspective, and that these conclusions are likely more limited to cognitive-behavioral (CBT) therapy approaches (Deffenbacher, Oetting, & Digiuseppe, 2002). While effective, CBT also has its limitations, and because one mode of treating anger has been proven to be effective under certain circumstances, this does not mean that there cannot be others. There is currently no strengths based approach to treat anger that can be compared to the current deficit based modes. Clinicians are held to the standard that they implement the best possible approach and utilize the most effective treatments when working with clients. The aim and purpose of this dissertation is to explore the development of a strengths based solution-focused protocol to be piloted and used for comparisons with currently used deficits based perspectives. The following discussion will include a literature view that discusses pertinent information regarding the study of anger and the foundation and motivation for this study. Following the literature review the design of the

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protocol will be defined followed by guidelines for group leaders, a model for

implementing the protocol, a sample implementation design for a pilot group using the

protocol, and a method for comparing the protocol to a currently used CBT model. The

discussion and future directions will follow and the sample protocol will be located in the

appendix.

Chapter Two

Literature Review

What is Anger; is it Defined?

Like many other feelings or emotions, anger is ubiquitous and intangible. Digiuseppe and Tafrate in a book on anger, state: "The primary problem with the study of anger as a clinical phenomenon or as a disorder is definitional confusion." As evidenced in the literature, there are many and differing variations of the definition of anger (Digiuseppe & Tafrate, 2007; Digiuseppe & Tafrate, 2001; Feindler, 2006; Gardner & Moore, 2008). Early attempts to define anger were based on physiological indices. Some authors define anger as cognition, while others don't emphasize cognition enough. Some researchers overemphasize the link between anger and aggression (Digiuseppe & Tafrate, 2007). Digiuseppe and Tafrate (2007) acknowledge that they originally defined anger as, "an internal, mental, subjective feeling-state with associated cognitions and physiological arousal patterns." They then recognized that this definition can be applied to all emotions. In addition, they argue that broad definitions fail to distinguish anger from other emotions (Digiuseppe & Tafrate, 2007). They concede that as a field, we do not apply this same distinction to other emotions, such as depression or anxiety. We do not assume that depression is the same as diminished activity or withdrawal, and we do not consider anxiety the same as avoidance or escape. Anger is the only emotion that is viewed as a synonym to the behavior that follows it (Digiuseppe & Tafrate, 2007). Digiuseppe and Tafrate (2007) note that the first step in the study of a clinical construct is to establish an acceptable definition of the construct. When a clear definition of a

construct is absent, then the investigation and ability to develop valid assessment instruments for that construct is significantly hindered (Digiuseppe & Tafrate, 2007). In acknowledging the differing definitions that exist for the construct of anger, Digiuseppe & Tafrate relate it to the proverbial three blind men, each of which feel a different part of an elephant and make a different, yet somewhat accurate description of the animal. The current definitions available address some aspect of anger, yet often fail to include other, just as important components of the construct (Digiuseppe & Tafrate, 2007).

The common English language definition of anger is, "A strong passion or emotion of displeasure or antagonism, excited by a real or supposed injury or insult to one's self or others, or by the intent to do such injury" (www.webster-dictionary.net). Kassinove and Tafrate (2006) propose a comprehensive definition of anger that they recommend clinicians and researchers use. "Anger is a negative, phenomenological feeling state that motivates desires for actions, usually against others, that aim to warn, intimidate, control, or attack, or gain retribution." They note that it is associated with cognitive and perceptual distortions and deficiencies. Included in these distortions are: Misappraisals about its (anger's) importance, misappraisals about the capacity to cope, justice oriented demands, evaluations of others, dichotomous thinking, overgeneralization, attributions of blame coupled with beliefs about preventability and/or intentionality, subjective labeling of the feeling, and fantasies of revenge and punishment. They also recognize that it (anger) may, but not always, be typically associated with physiological changes and socially constructed and reinforced patterns (Kassinove & Tafrate, 2006). Digiuseppe & Tafrate (2007) note that an agreed upon definition of anger

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has been hard to distinguish and that such an agreed upon definition has important implications for accurate assessment as well as treatment.

In addition, anger can be further divided into subtypes, particularly state vs. trait anger. It is important that not only a broad definition of anger is identified, but that the subtypes are identified and defined. In attempts to facilitate the understanding of anger, Spielberger and his colleagues adapted state-trait personality theory to anger (Deffenbacher et al., 1996). State anger refers to a transitory emotional-physiological condition consisting of subjective feelings and physiological activation. In regards to affect, state anger is experienced along a continuum from little or no anger through mild to moderate emotions such as irritation, annoyance, and frustration to highly emotionally charged states such as fury and rage (Deffenbacher et al., 1996). Physiologically, state anger varies from little or no change in physiological arousal to marked sympathetic arousal, increased tension in facial and skeletal muscles, and release of adrenal hormones. State anger is an emotional physiological condition that occurs in response to an immediate situation, varies in intensity, and vacillates over short periods (Deffenbacher et al., 1996). Trait anger, on the other hand, refers to a stable personality aspect of proneness to anger or the tendency to experience state anger. Therefore, high trait anger individuals experience more frequent and more intense state anger. Trait anger is thought to be a relatively stable individual difference in frequency, intensity, and duration of state anger (Deffenbacher et al., 1996). In suggesting trait anger as a broad personality disposition toward anger, state-trait anger theory leads to five general predictions. (a) Trait anger reflects a tendency to become more easily angered (the elicitation hypothesis; i.e., high-anger individuals should be more easily angered, which should be reflected in

greater numbers of things that anger them and in greater frequencies of daily anger). (b) Trait anger reflects a tendency to respond with more intense anger when provoked (the intensity hypothesis; i.e., high-anger individuals should experience stronger anger reactions). (c) Because of greater intensities and occurrences of anger reactivity, high trait anger individuals are projected to manage less well with anger and to express themselves in less positive, less beneficial ways. That is, trait anger reflects a tendency to express anger in less adaptive and less purposeful ways (the negative expression hypothesis), which should be reflected in more frequent anger suppression and outward, negative expression of anger and less common presentation of positive coping. (d) Because of greater incidences and intensities of anger and because of less positive coping, high trait anger individuals are more likely to experience negative anger-related consequences. That is, trait anger reflects a tendency to experience more frequent or severe anger-related consequences (the consequence hypothesis). (e) If trait anger reflects a unique personality disposition toward anger and not other emotional traits, then trait anger should relate to anger related constructs more powerfully than to constructs that do not involve anger (the discrimination hypothesis) (Deffenbacher et al.,1996).

Defining anger and the subtypes of anger is an important concept to consider in creating a possible approach or method in anger management treatment. Another important concept that coincides with defining anger and its subtypes is the mode of anger expression. Anger can be internalized or externalized. Externalized anger can be defined as anger that is expressed outwardly, toward people or things in the environment (e.g., assaulting or striking others, making verbal threats, using profanity profusely), whereas internalized anger is suppressed or directed inwardly (e.g., frustration or

becoming agitated). The proposed protocol is directed at anger that is directed outwardly or externalized anger.

For the purposes of this protocol, we will use the previously discussed definition of anger suggested by Kassinove and Tafrate (2006), recommend for use by clinicians and researchers. "Anger is a negative, phenomenological feeling state that motivates desires for actions, usually against others, that aim to warn, intimidate, control, or attack, or gain retribution." This definition is an action oriented definition that goes well with the objective of the protocol to treat anger that is maladaptively expressed by individuals. The definition focuses on behaviors and not just the affective state of anger.

Anger is a Neglected Area of Study; No DSM-IV Diagnosis Exists

Literature review and research supports the notion that there is currently no DSM-IV diagnosis for anger or anger disorders (Deffenbacher, Oetting, & Digiuseppe 2002; Digiuseppe, 1999; Digiuseppe & Tafrate, 2001; Digiuseppe & Tafrate, 2003; Feindler, 2006; Gardner & Moore, 2008; Gorenstein, Tager, Shapiro, Monk, & Sloan, 2007, Kassinove & Tafrate, 2006). The construct of anger is a neglected area of study. There are several hypotheses as to why this is true. There are no disorders where anger is a necessary or defining condition, and there are no DSM-IV categories for dysfunctional anger (Deffenbacher, Oetting, & Digiuseppe, 2002). The closest the DSM-IV comes to diagnosing anger is with Intermittent Explosive Disorder (IED). IED is a behavioral disorder characterized by extreme expressions of anger, often to the point of uncontrollable rage. These anger expressions are disproportionate to the situation at hand. It is currently categorized in the Diagnostic and Statistical Manual of Mental Disorders as an impulse control disorder (American Psychiatric Association, 2000).Kleptomania,

Impulsive Gambling, Trichotillomania, Impulse Control Disorder Not Otherwise

Specified, and Pyromania all accompany IED in the larger family of Axis I impulse

control disorders listed in the DSM-IV-TR. The essential feature of Impulse-Control

Disorders is the failure to resist an impulse, drive, or temptation to perform an act that is

harmful to the person or to others (American Psychiatric Association, 2000). For most of

the disorders in this section, the individual feels an increasing sense of tension or arousal

before committing the act and then experiences pleasure, gratification, or relief at the

time of committing the act. Following the act there may or may not be regret, self-

reproach, or guilt (American Psychiatric Association, 2000). Impulsive anger is

unpremeditated, and is defined by a disproportionate reaction to any provocation, real or

perceived. Some individuals have reported affective changes prior to an outburst (e.g.,

tension, mood changes, and energy changes) (American Psychiatric Association, 2000).

Taking this into consideration, it is easier to see the differences between IEP and anger.

Anger is at times un-premeditated, and those who have anger problems do not always act

on their feelings. Additionally, those who act on their anger do not always feel the

gratification, and pleasure that those experiencing IEP feel. For individuals maladaptively

expressing anger, the anger is not an unwarranted impulse, but it often the result of these

individuals feeling wronged, insulted, antagonized, or agitated.

Digiuseppe (1999) notes that between the years of 1985 and 1997 there were

approximately one tenth as many articles on anger as there were on depression and about

one seventh as many articles on anger as there were for anxiety. Digiuseppe and Tafrate

(2003) discuss the notion that the scientific study of anger treatment has lagged far

behind that of other disorders such as anxiety and depression. Less is known about anger

than about anxiety and depression. This leads to the belief that there is less scientific knowledge about anger on which to base the interventions and treatments for dysfunctional anger. This may cause clinicians to shy away from treating anger. Additionally, the lack of diagnostic categories for anger disorders results in researchers and clinicians applying one intervention across the domain of all angry clients (Digiuseppe & Tafrate, 2003).

Little agreement exists among researchers and clinicians as to what exactly constitutes an anger problem, and studies to determine the effect of anger treatment have been conducted using various methods. The studies examined in Digiuseppe & Tafrate's 2003 meta-analytic review of anger treatment for adults noted that some studies defined anger problems psychometrically. In this study, they included 50 between-group studies with control groups and 7 studies with only within-group data. They then conducted a meta-analysis of adult anger treatments. In total, they examined 92 different treatment interventions and included over 1, 000 subjects. They identified relevant studies that were present among the existing literature base. The studies they included followed the following criteria: (a) include studies published in or after 1970, (b) include at least one anger outcome measure, (c) provide at least two treatment sessions, (d) focus on adult subjects, (e) provide enough information to calculate effect sizes for group data (Digiuseppe & Tafrate, 2003). Most of the studies identified participants psychometrically, by choosing people who had a high score on a measure of anger. Using the said techniques, they identified 57 studies to use in the meta-analysis. Fifty of the studies compared one treatment to a control condition (between-group studies), and 7 studies evaluated at least one treatment with pre-post-treatment measures (within-group

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studies). Results showed that subjects who received treatment showed significant and moderate improvement compared to untreated subjects and a large amount of improvement when compared to pre-test scores (Digiuseppe & Tafrate, 2003). It was shown that anger interventions produced reductions in the effect of anger, reductions in aggressive behaviors, and increases in positive behaviors.

Other studies of prison inmates used a recent history of aggressive behaviors as the measure of anger, presenting a floor effect for anger measures. Researchers may have included participants with minimal degrees of anger disturbance, or they may have included highly variable subgroups of angry people. The variances on not only degree of anger, but the characteristics used to measure anger have an impact on treatment and treatment outcomes. The absence of guidelines for anger disorders or anger subtypes hinders research (Digiuseppe & Tafrate, 2003).

Kassinove and Tafrate (2006) suggest that working with angry clients is difficult because the clients are often unreceptive to treatment, and they typically avoid interactions. Additionally, when angry individuals are forced to confront issues, they begin blaming others (Kassinove & Tafrate, 2006). Because angry clients do not take personal responsibility for reducing their anger, it is often difficult to engage them and successfully implement intervention techniques (Kassinove & Tafrate, 2006).

Digiuseppe and Tafrate (2001) believe that one reason for lack of research is due to practitioner discomfort that stems from the lack of knowledge regarding effective intervention strategies. Practitioners often recognize the scarcity of treatment-outcome studies as well as the complete lack of standardized assessment instruments that focus on anger as a clinical problem (Digiuseppe & Tafrate, 2001). Researchers acknowledge that

anger is a prominent and important emotion, but also recognize the lack of attention given to the construct. The lack of attention given to clearly defining anger and in anger research leaves a lot unanswered when one considers appropriate and effective ways of treating those with anger problems.

To Treat Anger or Not to Treat Anger

Digiuseppe and Tafrate (2007) note that another possible explanation for the lack of clinical research on anger may be due to the failure of our language to discriminate between functional and dysfunctional anger. The state of anger sometimes leads to functional behavior, and always refraining from anger would interfere with signals to engage in the resolution of conflicts (Digiuseppe & Tafrate, 2007). A state of anger may occasionally lead to adaptive behavior. However, the frequent experience of trait anger may be more dysfunctional (Digiuseppe & Tafrate, 2007).

Digiuseppe and Tafrate (2003) recognize that the differentiation between disruptive, maladaptive anger and adaptive normal anger is an important issue. They note that some low level anger and annoyance are adaptive. Additionally, the concept of the flight or fight response is important when meeting a potential danger or a harmful situation (Digiuseppe & Tafrate, 2003). In human interactions, raising ones voice in negotiations or while prompting a young child to follow directions may convey assertiveness, or warn of the possible consequences of noncompliance. Expressing one's anger when not receiving adequate service may lead to better service in the future (Digiuseppe & Tafrate, 2003). There are instances where anger is helpful and necessary. However, anger can also be maladaptive and detrimental.

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The question of what defines maladaptive anger is a tough one, and the lack of diagnoses related to anger does not make it any easier to answer (Digiuseppe & Tafrate, 2003). Trait anger is recognized as an important factor contributing to many Axis III problems. Included in these problems are such things as high blood pressure, stroke, and cardiovascular disease (Digiuseppe & Tafrate, 2003).

Gardner and Moore (2008) acknowledge that the emotion of anger is usually intended to serve as an adaptive function such as in the basic purpose of preparing human beings to respond to threats in the environment. However, when anger is seen in other contexts beyond the preparation of one to deal with threat, the emotion can lead to chronically heightened arousal and can be associated with dysfunctional and problematic behavior (Gardner & Moore, 2008). Heightened intensity, frequency, and duration of anger are precursors to a variety of interpersonal, health, occupational, and legal difficulties (Gardner & Moore, 2008). It is these instances in which treatment of anger would be useful and at times necessary.

Intense anger expressed in hostile ways can lead to many problems. Elevated anger that is expressed aggressively has been found in partner violence; abusive parenting patterns, and disturbed family functioning (Deffenbacher, Oetting, & Digiuseppe, 2002). Anger and hostility also contribute to health problems, such as cardiovascular disease (Deffenbacher, Oetting, & Digiuseppe, 2002). In addition to health problems, anger has been an implication in school violence, bullying, and disrupted teen relationships (Deffenbacher, Oetting, & Digiuseppe, 2002; Gorenstein, Tager, Shapiro, Monk, & Sloan, 2007). This demonstrates the need for a variety of appropriate interventions for anger treatment.

Current Treatment of Anger and What is Being Utilized

Literature suggests that counseling and psychotherapy are effective for anger reduction (Deffenbacher, Oetting, & Digiuseppe, 2002). It also suggests that nearly all the research done on anger has come from one general perspective, and that these conclusions are likely more limited to cognitive-behavioral (CBT) therapy approaches (Deffenbacher, Oetting, & Digiuseppe, 2002). Recent meta-analyses of CBT interventions show that the mean effect sizes for CBT interventions differ significantly from 0.0 and that the average CBT client fared better than 76% of control participants (Deffenbacher, Oetting, & Digiuseppe, 2002). This indicates that meta-analyses suggest at least moderate effects for CBT interventions for anger reduction in adults. Research provides sufficient empirical support for four specific CBT interventions including: relaxation, cognitive, skill building, and combinations. There is a considerable amount of research concerning cognitive-behavioral therapy on anger problems (Beck & Fernandez, 1998). CBT interventions have proven to have large effect sizes; however the CBT treatments for anxiety and depression have produced much larger effect sizes. This may be occurring because cognitive models of anger lag behind cognitive models of anxiety and depression and limit the efficacy of anger interventions (Digiuseppe & Froh, 2002). Another cognitive approach to anger management is problem solving (Deffenbacher, Oetting, & Digiuseppe, 2002). The problem solving approach assumes that angry individuals have problem solving deficits in approaching and addressing angering events. In this deficits approach, clients are taught the general steps to problem solving and are then encouraged to practice applying them to conflict and anger (Deffenbacher, Oetting, & Digiuseppe, 2002). Here, clients are recognizing their faults and being taught

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strategies to solve their problems rather than being made aware of their strengths and how to amplify them and use them in situations regarding anger and conflict. To date, research has not yet supported theoretical models suggesting which cognitions best moderate anger and should be treated in therapy (Digiuseppe & Froh, 2002). Currently, there are too few replicated studies employing well-defined interventions with specific populations to assess effects by type of anger problem and client group (Deffenbacher, Oetting, & Digiuseppe, 2002).

Digiuseppe (1999) conducted a review of the research on the treatment of anger and noted that most of the research has tested cognitive-behavioral or cognitive therapies. Two studies using mindful meditation were recognized. It was noted that other orientations have abstained from empirical corroboration. No psychodynamic, family systems, gestalt, or client-centered research studies were found to draw from (Digiuseppe, 1999; Digiuseppe & Tafrate, 2007). The lack of research supporting different types of interventions could be taken to mean that these therapies are not effective, however, in reality, it means that they have yet to be tested (Digiuseppe & Tafrate, 2007). This leads to the conclusion that with so many orientations missing from the outcome research, we have a limited view on how to best treat anger (Digiuseppe, 1999).

Deffenbacher, Oetting, and Digiuseppe (2002) suggest that researchers and practitioners develop and test pilot protocols for anger reduction, and when alternative protocols are developed, they can be evaluated in controlled outcomes trials and then can be compared to untreated groups or other established interventions (Deffenbacher, Oetting, & Digiuseppe,2002).

Deffenbacher, Oetting, and Digiuseppe (2002) grant that the most efficacious intervention should be considered the intervention of choice to treat a condition until another intervention is proven more effective. Empirical evidence for a specific intervention must include information on absolute effectiveness and relative effectiveness (Deffenbacher, Oetting, & Digiuseppe, 2002). The intention of this dissertation is to develop an alternate, systems and solution-focused protocol to be tested and used for anger management treatment.

What is Missing in the Current Research?

It was noted earlier that no empirical evidence for the effectiveness of psychodynamic, family systems, gestalt, or client-centered research studies were found (Digiuseppe, 1999; Digiuseppe & Tafrate, 2007). It was also noted that there was a lack of diversity when it came to theoretical orientations used to treat anger and anger disorders. In addition to these specific theoretical orientations and approaches to treatment, the idea of using solution- focused therapy to treat anger is also absent from the literature findings. Solution-focused therapy is a strengths-based approach that emphasizes the resources that an individual possesses and how these can be applied to the change process (Corcoran & Pillai, 2009). Corcoran and Pillai (2009) conducted a review on the treatment outcome research involving solution-focused therapy to determine its empirical effectiveness. The review involved experimental or quasi-experimental designs conducted from 1985-2006 and was limited to published studies written in the English language. After searching the literature, ten studies were located and described. No particular characteristics were found regarding studies with high versus low effect sizes (Corcoran & Pillai, 2009). Treatment outcome research on

solution focused therapy is slowly increasing. There are a number of proposed reasons

for the lack of current research. Included in these are the ideas that solution-focused view

intervention begins at the assessment stage and most measures tend to be problem-

focused in nature. This would assert that time devoted to problem focus would detract

from the strengths based orientation (Corcoran & Pillai, 2009).

A second idea that accounts for the lack of research may be that solution-focused therapy

is brief in its focus. It may be argued that a change may not be apparent after only few

sessions and as it may be assessed by standardized measures. Additionally, requiring

people to attend a set number of treatment sessions does not follow the tenants of

solution-focused therapy (Corcoran & Pillai, 2009). A third, and most likely the major

explanation for the lack of research done on solution-focused therapy is that its origins lie

in the constructivist approach (Corcoran & Pillai, 2009). This approach asserts that

knowledge about reality is constructed from social interactions. Results of Corcoran &

Pillai's review suggest that the effects of solution-focused therapy are equal to current

cognitive approaches and more rigorously designed research needs to be done to establish

its effectiveness (Corcoran & Pillai, 2009).

Characteristics of Angry Clients

An important variable in treating any clinical population is the characteristics of

that population. Clients presenting with anger problems have many behavioral,

personality, and even physiological characteristics to consider before a treatment protocol

can be considered. Often clients with anger problems see themselves as victims of

injustice and it is often helpful to teach them the distinction between adaptive and

destructive anger (Digiuseppe & Tafrate, 2001). Clients with anger problems also often

have difficulty forming alliances with their therapists. They come to therapy wanting to change others or to vent about being treated unfairly (Digiuseppe & Tafrate, 2001). Additionally, research has indicated that people may be more prone to anger and aggressive tendencies when they believe they are better than others and their special qualities are not being recognized. They often exhibit a sense of superiority and entitlement (Digiuseppe & Tafrate, 2001). A longstanding idea is that low self-esteem causes aggression. However, recent research has not confirmed this. Although aggressive people typically have high self-esteem, there are many non-aggressive people with high self-esteem. Newer constructs such as narcissism and unstable self-esteem are most effective at predicting aggression (Baumeister, Bushman & Campbell, 2000). The connection between self-regard and aggression is best described by the theory of threatened egotism, which depicts aggression as a means of defending a favorable view of self against someone who tries to discredit that view (Baumeister, Bushman & Campbell, 2000). Bushman & Baumeister (1998) completed two studies to test linkage among self-esteem, narcissism, and aggression where participants were insulted (or praised) by a confederate posing as another participant. Later they were given an opportunity to aggress that person (or another person) by sounding an aversive blast of loud noise. In both studies, the highest levels of aggression were exhibited by people who had scored high on narcissism and had been insulted. Self-esteem by itself had no effect on aggression, and neither did either high or low self-esteem in combination with receiving the insult. These results confirmed the link between threatened egotism and aggression and contradicted the theory that low self-esteem causes violence. This

research adds the personality trait of narcissism to the characteristics of some angry clients.

Persons with personalities that have a high level of anger are characterized as quick tempered, fiery, and hotheaded. They may frequently yell, argue, make mean verbalizations, or act sarcastically (Kassinove & Tafrate, 2006). Though some clients may outwardly express their anger, others turn their anger inward (Kassinove & Tafrate, 2006). They are aware of their anger but do not show it to others. They may ruminate and hold on to their anger for extended periods of time (Kassinove & Tafrate, 2006).

Digiuseppe cites Deffenbacher (1999) as identifying 14 different ways that people express anger. Included in these are direct expression of anger, reciprocal communications, thinking before responding, time out, physical assault of objects, negative verbal anger expression including verbal assaults or noisy arguing, dirty looks, body language, anger in/suppression, anger in/critical, anger control, corrective action, diffusion/distraction, passive aggressive sabotage, relational victimization or social isolation of the target (Digiuseppe, 1999). Digiuseppe also notes that Deffenbacher (1999 argues that the diversity of the behavioral component of anger has provided confusion in defining anger and has also delayed our understanding of it.

In evaluating the research on anger management, another important consideration is that of whether the client was mandated, or whether they voluntarily admitted themselves for therapy. Most studies reviewed involve voluntary, self-selected groups, such as college students with high trait anger, angry volunteers, or medical patients with anger-involved problems such as cardiovascular disease (Kassinove & Tafrate, 2006). These individuals are often motivated to participate and also report accurately and

honestly (Kassinove & Tafrate, 2006). Though these individuals are motivated, it should also be noted that often individuals do not see themselves or present themselves in a completely accurate way. In their article, *Does a Fish See the Water in Which it Swims? A Study of the Ability to Correctly Judge One's Behavior;* Leising, Rehbein & Sporberg (2006) investigates the association between the interpersonal behavior that people exhibit and their ways of interpreting that behavior. It was hypothesized that people would underestimate the behaviors that they exhibit most frequently. The hypothesis was tested using the constructs of dominant and submissive behavior. Eighty-nine female participants were interviewed about their ways of interacting with others and were then judged for their dominance. After the interview, each participant interacted with a confederate in three role plays taken from assertiveness training. After the role plays, both the participant and the confederate judged how dominant the participant had been. The hypothesis was confirmed. Dominant participants underestimated their own dominance in the role plays, compared with the judgment of the confederate. Submissive participants underestimated their own submissiveness (Leising, Rehbein & Sporberg, 2006). Individuals exhibiting anger related problems that are mandated to treatment or who are strongly encouraged to attend by external sources may not be so motivated to participate or report accurately (Kassinove & Tafrate, 2006). This poses a number of assessment and intervention problems.

Change oriented therapy is a client-informed, outcome-oriented model for therapy that emphasizes collaboration, competency, and change-affecting processes.   This implies an action phase of treatment and the willingness of clients to understand and comply with homework. Those who are mandated or feel the pressure to attend treatment

may not be ready to change and may not even see their anger as their problem (Kassinove & Tafrate, 2006). Clients exhibiting these feelings and attitudes towards their problems are not likely to want to participate in therapy and are likely not going to be willing to comply with treatment or complete homework assignments. Kassinove & Tafrate (2006) state that these individuals are not good candidates for change-oriented therapy. Kassinove and Tafrate (2006) cite Howells & Day (2003) as stating that client readiness for change is an important and under researched area of study. They note that interventions researched are generally change-oriented therapies and they assume that the client is experiencing difficulties and is at least somewhat motivated for change (Kassinove & Tafrate, 2006). However, this is not often the case and individuals with anger issues minimize or externalize their issues. To them, their anger may not seem unreasonable and may seem like it is a natural response (Kassinove & Tafrate, 2006). These individuals are not motivated for change and are at a pre-contemplative or contemplative stage of change. Action oriented therapy is not relevant for them and will not fit their frame of reference (Kassinove & Tafrate, 2006). Knowing this, one would assume that a solution-focused approach would be more suitable to their stage of change. A Solution-Focused approach would be more suitable because Solution-Focused treatment does not focus on the problems a client may be experiencing, but instead allows them to recognize the areas in their lives where they are successful and are not experiencing difficulties. The Trans theoretical Stages of Change model endorsed by Prochaska and di Clemente is one of the most influential models of behavior change and has become prominent in both the clinical intervention and health promotion literature (Williamson, Day, Howells, Bubner, & Jauncey, 2003)   The model was originally

developed to describe the process of behavior change for addictive behavior, and postulates that individuals pass through a series of stages involving a series of different processes when attempting to change their behavior (Prochaska & di Clemente, 1993). Precontemplation is the earliest stage in the model, referring to individuals who do not wish to change their behavior or do not recognize a problem, Contemplation is the stage in which people seriously intend to change within the next 6 months, and Action is the stage at which people actually start to modify their behavior, experiences, or environment to overcome a particular problem (Williamson et al. 2003). Noting this information and recognizing the idea that solution-focused treatment is individual and meets each individual where they are in their process, it is likely that solution-focused treatment would be effective for persons at the pre-contemplative and contemplative stages of change. This is hypothesized because individuals do not have to be ready to change to recognize times in their life when they aren't angry and when they are not experiencing distress with anger.

Lee, Uken, and Sebold (2004) discuss the benefits of using a solution-focused approach that separates punishment from treatment. In it, they acknowledge that in solution-focused therapy the facilitator engages in and develops a meaningful working relationship with the participants. The facilitators are not there to hand out punishments but instead, they provide treatment to the participants (Lee, Uken, & Sebold, 2004). They also note that the participants are more likely to talk about issues related to changes they need to make rather than wanting to present a positive image to satisfy the system. It is clear after reviewing the research, that the idea of client mandation is an important concept to consider while creating a treatment for clients presenting with anger problems.

Additionally, recall the earlier discussion of the contextual factors that relate to anger. These may include but are not limited to gender, race, ethnicity, and subcultural identities. These cultural and contextual factors will direct the appropriate versus inappropriate expression of anger for purposes of the pilot study.

The preceding discussion indicates that the majority of treatments are CBT in their nature and that cognitive behavioral treatments are deficits based and work with clients who are in the action phase of treatment. These clients are willing and compliant and they recognize that they have a problem. These clients also willingly admit themselves to treatment. The studies discussed utilize a deficits based approach with clients who admitted themselves to therapy, but would the deficits based approach be successful with clients who are mandated for treatment? This is a question that needs to be addressed. However, the first step in the process of addressing deficits versus strength based approaches will be to develop and pilot a new strength based protocol. To adequately pilot the new protocol, the phase of work should match the work of prior deficit based protocols. That will mean using the same non-mandated or voluntary clients used in those past studies. For the purposes of the pilot study it would be optimal to match the current literature using a mandated clientele and a CBT approach with a mandated clientele using a BSF approach before going to the next step. However; in order to match populations with those studied by current deficit based approaches, we will tailor this pilot study to a non-mandated group.

Current Length of Treatment Used in Anger Management

Current session length and content for anger management is typically constrained by treatment protocol (Deffenbacher, 2006). Most intervention falls between 4 and 10

sessions and incorporates a duration of around 6-12 hours. Current studies did not allow

for follow up post-treatment contact to address new anger issues or assess for relapse

(Deffenbacher, 2006). These conditions are typical for outpatient therapy and are

appropriate for controlled outcome research (Deffenbacher, 2006). Persons with anger

problems are often resistant to therapy and do not want to attend. Requiring them to

attend a certain number of sessions for an exact duration may only increase this

resistance. As previously noted, requiring people to attend a set number of treatment

sessions does not follow the tenants of solution-focused therapy (Corcoran & Pillai,

2009). Working with the client in a therapeutic alliance and not forcing them to attend

treatment may increase their willingness to participate in treatment.

Brief-Solution-Focused Therapy (BSFT)

There are many interventions that enhance client empowerment and one of them

includes focusing on client strengths (Greene, Lee, & Hoffpauir, 2005). Strengths-based

and empowerment approaches emphasize the importance of using language and dialogue

in creating an alliance with clients (Greene, Lee, & Hoffpauir, 2005). The strengths-

based approach holds a person accountable for solutions instead of focusing on problems

(Lee, Uken, & Sebold, 2004). Lee, Greene, and Rheinscheld (1999) cite de Shazer (1994)

as acknowledging that in solution-focused treatment, therapy is a conversation between

the client where the therapist asks questions in order to help the client think differently

about their situation and subsequently engage in a solution-building process. The aim is

to assist clients in construction solutions that do not contain their original problem.

Included in these are exception questions which are inquiring about times when the

problem is less intense, absent, or dealt with in an acceptable manner (Lee, Greene, &

Rheinscheld, 1999). Outcome questions are also a part of the process. These help clients to create a view of life without the problem present. An example is the miracle question. The therapist asks the client what life would be like if a miracle occurred while they were sleeping and their problem was magically solved. They inquire as to how they would know a miracle occurred and what would be the first sign that a miracle occurred and the problem was solved (Lee, Greene, & Rheinscheld, 1999). Also involved in BSFT are coping and scaling questions. Coping questions ask the client how they manage to survive and cope with their problems. Scaling questions ask the client to rank their situation or their goal on a 1-10 scale, one representing the worst possible scenario and ten representing the most desirable outcome (Berg, 1994). Scaling allows clients to see how they progress and allow them to set goals to progress towards. Relationship questions are also a component of BSFT. These questions ask clients how their significant others react to their problems (Berg, 1994). In BSFT task assignments are used to help clients identify exception behaviors to the problem for which they are encouraged to do more of what works (Lee, Greene, & Rheinscheld, 1999). BSFT enters upon using "solution talk" rather than "problem talk". Overall, its focus is on the times when the client is not experiencing the problem behavior or is able to control the problem behavior in an acceptable way. The therapist then assists the client in noticing, amplifying, sustaining, and reinforcing these exception times (Lee, Greene, & Rheinscheld, 1999). Clients are helped to construct their lives around the non-problem behavior. Therapists assist the clients in creating a solution-picture which is absent of the maladaptive behavior (Lee, Greene, & Rheinscheld, 1999).

Earlier, it was noted that the idea of stages of change is an important aspect to consider while working with persons with anger problems. Clients may not recognize their problems and may not be ready for change (Kassinove & Tafrate, 2006). BSFT circumvents this problem in that it does not focus on the client's problems, but instead recognizes their strengths. Clients will not be forced to look at their deficits, which they may not acknowledge in the first place. This may lead to successful outcomes and a willingness to participate in treatment. Some may question how you can improve a problem if an individual does not acknowledge it. In using BSFT, individuals are encouraged to look at areas in which they have not had problems. BSFT postulates that it is not until individuals focus on the non-problem areas that they recognize the problem areas and further acknowledge that they do have a problem.

CHAPTER 3

Foundation and Motivation for Proposed Protocol

The proposed protocol has been formulated based upon questions raised by

previous research done by Lee, Greene, and Rheinscheld (1999) in their article titled; A

Model for Short-Term Solution-Focused Group Treatment of Male Domestic Violence

Offenders (MDVO's). Their research focuses on the treatment of MDVO's using a

solution-focused, strengths based brief approach rather than a cognitive/deficits based

approach. The approach taken by the above researchers does not deny or minimize the

aggressive and violent behaviors exhibited by the MDVO's, but instead focuses on

exception and solution behaviors, amplifies them, supports them, and reinforces them

through a solution-building process. Lee, Greene, and Rheinscheld (1999) found that

their approach to working with MDVO's in a solution focused manner produced

encouraging results. Between October of 1993 and May of 1997, 117 clients participated

in the group. Of the 117 participants 112 were mandated and 5 were voluntary clients.

Eighty-eight clients completed the group and of the 88 only six were recharged due to

problems of aggression (Lee, Greene, & Rheinscheld, 1999). This would indicate that

this particular group had a 75% completion rate and a 7% recidivism rate. Lee, Greene,

and Rheinscheld acknowledge that even though they did find their results encouraging

and favorable, a lot of research and investigation is still needed using this approach to

attain a better understanding of the change process. In reading this research done by Lee,

Greene, and Rheinscheld (1999), many similarities can be seen between MDVO's and

clients who are in treatment for anger disorders or anger problems. Not only do the

MDVO client population and angry client population share many personality as well as behavioral characteristics, but additionally, both groups are often mandated for treatment. This research done and the subsequent article written by Lee, Greene, and Rheinscheld (1999), proposes a treatment model for a brief solution focused group for MDVO's. In reviewing the literature, it does not appear that there is a brief solution focused protocol designed to target a population of clients diagnosed with anger related issues. In comparing the characteristics of the two groups as well as considering the positive outcome obtained by Lee, Greene, and Rheinscheld (1999) one would assume that using the solution focused strengths based method to treat angry clients would be an effective approach. Therefore, the proposed protocol is modeled after a solution-focused approach, and its aim is to use a group format to treat the maladaptive expression of anger.

In considering areas that are overemphasized and areas that are neglected in the treatment of anger, two definite ideas stand out amongst the current literature. It is evident that there is an extreme emphasis on using a cognitive-behavioral method for treatment as well as a method that is deficits-based. There is research that supports the cognitive model as being effective in the treatment of anger, however; there is a lack of research done on a strengths-based solution. The current literature focuses mainly on a deficits based problem solving approach rather than a strengths-based solution amplifying approach. The current treatment methods identify problems and work to change them. A strengths-based approach would identify what is currently working for the client and acknowledge the situations in which anger is appropriately handled. After identifying these situations, they can be amplified and applied to problem areas.

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This proposed protocol would have several positive implications to the field of psychology and anger management. Psychologists may use the proposed protocol to treat anger management clients in a group format and in a relatively short period of time. It will allow them to use positive psychology and the strengths of the client to work through the client's problems. Additionally, the following protocol will be designed to be implemented in a shorter period of time. In doing this, one would hope that the clients will be able to stick with the program and complete it rather than dropping out or becoming resistant to the therapy due to its duration. Keeping the clients in treatment will increase the odds of success and reduce the odds of recidivism. In addition, reactive clients are not likely to respond when they feel they are being accused or blamed. Using BSFT, group leaders will avoid this possible reaction from already reactive clientele. Also, the following protocol will be a new and useful addition to the current literature. It will be created with the intentions of being utilized. After the protocol is utilized, outcome measures may be obtained to determine its effectiveness. If the protocol is deemed effective, it will then promote the use of BSFT and expand the knowledge and research base in the field of BSFT.

Defining the Terms of the Protocol

In creating a protocol to treat an identified group, it will be important to specify the provisions of the protocol in regards to what specifically it is designed to treat as well as the specific population it is designed to target. Current researchers suggest that more work needs to be done in the area of defining anger. One major issue to consider is the actual definition of anger. In researching anger and anger management, it is apparent that anger is defined in many different ways. Because there are many different definitions of

anger, one would assume that the approach to treating anger will vary as well. Finding a successful approach to treating anger and anger related disorders will be much easier if anger is operationally defined. Operationally defining anger will allow for an understanding and concrete definition of what "anger" is and what exactly a proposed protocol is targeted at treating. Creating a specific definition of anger to be used with the proposed protocol will reduce if not eliminate the problem of deciphering what is being treated. Some may question whether the proposed protocol is treating anger or simply a hostile dominant personality style. Hostility is a negative attitude toward others, consisting of animosity, condemnation, and ill will (Smith, Glazer, Ruiz & Gallo, 2004). Hostile personality style is the inclination to interpret the actions of others as having an aggressive intent. As a cognitive characteristic, hostility involves, ''a devaluation of the worth and motives of others, an expectation that others are likely sources of wrong-doing, a relational view of being in opposition toward others, and a desire to inflict harm or see others harmed''(Smith, 1994, p. 26). In contrast, anger is ''an unpleasant emotion ranging in intensity from irritation or annoyance to fury or rage'' (Smith, 1994, p. 25). As a personality trait, anger refers to the propensity to experience regular and distinct episodes of this emotion. Aggression involves a variety of verbal and physical behavior, ''typically defined as attacking, destructive, or hurtful actions'' (Smith, 1994, p. 26). As a trait, aggressiveness is the disposition to display such behavior. It is often difficult to separate the concepts of hostility, anger, and aggression. Anger involves the ''relational theme,'' or cognitive script (Lazarus, 1991), of unfair interference or harm, and both anger and hostility involve the intention and tendency of inflicting harm utilizing aggression. These personality traits are associated with one another but not closely

enough to be used interchangeably as the meaning for a single construct (Smith, Glazer, Ruiz & Gallo, 2004). Therefore, though some hostile dominant people may be angry or express their anger, it is not proven that all hostile dominant people are angry or express their anger maladaptively.

The proposed treatment protocol will specifically target the areas of strength clients exhibit during times when they are not maladaptively reacting to anger and use the strengths to encourage adaptive reactions. For the purposes of this protocol the definition of anger to be used is: "Anger is a negative, phenomenological feeling state that motivates desires for actions, usually against others, that aim to warn, intimidate, control, or attack, or gain retribution.", and the treatment will be geared toward individuals in this state who experience these feelings due to external events and express these feelings outwardly with maladaptive or inappropriate behaviors.

In addition to identifying the intended purpose of the protocol, it is essential to identify inclusion and exclusion criterion of the targeted population. The environment (inpatient vs. outpatient) where the protocol is to be administered as well as the circumstances behind treatment (mandated vs. voluntary) are important elements to identify while designing and implementing a treatment protocol. Making a protocol that targets a limited and very specific population would be beneficial for outcome research and in determining how effective the protocol is in treating anger. However; designing a protocol that is too limited in who it is designed to treat limits the utility of the protocol. For purposes of practicality, and in order to obtain outcome research in the future, the following protocol will be designed to incorporate individuals who have volunteered to come to treatment after recognizing their own difficulties in managing and appropriately

expressing their anger. In order to participate in the proposed group, it will be required that selection criteria are met. It would be desirable to include in the selection criteria that group members are repeat offenders and are currently in the system, so that outcome measures can be longitudinally studied. However; because this is a pilot study of the proposed protocol this will not be considered as a selection measure. The next step, to implement the protocol in a correctional setting will allow better ease at which to measure results longitudinally based upon members and their repeat offenses.

Selection criteria for a solution based approach are likely to have fewer selection criteria than a deficits based group, but for the purpose of comparison, this pilot protocol will use selection criteria that are currently used with CBT deficits based groups. Yalom (2005) discusses that it is easier to create exclusion criteria than inclusion criteria, and that even if excluded from one group, it is likely that an individual fits into another group. Therefore, he suggests that patient screening for group fit and client ability to work towards group goals is important. He discusses that those who are brain damaged, psychotic, or addicted to drugs and alcohol are a poor fit for group, but then adds the qualifier that these types of lists are of less value than underlying principles (Yalom, 2005). Therefore, he falls back onto the idea that group participants must be able to participate in the primary task of the group, and must pass pre-group screening conducted by a mental health professional (Yalom, 2005). Reilly & Shopshire (2008), created a cognitive behavioral group for anger management and had relatively the same selection criteria. They indicated that the participants must be free from alcohol and drugs for two weeks prior to group, and if they have a "slip" during the stages of the group, they are not dismissed, however; if there are further repetitive "slips" or a "lapse" they are dismissed.

They also indicated that members are not actively psychotic and that they maintain their psychiatric medication regimens so that they are able to comprehend group material, complete assignments, and participate during group. Additionally, if clients could not process material or handle feedback appropriately, they were referred for further psychiatric treatment instead of group therapy. Burlingame et al., (2006) also suggests a number of relevant selection criteria. Among the criteria that are listed, several have been chosen that will be used in selecting group members that are congruent with the previously discussed literature. Included in these criteria are (a) the client is having difficulties in relationships with family, friends, and others (b) the client can discuss his or her feelings to some extent; he or she may have some insight and/or previous counseling (c) the client is committed to the meeting time and duration of the group (d) the client's health will not be jeopardized in any way by attending and participating in the group. In addition to inclusion criteria, there are a number of exclusion criteria that if met, would prevent someone from being allowed to participate in the group: (a) the client is actively psychotic (b) the client reports suicidal gestures (c) the client reports that he or she will not feel comfortable in a group and will not be able to discuss his or her problems (f) the client is prone to deviate from the group and will disturb other group members and hamper their ability to receive treatment (g) the client is actively using substances. Pre-group screening will be implemented to assess individuals' fit for the group in terms of treatment goals and to ensure that individuals being considered for the group do not pose a physical threat to other group members as well as to ensure that potential group members do indeed possess the ability to interact with other group members.

Additionally and as previously discussed, it is important to recognize all aspects of the construct of anger. The ideas of state anger and trait anger are important to consider. Previously discussed findings explain that state and trait anger are often found together and are simultaneously affecting an individual's behavior. The following protocol has been specifically designed to recognize and adapt both trait and state anger. It is designed to treat individuals who experience anger whether it be trait or state based and, and respond to this anger by expressing it with maladaptive or inappropriate behaviors.

The main research base for treatment of anger has been done on a college aged student population. The subjects as well as the research considered in creating the following protocol vary based on demographics. These demographics include factors such as age, diagnosis, gender, and racial/ethnic identity. Therefore the following protocol will also be designed to treat an adult population with varying demographic features.

Guidelines for Group Leaders

An integral component to running a group is the group leaders. In order to run an effective group that does not harm group members, group leaders need to be properly trained and educated. For the purposes of this protocol, it is essential that group leaders possess a master's degree or doctorate degree in the mental health field. In addition group leaders are to have had some education and experience in group therapy. Education is defined as taking group psychotherapy courses in their pursuit of a higher education degree, or attending seminars on group therapy. The education component is paired with the experience component. The experience component consists of group psychotherapy training as a leader or co-leader of other groups. In addition to having group

psychotherapy experience, it is essential that leaders are educated and have experience in anger management and have worked with anger management clients in the past. Leaders should be aware of the personality styles of angry clients as described in previous discussions. In addition to being aware of the characteristics of angry clients, leaders must be able to take a power-down stance when working with anger management clients to prevent power struggles that may result in group attrition or violence. Group leaders must also have training in and support brief solution-focused treatment modalities. It is proven that leaders who believe in the treatment approach they are implementing work harder with their clients to promote change for the better. A great resource to become educated in brief solution focused therapy is *Becoming Solution-Focused in Brief Therapy* written by John L. Walter and Jane E. Peller (1992). Additionally, the book *Solution-Focused Treatment of Domestic Violence Offenders* (Lee, Sebold & Uken, 2003) is a great resource for educating oneself about BSFT in group format with mandated clients. After fulfilling these requirements, it is preferable that potential group leaders thoroughly read through the protocol and participate in mock group therapy sessions with co-leaders and members of their professional cohort. The purpose of the mock therapy sessions is to familiarize leaders with how sessions should run and the content they will be covering. Additionally, it will prepare leaders for possible conflict between group members as well as resistance to therapy. If these guidelines are met, group leaders should be competent and prepared to run the proposed pilot protocol.

CHAPTER 4

Proposed Protocol for Solution-Focused Group Treatment of Individuals

Expressing Externalized Anger

The development of this protocol is based on previous research done by Lee, Greene, and Rheinscheld (1999) in their article titled; A Model for Short-Term Solution-Focused Group Treatment of Male Domestic Violence Offenders (MDVO's). The overall goal of this group is to provide short term treatment aimed at reduction and termination of maladaptive or inappropriate expressions of externalized anger. Group size ranges from no less than four but no more than ten participants. The protocol will consist of three phases which are divided into six sessions. Each session will last between one and one and a half hours. The first three sessions will be held on a weekly basis and the last three sessions will be held every other week. The reasoning behind holding the last three sessions every other week is to provide group members sufficient time and opportunity between sessions to accomplish assignments as well as process the new realities that they construct during session.

Phase One-Sessions One and Two

Phase one will consist of the first two sessions and will involve (1) the establishment of group rules and structure; (2) the joining between the leaders of the group and group members as well as between the members of the group; (3) searching for exceptions; (4) and the establishment of goals.

Session one will consist of establishing the rules and structure of the group and the joining process between group members and leaders as well as among group members.

Establishing the rules and structure of a group at the beginning is important so that members have an understanding of what will be expected as group members. In keeping with the solution- focused brief treatment model proposed by Lee, Greene, and Rheinscheld (1999), this group will also include a contract. The contract will be reviewed, read, and signed by group members as well as the group leaders. The contract is concise and includes the following components: number of sessions that must be attended to receive completion status (members are asked to attend all six sessions but if arranged ahead of time, they may make up one session); to maintain confidentiality; to handle conflict in group in a non-aggressive and non-violent manner.

Because group members will not likely be familiar with one another and may be reluctant to share information with strangers, the process of joining will be important to secure the attention of and to engage group members who may be hesitant to open up. To ease the joining process, it is recommended that leaders are self-disclosing and display appropriate modeling behavior. If leaders use examples to relate to members, it helps members to open up. Modeling is also important because it helps to facilitate the group process. Included in behaviors to be modeled are acceptance, hope, and encouragement (Delucia-Waak, Garrity, Kalodner, & Riva, 2004). Berg (1994) notes that to facilitate the joining process, it is recommended that group leaders should avoid provoking defensiveness and getting into debates and arguments with group members. In keeping with the solution-focused model, Berg also notes that taking a "one down" position and seeing the group member as the "expert" on themselves is an effective way to facilitate the group process. Allowing the members to be the "experts" on their situation and allowing each member to tell their story to the group as well as to inform other group

members and leaders as to how they came to be in the group fuels the joining process. This allows for leaders as well as group members to empathize and relate to one another. During this time, leaders take a "one down" position as they listen to and acknowledge each member's perspective on their own situation. Leaders do not interrupt group members as they tell their story, but instead listen and acknowledge each member's viewpoint as they attempt to understand the situation as the member has experienced it. This is an example of group leader modeling in which leaders set an example for members to be more open to looking into how they can adjust their maladaptive or inappropriate behaviors and actions associated with their anger.

In the second session, group leaders facilitate the process of group members recognizing and utilizing exceptions. The process of recognizing and utilizing exceptions is the beginning of the process where group members construct their own solution picture. After the members have finished telling their stories, group leaders question them as to times when they have gotten angry and not exhibited maladaptive or inappropriate behaviors or actions in response to their anger. Leaders inquire about if there were times when anger was handled appropriately, what these particular situations were or looked like, and what the outcome was. Each group member is encouraged to share at least one of these instances where they were successful in handling their anger appropriately or adaptively. It is hoped that participating in this process will cause members to become curious about and increase the times when they are using appropriate ways to cope and deal with their anger. When the group members acknowledge the times when they are able to engage in appropriate expression of anger, they begin to see themselves

differently and quite possibly begin to construct a different and more positive reality about themselves.

During this time, leaders provide members with compliments about their strengths, successful endeavors, and exception behaviors. Complimenting members is helpful in developing their cooperation and decreasing their resistance and defensiveness. Compliments lead clients to being more open to searching for, identifying, and implementing solution patterns.

The final task in the first phase is for members to establish their goals. In keeping with the solution-focused method and adapting it to use with clients who express their anger maladaptively or inappropriately, members are required to identify a goal that is interpersonal. The goal must be initiated by the client and must relate to another entity. This entity may be a family member, a spouse, the group member's children, a friend, other group members, or society in general. The goal should be defined through a solution-focused approach, where it is something that the member can do positively rather than something that the member is trying to avoid or get rid of. For example, a member may wish to make their goal to increase the amount of times they take a time out and walk away from an anger inducing situation rather than make the goal to decrease the amount of times they physically act out when they get angry. In order to raise the chance of success in achieving a set goal, goals are to be established with clear, precise, behavioral provisions and be able to be fulfilled within the six session model.

The solution-focused technique of using outcome questions is used by group leaders during the goal construction process. Future oriented questions may be "At the completion of group, when you achieve these goals, how would other members know?"

or "Imagine I meet you out in the community and the problem that you came to group with is now gone. How would you describe your life without this problem?" Questions may also focus on how the member will know they accomplished their goal, or how they will know there is a difference post-group in comparison to pre-group. The member is then asked to describe in detail what life will be like when their presenting problem no longer exists. For example, Sarah states "I will not be asked to leave public places due to my angry outbursts, and I will avoid physically assaulting others when I am angry, by taking a time-out and walking away from the situation." Sarah would then be asked to elaborate on the solution statement with questions about how she will know that she needs to take a time-out, where she will go on the time-out, and how she will know that she is ready to return from the time-out.

It is inevitable that there will be instances where group members are resistant and take the stance that they do not have anger problems and are only attending group because they are mandated to do so. These members likely see the source enforcing mandation as the problem rather than their own maladaptive expression of anger. In these situations, the group leader and the member work together to establish goals considering this reality. In working with members to set goals, leaders use questions to encourage members to describe what changes the mandating source would have to see to be persuaded that progress has occurred. A component of this goal setting includes the group member ranking on a one to ten scale, one being the lowest, and ten being the highest, where they currently are and where they would like to be at the completion of group in terms of their problem and goal.

Phase Two-Sessions Three, Four, and Five

Sessions three, four, and five compose phase two, the middle phase of the short term, solution-focused group for clients expressing their externalized anger. The main focus of this phase is for leaders to assist group members in expanding, amplifying, and reinforcing their identified solution behaviors from phase one. Group members are asked to detect and inform other group members and group leaders of the exceptions to their problem behavior and/or solution behaviors that occur between sessions. In their model of short term solution-focused treatment of MDVO's, Lee, Greene, and Rheinscheld (1999) cite Berg (1994) as using the acronym "EARS" during this phase of treatment. The proposed protocol for a short-term solution-focused group for individuals expressing externalized anger will also use this acronym. The acronym "EARS" is meant to describe the process of group members providing an exception or solution behavior and the group leader amplifying and supporting the exception or behavior. "EARS": stands for Elicit, ask about positive changes; Amplify, ask for details about the positive change; Reinforce, make sure the group member notices and values the positive changes; and Start again, ask what else is better. During the "EARS" process, the group leader provides the group member(s) with compliments and uses solution-focused techniques to reinforce the group member's new reality that they are experiencing and working to develop. The goal of this process is to help instill the new reality in the feeling, thinking, and behaving domains of the member.

Once the group members have established specific components of change for themselves, they are asked how they think other people will react to their progress. Specific relationship questions such as "Who has noticed changes in you?" "Suppose

your (insert specific person) were here, what do you think he/she/they have noticed?" "What have others said?" "What have you done that has contributed to the change in the way others react to you?" "How have the reactions of others toward you helped you to act differently?"

If it is reported by a group member that there are no exceptions and nothing is going well, group members can use coping questions. The intent of such questions is to redirect the members focus on the negative aspects of the situation to the strengths and resources and how they keep going despite the negatives. Examples of coping questions include: "How do you keep going when things are so bad?" "I'm wondering how you even managed to get here today with all you have going on." "How did you make it through the last week without acting out on your angry feelings?" "What have you done to keep your anger from getting to a level where you use maladaptive or inappropriate means to express it?"

In this phase of treatment, group leaders also use scaling questions. They can be helpful in assisting members to recognizing the changes that have occurred in regards to a specific situation. Members are asked to rate the level of their anger when they act on and express it when they began group on a scale of 1-10; one being they act on even the smallest amount of anger and ten being it takes a very significant level of anger before they act out. They are then asked to rate the current level of anger that causes them to act out on the same scale. If after comparing the numbers, it is found that the number has increased; members are then asked questions to support the positive change that has occurred. Included in these questions are: "What have you been doing differently to more appropriately express your anger?" "How did you know to do this?" "What did you

tell yourself during the situation causing your anger to keep yourself from inappropriately acting on that anger?"

In addition to solution-focused techniques, many techniques central to any group treatment approach are utilized with group members. Group cohesion is an integral part of the change process. When a group member feels as though others are in the same place or position as he or she is, it is likely that they will be more willing to share their successes as well as their short-comings. Group leaders initiate this process by asking members to comment on the progress of their fellow group members. Group leaders may use questions including: "What do others have to say about the changes Sarah is reporting?" "What do you think Sarah will need to continue to do in order for these changes to continue?" During this process, members work together to help create exceptions and solution behaviors that will be helpful to one another and their particular presenting problems. In this process, empowerment is used in that members begin to discover the ways in that they have been resourceful in dealing with the issues of maladaptive anger expression.

Phase Three- Session Six

The final session and last phase of treatment is the termination phase and session. Group leaders focus on evaluating, consolidating, and celebrating the progress and success members have experienced in achieving their goals. Group leaders review, augment, and encourage the changes that group members have made. It is essential that group members recognize what is working for them so that they can attach their positive efforts and actions to the positive outcomes that they have been experiencing. During the final session the scaling question is used by group leaders to help the members evaluate

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the differences in their perceptions of their situation between the beginning and ending of the group treatment. For example, group leaders may ask "Suppose when we started group, your situation was at a one, and where you wanted to be was at a ten, where would you say you are at today between one and ten?" In addition to rating progress, scaling questions are used to evaluate members' confidence in their ability to maintain the change they have created. Group leaders also work to bring and keep the solution picture and reality into the group members' minds. In order to do this, they ask future oriented questions. Some of these questions may include: "What will you continue to do to maintain the changes you have made?" "What will others say you need to do to keep yourself on track?" In order to maintain the positive changes that group members have been working toward it is helpful for the members to be able to connect the positive changes in their actions and take responsibility for these changes. After group leaders assist members in acknowledging and recognizing their successes it is important to go one step further and recognize signs that indicate they may be reverting back to maladaptive expressions of their anger. Group leaders may use relationship and scaling questions to help group members establish indicators of waning, and in helping members to establish contingency plans for the prevention of regression. Some questions that group leaders may use can include: "What would be some red flags that tell you that you are reverting to your troublesome behaviors?" What will (insert specific person) notice about you that is different from now?" "When you notice that you are going back, what can you do differently to get back to where you are now?"

The final sector of this phase includes acknowledging the strengths of group members and celebrating these strengths. During this process, group leaders give prolific

and genuine compliments to each group member on specific changes that the particular group member has made in regards to adapting their expression of their anger from a maladaptive or inappropriate method to an appropriate or acceptable method. The final goal is for group members to take the credit for their successes and see that they constructed their new reality and accomplished their goals.

Sample Implementation at a University Counseling Center

To describe the actual implementation of the protocol, the Counseling and Wellness Services (CWS) at Wright State University (WSU) will be used as an example. After getting the protocol accepted, group members will be recruited through the intake process at CWS. During intake, psychologists, psychiatrists, or psychology trainees will ask their clients if they may have a problem with their ability to adaptively express their anger. If the client indicates that they do have an anger problem, the mental health professional will then suggest the group to the client and describe the group process. If the client agrees, he or she will be scheduled for a group pre-screening session. During the session, the potential group member will be assessed first using the inclusion and exclusion criteria explained above. If the client meets inclusion criteria and does not possess any characteristics in the exclusion criteria, he or she will be administered an assessment measure that is designed to measure an individual's anger and any maladaptive expression of anger. Possible scales to use are the Anger Expression Scale (Spielberger, 1988), which uses three subscales: Anger In (AX/In), Anger Out (AX/Out) and Anger Control (Ax/Con). These together give a total of anger experienced. Another measure that could be used is the anger scale of the State-Trait Personality Inventory. The client's scores will then be collected. These scores will be kept and at the conclusion of

the group, clients will be re-administered the measure they took prior to group. Pre-post data will be evaluated to determine the amount of measured change, if any that the client underwent. After being given an anger assessment measure, the client will then be given the Target Complaints Scale (TCS) (Battle et al., 1966).to determine their goals for the group. The TCS is also referenced in the literature as the Target Goals and Target Objectives Scale. The TCS is an individualized measure of psychotherapy outcome based on a patient's description of their problems and difficulties/goals and objectives for which they sought treatment. The instrument is recommended because of its direct relevance to individual patient experience and strong face validity (Burlingame et al., 2006). Additionally, the TCS is consistent with the solution-focused approach to treatment in that it focuses on goals or objectives and not the problems or deficits that the client is experiencing. After these instruments are administered and scored, they will be set aside until the conclusion of the therapy group, at which time they will be re-administered. Outcomes will be measured on a pre-post score basis for patient improvement. When at least 4 individuals have been approved for group, it may be run. The group will follow the proposed protocol from beginning to end. At the end of group, the same screening measures will be administered and outcomes will be calculated. It is also suggested that a simple pre-post statistical t-test be used to analyze the data collected.

Comparing the Protocol to Currently Used Treatments

After the initial pilot of the group protocol and the addition of any adjustments to the protocol from the pilot, a second phase of study might then be initiated. A possible way to measure the effectiveness of the proposed protocol would be to use a randomized clinical trial approach comparing a currently used CBT anger management group with the

proposed protocol and a wait list control. The groups would be run simultaneously at the university counseling center. A clinician who uses and strongly advocates for the cognitive behavioral theoretical model will run the CBT group, and a clinician strongly believing in and advocating the Solution-Focused model will run the Solution-Focused Group. The wait list will consist of students who have been pre-screened and filled out the assessment measures. They will not attend either group, but at the conclusion of the groups will fill out the measures again to provide an untreated comparison group. At the conclusion of the study, the waitlisted group will have the opportunity to attend group. This will ensure that all potential clients will have equal access to treatment. The outcome data of the three groups will be compared to determine which group appears to be more effective in treating maladaptively expressed anger. To compare data, it is recommended that an ANOVA statistical test be run to determine the effectiveness of each group in comparison to one another.

CHAPTER 5

Discussion

The solution-focused group treatment proposed is based upon the solution-focused group treatment model for MDVO's discussed by Lee, Greene, and Rheinscheld (1999). Like the model proposed for treatment of MDVO's, this model is also influenced by a strengths perspective, systematic thinking, and social constructivism. The use of a brief solution-focused group treatment approach to the treatment of anger is new and uses positive, strengths based language rather than deficits and blame focused language. It focuses on solutions, aptitude, and abilities using a group process model. Like the model for treatment of MDVO's, the model for clients expressing externalized anger does not minimize the maladaptive, possibly aggressive or violent behaviors associated and acted upon by the members. The solution focused approach posits that affirmative changes can be made in a short period of time by using solution talk rather than problem talk. The approach focuses on client's strengths and competencies as well as solution behaviors.

Implementing the proposed protocol will serve several positive purposes for the field of psychology. It will provide an opportunity for research on anger management groups. Currently there is an over-emphasis on using cognitive behavioral approaches for anger management. The lack of different approaches to treatment has led to a gap in research and a lack of alternative methods. Creating and running this protocol will provide an opportunity to investigate and analyze an alternate approach that may be more effective than current treatment methods. As mentioned, there are many deficits based approaches to anger management, yet there are no identifiable strengths based

approaches. This proposed protocol will create an opportunity to compare and contrast strengths- based to a deficit based approach.

In addition, current trends in practice have led to many limitations in regards to the amount of sessions that insurance providers will cover for patients. The following protocol has been designed to be implemented and completed within six sessions. This small amount of sessions will likely fit into the amount of covered sessions provided to clients through their insurance providers. Knowing that they will have coverage for their treatment and be able to complete treatment is likely to increase the likelihood that individuals will begin and complete treatment. This will provide further opportunities for research in that individuals are completing treatment and outcomes can be measured.

The proposed protocol is also designed as a group treatment model. This is positive for the field in that it is providing an opportunity to treat a greater amount of individuals. Anger management groups are often held through college counseling centers as well as institutions that have a waiting list for clients. The group format allows for the treatment of a larger amount of individuals by a single therapist. A proposed method for effectively implementing this protocol will be described in a later section, as well as a description of how this protocol could be studied in the future.

Though there is no research base for the use of strengths-based interventions in the treatment of anger management, there is some evidence of other instances where a strengths-based approach was effectively implemented. Taking these instances into consideration and applying similar constructs to an anger management protocol is likely to be an effective method of treatment. Ayland and West (2006) developed a strengths based program using a narrative therapy approach and incorporating relapse prevention to

work with youth with intellectual difficulties who have been sexually abused. The program utilizes two different concepts. The first concept and the one most relevant to this literature review focuses on the young person identifying their strengths and components of their "good life" in order to understand the consequences of their actions (Ayland & West, 2006). They then work to develop their ability to choose the "good way" to handling situations instead of resorting to maladaptive behavior patterns. The other concept deals with the young person's sense of loss and trauma and helps them develop a sense of the impact their behavior has on others while assisting them in repairing relationships where it is possible (Ayland & West, 2006). Current success has been shown by the young people and their families using the language and concepts to describe and monitor their behavior. In addition, of the young people who have completed the program, there have been no reports of any new instances of re-offending (Ayland & West, 2006). This shows that strengths-based approaches do hold validity in working with both young people, as well as those who are intellectually impaired.

A solution-focused approach that incorporates empowerment-based practice as well as social constructivism and a strengths-based perspective is well suited for treating ethnic and racial groups with diverse cultural values and practices (Lee, 2003). The solution-focused approach views the solution to a client's problem as based on their perception of it. This approach relies on the therapist not relying on previous experiences or theoretical truths to understand and interpret therapeutic needs of their clients (Lee, 2003). In solution-focused therapy the client is the expert on their problem as well as the solution to their problem. Using the strengths and positives of the client, the approach utilizes the culturally based resources and strengths available to the client that fit within

their cultural frame of reference (Lee, 2003). Because clients with anger problems range in ethnic as well as cultural diversity, solution-focused therapy would likely be a good form of treatment for them.

There is little research that answers the question of whether individual or group therapy is more effective (Deffenbacher, 2006). Individual therapy allows for the therapist to gain greater knowledge about the client and the specifics of their case and situation while group therapy offers the client alternative perspectives and normalization of their circumstance (Deffenbacher, 2006). It is clear that most outcome research has been conducted in a group format and indicates treatment effectiveness, therefore suggesting that practitioners consider group intervention (Deffenbacher, 2006). Lietz (2007) took a case study approach by illustrating and investigating strengths-based treatment in a single-parent group and in two groups of children and youth in a residential treatment facility. The case examples demonstrated success in working from a strengths perspective. Premature termination, persistent negativity, and poor attendance appeared to improve (Lietz, 2007). Lietz notes that working in a group setting allows for members to share each other's strengths and experience them together; making the overall total experience more powerful. In addition, in individual practice it is common that the therapist and client talk about how the client's strengths impact their life. In group treatment, a group of peers can share personal stories of success and be instantly validated by their peers (Lietz, 2007). Taking these ideas into consideration, it is evident that a group format of solution-focused intervention would likely be an effective approach to the treatment of individuals with anger problems. In reviewing the base of

literature involving anger, solution-focused strengths based treatment, and group treatment, there are many converging ideas.

There is evidence that solution focused methods are an effective mode of treatment and it is likely that they can be effective in anger management as well, however there are always potential problems or things to consider while implementing such groups. In regards to anger management and the expression of anger, it is important to look at the expression of anger in general in relation to culture as well as context. Different cultures express anger in different ways, and acknowledging this prior to treatment and during the treatment process is important. Some individuals may be opposed to or have difficulty applying solution –focused techniques based upon their culture and beliefs. It will be important for the group leader to be aware of this. Another possible problem is that the following protocol is designed to treat a group of individuals mandated for treatment. Ensuring that individuals attend all sessions and are present both physically and mentally will have a definite effect on the outcome of the group. As with any group, attitudes amongst these individuals will be different, and getting the group members to join with one another may possibly take longer than the allotted amount of sessions as described in the protocol.

The main research base for treatment of anger has been done on a college aged student population. Basing outcome conclusions on such a unique and uniquely different population may also cause problems. Present day college students vary in age from around 18 or 19 all the way into the fifties and sixties. A college aged student population will vary in all diversity variables including but not limited to gender, sexuality, race, ethnicity, disability, and religion. All of these differing populations will have different

feelings about anger as well as if and how it is expressed. This may cause a variance in the results of the effectiveness of the proposed protocol.

The final area of discussion is in the measuring of the effectiveness of the protocol. It will be necessary to locate pre-post outcome data measures that are consistent with the solution-focused theory. Many current assessment measures focus on deficits. It will be necessary to first administer an anger or hostility measure to get a client's perceived anger score. After determining that the client has an anger problem, it will be necessary to implement a measure such as the Target Complaints Scale/ Target Goals and Objectives Scale (TCS) that measures the client's goals. Once these instruments are administered, the clinician will have a score to begin with and to compare to the post treatment data. Post-treatment data will consist of the scores obtained on the same measures administered pre-treatment. The assessment instruments used to collect the data are self-report measures. This always poses the question of whether or not the patient is accurately portraying his or her symptoms. A possible way to correct for this possible problem is to administer the measures to a close friend or family member of the patient if possible to get their view of the patient. Again, it may be difficult to get another person to come in for the pre-screening appointment, and sending testing instruments or questionnaires home poses the possible threat of compromising the testing instrument and items it contains. Creating an informal questionnaire for someone who knows the client well to complete is a way of solving this problem. Anger is an area that lacks research. Not only is there a lack of diagnoses for anger in the DSM-IV-TR, but there is also a lack of variance in modalities to treat anger. The breadth of treatment methods lies in the Cognitive Behavioral Orientation. Clinicians are responsible for implementing the best

possible treatment for a client's diagnosis. With a lack of research in other orientations how are clinicians to be sure that they are implementing the best possible treatment, when we have yet to explore many other approaches. The proposed protocol aims to develop an alternative and possibly more affective approach to treating clients who maladaptively express anger.

The research base that is currently available is focused on a deficits based model of treatment. This approach is significantly easier to implement on a population of individuals who are at the action phase of treatment, able to recognize their problems, and have a desire to attend treatment to seek help in resolving their problems. There is no existing comparison protocol that is strengths based in nature and serves a population of people who are mandated for treatment. The implementation of the proposed pilot protocol would add to the literature the idea of a strengths based approach to anger management specifically designed to be used with a mandated population.

Future Directions

Future intentions include utilizing the proposed protocol in a college counseling center. This is likely to take a lot of effort on the part of the group leader or individual implementing the new protocol. Changing or adding to the way things are currently done in an institution is likely to take some time, as it is hard to get individuals to change their current ways and accept new ways. This will be easier if the group leader believes in the protocol and methods he or she is attempting to get accepted. The protocol is more likely to be accepted if the individual introducing the protocol presents it in an educated manner with the reasons why it is likely to work. Using the information provided in the literature review of this paper about solution-focused treatment as well as group treatment is

encouraged if one is to attempt to get others approval of the protocol. In addition, noting

the advantages to using the protocol such as its projected efficiency and its projected

ability to save time and money for an institution, will likely be advantageous. Getting at

least one other person to support the idea and present it with the individual attempting to

get it accepted is also likely to aid in getting others to allow an opportunity to see if the

protocol is effective and provides the results it projects to provide.

Following the implementation of the protocol in a college counseling center will

provide information on how to modify the protocol to make it more efficacious. After

deemed effective, the protocol will likely be a candidate for use within correctional

facilities where longitudinal data will be available.

Phase 1
Session One: Establishing the rules and structure of the group and the joining process between group members and leaders as well as among group members

Instructions to group leaders

In the first session, the purpose, overview, group rules, contract, and rationale for the anger management treatment are presented. Most of this session is spent presenting conceptual information and verifying that the group members understand it. Then the leaders begin the joining process.

Part 1 Suggested Remarks for overview, rules, contract

(present the following script or put in own words)

Purpose and Overview

The purpose of the anger management group is to:

1. Learn to manage anger

2. Set goals for yourself

3. Recognize exceptions to problematic behavior

4. Receive support and feedback from others

5. Utilize exception behaviors during and at the conclusion of group

Rules

1. Attend all 6 sessions
2. Handle conflict in a non-aggressive, non-violent manner
3. Maintain confidentiality
4. Participate in group discussions
5. Refrain from the use of alcohol or drugs for duration of group sessions

Here, leaders present rules, contract, obtain signatures, collect contract, ask members if they have any questions, and move on to part 2 of session 1.

Part 2 Joining of group members to one another and to leaders

Instructions to group leaders

Here leaders focus on the joining of members and rapport building through the introduction of themselves and the introduction of all group members by themselves

- Leaders are to display modeling behavior utilizing self-disclosure, hope, acceptance, and encouragement

- Leaders are to take a "one down" stance and allow clients to be the experts on themselves

- Leaders do not interrupt, but allow each individual the time to tell their story from their own perspective

- Leaders encourage participation from all group members

- Leaders introduce themselves and utilize modeling behavior

Group member's task

1. Each member introduces himself and tells his story

After all group leaders and members have introduced themselves and told their stories, leaders ask if there are any questions. They then remind group members of the time, day, and location of the second group session and dismiss all group members.

Phase 1
Session Two: Searching for exceptions and establishing goals

Part 1 Recognizing and utilizing exceptions

Instructions to group leaders

In the second session, group leaders facilitate the process of group members recognizing and utilizing exceptions and assist group members in establishing their goals

- Leaders inquire about if there were times when anger was handled appropriately, what these particular situations were or looked like, and what the outcome was. Each group member is encouraged to share at least one of these instances where they were successful in handling their anger appropriately or adaptively

- Leaders provide members with compliments about their strengths, successful endeavors, and exception behaviors and encourage other members to do the same

- Leaders check in with clients and challenge them to recognize the positive outcomes of the exception behaviors, as well as how they felt when they displayed exception behaviors

Group member's tasks

1. Members tell their stories

Here, leaders move on to part 2, establishing goals

Part 2 Establishing goals

Instructions to Leaders

The final task in the first phase is for members to establish their goals. In keeping with the solution-focused method and adapting it to use with clients who express their anger maladaptively or inappropriately, members are required to identify a goal that is interpersonal.

- The solution-focused technique of using outcome questions is used by group leaders during the goal construction process. Future oriented questions may be **"At the completion of group, when you achieve these goals, how would other members know?" or "Imagine I meet you out in the community and the**

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***problem that you came to group with is now gone. How would you describe
your life without this problem?"***

- Questions may also focus on **how the member will know they accomplished
  their goal, or how they will know there is a difference post-group in
  comparison to pre-group**

Group member's tasks

1. Member recognizes a goal that he would like to accomplish and the goal must be
initiated by the client and must relate to another entity

2. The goal should be defined through a solution-focused approach, where it is something
that the member can do positively rather than something that the member is trying to
avoid or get rid of
     (For example, a member may wish to make their goal to increase the amount of
times they take a time out and walk away from an anger inducing situation rather than
make the goal to decrease the amount of times they physically act out when they get
angry.)

3. In order to raise the chance of success in achieving a set goal, goals are to be
established with clear, precise, behavioral provisions and be able to be fulfilled within the
six session model

4. After the member establishes the goal, he is asked to describe in detail what life will be
like when their presenting problem no longer exists

*After each group member has established an acceptable goal, group leaders have clients
write down their goals. Clients are then thanked for their participation, reminded of the
time, day, and location of the next session, and then clients are dismissed.*

Phase 2
Session Three, Four, & Five: Expand, amplify, and reinforce solution behavior from phase 1

Instructions to group leaders

The main focus of this phase is for leaders to assist group members in expanding, amplifying, and reinforcing their identified solution behaviors from phase one.

- Group leaders use EARS acronym: Elicit, amplify, reinforce, and start again

- Group leaders provide the group member(s) with compliments and use solution-focused techniques to reinforce the group member's new reality that they are experiencing and working to develop

- Leaders use specific relationship questions

- Leaders and members use coping questions if a group member reports no change

- Leaders ask group members scaling questions

- Leaders ask members questions to support positive change

- Leaders use group cohesion techniques

- Leaders use empowerment techniques

Group member's tasks

1. Group members are asked to detect and inform other group members and group leaders of the exceptions to their problem behavior and/or solution behaviors that occur between sessions.

2. Group leaders initiate the "EARS" process: They **elicit**, ask about positive changes; **Amplify**, ask for details about the positive change; **Reinforce**, make sure the group member notices and values the positive changes; and **Start again**, ask what else is better

3. Group leaders provide the group member(s) with compliments and use solution-focused techniques to reinforce the group member's new reality that they are experiencing and working to develop

4. Once the group members have established specific components of change for themselves, they are asked how they think other people will react to their progress

5. Group cohesion is an integral part of the change process. Group leaders initiate this process by asking members to comment on the progress of their fellow group members. During this process, members work together to help create exceptions and solution behaviors that will be helpful to one another and their particular presenting problems. In this process, empowerment is used in that members begin to discover the ways in that they have been resourceful in dealing with the issues of maladaptive anger expression

Homework

This process continues for session 3, 4, and 5. At the conclusion of each session group members are given the homework assignment to work on their goals and to record or remember instances where they have used their exception behavior. In addition, they are given the homework to record or remember how others react to their exception behavior.

After group members are given their homework assignment at the conclusion of each class, they are thanked for participation, reminded of the time, day, and location of the next session, and dismissed.

Phase 3
Session Six: Termination phase and session

Part 1 Evaluating and consolidating

Instructions for group leaders

- Group leaders focus on evaluating, consolidating, and celebrating the progress and success members have experienced in achieving their goals

- Group leaders review, augment, and encourage the changes that group members have made

- Group leaders use the scaling question to determine the progress members have made between the first and last session

- Group leaders use the scaling question to determine each member's confidence in their ability to maintain the change they have created

- Group leaders also work to bring and keep the solution picture and reality into the group members' minds

- Group leaders also assist members in distinguishing ways to recognize when they are reverting back to maladaptive patterns of managing their anger

Group member's tasks

1. Group members rate their change and their ability to maintain change using the scaling question

2. Group members recognize what is working for them and bring the solution picture and reality into their minds so that they can attach their positive efforts and actions to the positive outcomes that they have been experiencing

2. Group members connect the positive changes in their actions and take responsibility for them

3. Group members distinguish ways to recognize when they are reverting back to maladaptive behavior

Part 2 Acknowledging the strengths of group members and celebrating these strengths

Instructions for group leaders
- Group leaders give prolific and genuine compliments to each group member on specific changes that the particular group member has made in regards to adapting their expression of their anger from a maladaptive or inappropriate method to an appropriate or acceptable method

Group member's tasks

1. Group members take credit for the changes they have made and celebrate the accomplishment of goals

Group leaders close group by recognizing the hard work the members put in and the changes they have made. Group is dismissed.

References

Ayland, L., & West, B. (2006). The good way model: A strengths-based approach to for working with young people especially those with intellectual difficulties, who have sexually abusive behavior. *Journal of Sexual Aggression, 12*(2), 189-201. doi:10.1080/13552600600841680

Battle,C.C., Imber, S.D.,Hoen-Saric, R., Stone, A.R., Nash E.R.,& Frank, J. D. (1966). Target complaints as criteria of improvement. *American Journal of Psychotherapy, 20,* 184-192.

Baumeister, R. F., Bushman, B. J., & Campbell, K. (2000). Self-esteem, narcissism, and aggression: Does violence result from low self-esteem or from threatened egotism. *American Psychological Society, 9*(1), 26-29. doi: 10.1111/1467-8721.00053

Beck, R., & Fernandez, E. (1998). Cognitive-behavioral therapy in the treatment of anger: A meta-analysis. *Cognitive Therapy and Research, 22,* 63-74.

Berg, I. K. (1994). *Family-based services: A solution-focused approach*. New York: W.W. Norton.

Burlingame, G.M. et al. (2006). Core battery – revised: An assessment tool kit for promoting optimal group selection, process, and outcome. New York: American Group Psychotherapy Association.

Collins, S. W., & Hailey, B. J. (1989). The Anger Expression (AX) Scale: Correlations with the State Trait Personality Inventory and subscale intercorrelations. *Educational and Psychological Measurements, 49,*

Corcoran, J., & Pillai, V. (2009). A review of the research on solution-focused therapy. *British Journal of Social Work, 39,* 234-242.

Deffenbacher, J. L. (2006). Evidence for effective treatment of anger-related disorders. In E. Feindler (Ed.), *Anger related disorders* (1 ed., pp. 43-70). New York: Springer Publishing Company.

Deffenbacher, J. L., Oetting, E. R., & Digiuseppe, R. A. (2002). Principles of empirically supported interventions applied to anger management. *The Counseling Psychologist, 30*(2), 262-280. doi: 10.1177/0011000002302004

Deffenbacher, J. L., Oetting, E. S., Thwaites, G. A., Lynch, R. S., Baker, D. A., Stark, R. S.,Eisenworth-Cox, L. (1996). State-Trait Anger Theory and the utility of the Trait Anger Scale. *Journal of Counseling Psychology, 45*(2), 131-148. doi:10.1037/0022-0167.43.2.131

Delucia-Waak, J. L., Garrity, D. A., Kalodner, C. A., & Riva, M. T. (2004). *The handbook of group counseling and psychotherapy*. Thousand Oaks, California: Sage.

Digiuseppe, R. (1999). End piece: Reflections on the treatment of anger. *Psychotherapy in Practice, 55*(3), 365-379. doi: 10.1002/(SICI)1097-4679(199903)55:3<365::AID-JCLP8>3.0.CO;2-3

Digiuseppe, R., & Froh, J. J. (2002). What cognitions predict state anger. *Journal of Rational-Emotive & Cognitive-Behavior Therapy, 20*(2), 133-150.

Digiuseppe, R., & Tafrate, R. C. (2001). A comprehensive treatment model for anger disorders. *Psychotherapy, 38*(3), 262-271. doi: 10.1037/0033-3204.38.3.262

Digiuseppe, R., & Tafrate, R. C. (2003). Anger treatment for adults: A meta-analytic review. *Clinical Psychology: Science and Practice, 10*(1), 70-84. doi: 10.1093/clipsy.10.1.70

Digiuseppe, R., & Tafrate, R. C. (2007). *Understanding anger disorders*. New York: Oxford University Press.

Digiuseppe, R., Tafrate, R., & Eckhardt, C. (1994). Critical issues in the treatment of anger. *Cognitive and Behavioral Practice, 1,* 111-132. doi:10.1016/S1077-7229(05)80089-6

Feindler, E. L. (Ed.). (2006). *Anger related disorders: A practitioner's guide to comparative treatments*. New York: Springer Publishing Company.

Gardner, F. L., & Moore, Z. E. (2008). Understanding clinical anger and violence: the anger avoidance model. *Behavior Modification, 32*(6), 897-912. doi: 10.1177/0145445508319282

Gonzalez-Prendes, A. A. (2008). Anger-control group counseling for women recovering from alcohol or drug addiction. *Research on Social Work Practice, 18*(6), 661-625. doi: 10.1177/1049731507308356

Gorenstein, E. E., Tager, F. A., Shapiro, P. A., Monk, C., & Sloan, R. P. (2007). Cognitive-behavior therapy for reduction of persistent anger. *Cognitive and Behavioral Practice, 41,* 168-184. doi:10.1016/j.cbpra.2006.07.004

Greene, G. J., Kondrat, D. C., Lee, M. Y., Clement, J., Siebert, H., Mentzer, R. A., et al. (2006). A solution-focused approach to case management and recovery with consumers who have a severe mental disability. *Families in Society: the Journal of Contemporary Social Services, 87*(3), 339-350.

Greene, G. J., Lee, M. Y., & Hoffpauir, S. (2005). The languages of empowerment and

strengths in clinical social work: A constructivist approach. *Families in Society:*

the Journal of Contemporary Social Services, 86(3), 267-277.

Kassinove, H., & Tafrate, R. (2006). Anger related disorders: Basic issues, models, and

diagnostic considerations. In E. Feindler (Ed.), *Anger related disorders* (1 ed., pp.

1-27). New York: Springer Publishing Company, Inc.

Lee, M. Y. (2003). A solution- focused approach to cross-cultural clinical social work

practice: Utilizing cultural strengths. *Families in Society: the Journal of*

Contemporary Human Services, 84(3), 385-395.

Lee, M. Y., & Gaucher, R. (2000). Group treatment for dually diagnosed adolescents: An

empowerment-based approach. *Social Work with Groups, 23*(2), 55-78.

doi:10.1300/J009v23n02_05

Lee, M. Y., Uken, A., & Sebold, J. (2004). Accountability for change: Solution-focused

treatment with domestic violence offenders. *Families in Society: the Journal of*

Contemporary Social Services, 85(4), 463-476.

Lee, M.Y., Greene, G. J., & Rheinscheld, J. (1999). A model for short-term solution-

focused group treatment of male domestic violence offenders. *Journal of Family*

Social Work, 3(2), 39-57. doi: 10.1300/J039v03n02_04

Lietz, C. A. (2007). Strengths-based group practice: Three case studies. *Social Work with*

Groups, 30(2), 73-87. doi: 10.1300/J009v30n02_07

Metcalf, L. (1998). *Solution focused group therapy ideas for groups in private practice,*

schools, agencies, and treatment programs. New York: The Free Press.

Pichot, T., & Dolan, Y. M. (2003). *Solution-focused brief therapy: Its effective use in agency settings*. New York: The Hawthorn Press.

Prochaska, J.O., di Clemente, C.C. (1984). *The Transtheoretical Approach: Crossing Traditional Boundaries of Therapy*. Homewood, IL: Dow Jones Irwin.

Staudt, M., Howard, M. O., & Drake, B. (2001). The operationalization, implementation, and effectiveness of the strengths perspective: A review of empirical studies. *Journal of Social Service Research, 27*(3), 1-21.

Tafrate, R. C., & Kassinove, H. (2003). Angry Patients: Strategies for beginning treatment. In R.L. Leahy (Ed.), *Roadblocks in cognitive-behavioral therapy* (pp. 295-317). New York: The Guilford Press. Walter, J. L., & Peller, J. E. (1992). *Becoming solution-focused in brief therapy*. New York: Brunner/Mazel, Inc.

Williamson, P., Day, A., Howells, K., Bubner, S., & Jauncey, S. (2003). Assessing offender readiness to change. *Psychology Crime & Law, 9*(4), 295-307. doi: 10.1080/1068316031000073371