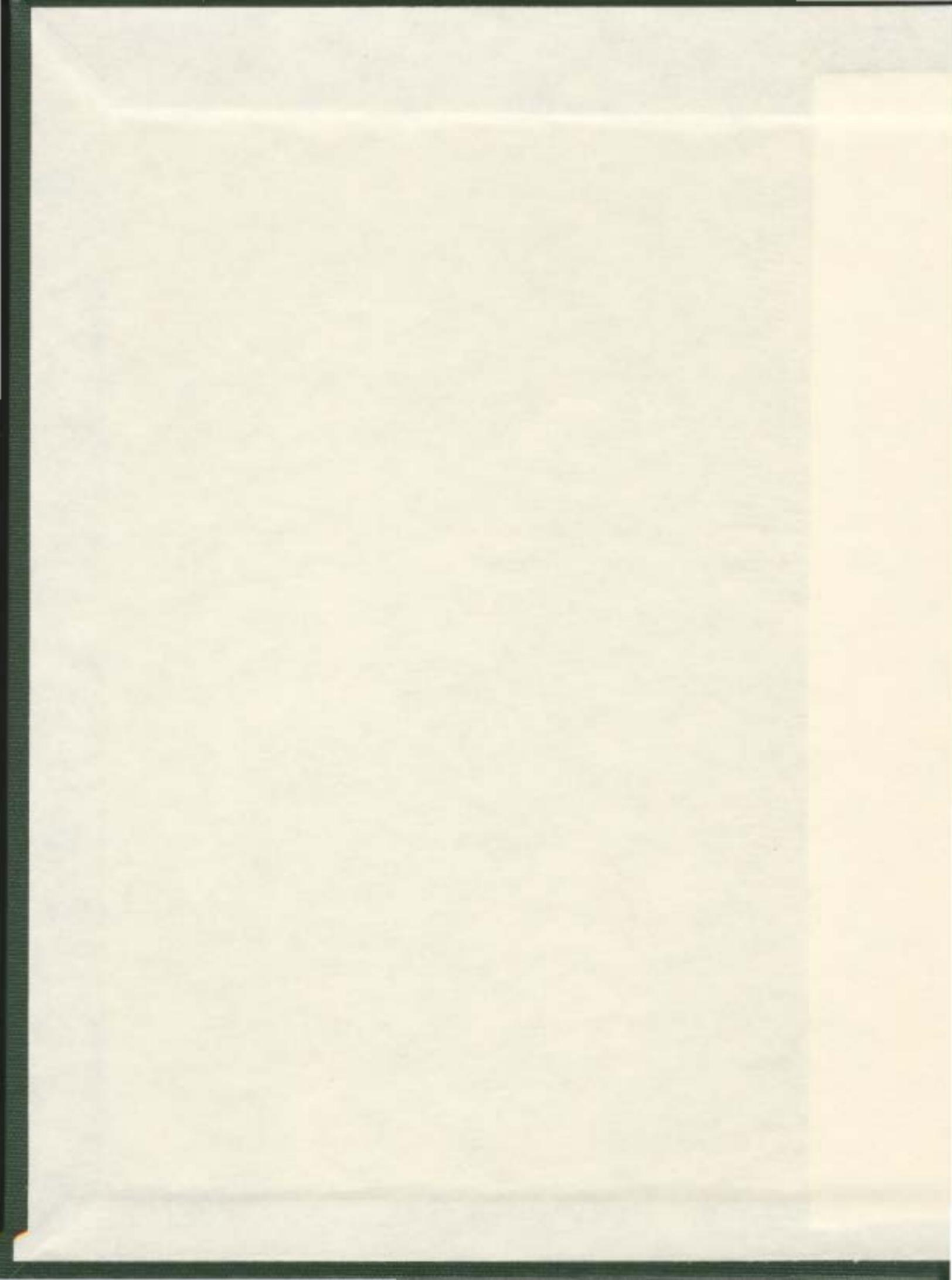


THE EFFECTIVENESS OF GROUP
PSYCHOEDUCATIONAL THERAPY ON OUTPATIENTS
FOR INCREASED ANGER MANAGEMENT

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The Effectiveness of Group Psychoeducational Therapy on Outpatients for
Increased Anger Management

By

©Soraya Carrim

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Abstract

The effectiveness of a group psychoeducational therapy approach to assess anger management was researched. A pilot anger management program at a mental health facility ran for eight weeks, two hours a week. It involved nine outpatient participants selected from referrals made by organizations in the community. During the group sessions, participants recorded their own perceptions of their anger using a questionnaire designed specifically for this project. These questionnaires were administered during the first and final sessions. The questionnaires were analyzed to determine if the sessions were effective in reducing the participant's perceived level of anger. Clinical observations were documented by the therapists to assess changes in the anger management skills of the participants. Statistically significant improvements in anger management skills were identified and all members of the group felt that they benefited from the group sessions and could approach their anger in a more appropriate manner. The findings are deemed to support the use of outpatient group psychoeducational anger management. A detailed description of the educational component of the program is offered.

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Chapter One – Introduction

1.1 Background and Rationale

The use of anger management group therapy has gained recognition over the last decade as an effective method of decreasing anger in individuals. Widely used researched interventions include cognitive/behavioural therapy, process therapy, and psychodynamic therapy. These have been used in a variety of settings with both inpatient and outpatient groups with noted success. Very little research has studied the use of psychoeducational therapy approach as an intervention for anger management, especially in an outpatient group setting.

This research studies the effectiveness of combining group psychoeducational therapy on anger management. It also assesses if this group psychoeducational therapy is effective with outpatient clients. If this type of therapy is effective in increasing anger management skills, its usage can be promoted as a future therapeutic intervention. The implication of offering this intervention to voluntary clients is also examined.

This thesis analyses the findings derived from a pilot study aimed at determining both the utility of a psychoeducational intervention and its application in a group setting. A literature review on anger management and previously researched interventions, as well as, a sample of the “curriculum” used that details the session content and the organizational outline prescribed for the eight-week intervention are all included within the text.

1.2 Outline of this Study

To establish if outpatient clientele will benefit from psychoeducational group anger management therapy, a sample of clients was invited to participate in the therapeutic group. They agreed, prior to the initiation of the sessions and at its termination, to complete self-report questionnaires at the time the group was ongoing. The intervention to be offered was based on the psychoeducational model developed by Dr. Khalili. Following his structured format, eight sessions were offered. This multidimensional approach to psychoeducational therapy, incorporating themes from cognitive behavioural therapy within the psychoeducational format, offered the members a curriculum for learning about and dealing with anger, a typical/conventional group process, and the opportunity to meet consistently with others needing the same level of instruction and therapy.

Clients, when necessary, were offered individual support from the researcher outside of group sessions as was established when the intervention structure was created. Detailed notes were taken both during the sessions and the individual meeting with clients. The researcher and therapist met to assess and record impressions and anecdotal data derived from each session.

As noted above, questionnaire data was also collected from the group participants. Items on the questionnaire were developed based upon a review of the literature, expert opinions from psychologists, and observations of a prior psychoeducational group therapy program developed by Dr. Khalili. These questionnaires were used to help determine the effectiveness of the intervention on clients who were referred to take part in anger management therapy. All referrals were

completed by a diverse range of mental health professionals, including staff from a clinic serving psychiatric illness, psychiatrists, general practitioners, and by self-referrals made through doctors, nurses, and social workers in the community.

The questionnaire, which was administered during the first and last sessions, asked respondents to rate their present feelings of depression, anxiety, and how angry they felt they would be in a number of different situations. The data was analyzed, both quantitatively and qualitatively, to assess if significant improvements in managing anger could be identified. Information as to clients' needs and possible future program directions were collected from each group member, as well as comments concerning the individual member's progress as the sessions progressed.

The psychoeducational program offered is described in detail in Chapter Four of this thesis. This program entailed instruction on the theory and nature of anger, suggested methods of responding to anger, and also provided group members with the opportunity to rehearse, elaborate, and integrate the content and skills offered during the sessions. In addition, supportive group therapy was offered. This allowed the group members the opportunity to form bonds and share personal experiences.

1.2.1 Research Questions

To assess the effectiveness of this intervention package, using psychoeducational therapy on voluntary, outpatient clients, the following specific research questions were addressed:

1. Does the content of a psychoeducational therapeutic intervention program prove effective as a means of addressing anger management problems?
2. Is this intervention effective with a voluntary outpatient population?
3. Can the effectiveness of this intervention be assessed using an instrument developed by the researcher?
4. What is the overall satisfaction level participants experienced as a result of this type of intervention?
5. Do participants experience a perceived increase in their anger management skills as a result of this intervention?

Chapter Two - Literature Review

2.1 Introduction

Current methods of group therapy for the treatment of anger management have not addressed its effectiveness with groups of voluntary, outpatient members. In addition, there is little literature on the effectiveness of using psychoeducational therapy when addressing anger management. Linking outpatient participants and psychoeducational therapy creates a potentially beneficial approach for anger management group therapy.

2.2 Manifestations of Anger and its Related Behaviours

2.2.1 Definitions of Anger

Although it is relatively easy to observe what is typically deemed to be an angry expression or reaction, explaining the nature of anger is surprisingly difficult and complicated. B. S. Sharkin (1988) defines anger as an internal condition that involves various degrees of interactions between physiological, affective, cognitive, motoric, and verbal components. Anger is seen as the “elicitation of one or more aggression plans by the combination of threat appraisal and coping procedures” (Robbins, 2000, p.7). Anger can also be defined as, “a strong, uncomfortable emotional response to a provocation that is unwanted and incongruent with one’s values, beliefs, or rights” (Thomas, 2001, p. 41). Schiraldi and Kerr (2002) suggest that anger involves a “thought that triggers or

maintains the anger, the physiological arousal, and then the tendency to behave as learned to protect or further our own self interests” (p. 3).

While many operational definitions for anger exist, an eclectic definition is used within this study, which accepts that key determinants of anger are both derived from clients’ self-definitions of being angry and, also, from the views held by significant others and professionals in their lives.

2.2.2 The Manifestation of Anger

McKenzie (1998) states that there are different ways that people express anger. These include yelling and cursing, blaming others, and retreating from their emotions. Gorkin (1998) presents what he calls the “Four Faces of Anger”. These are: 1) purposeful anger, 2) spontaneous anger, 3) constructive anger, and 4) destructive anger. He proposes that purposeful anger is intentional and involves a significant degree of self-control; spontaneous anger is immediate with little planning or premeditation in the reaction; constructive anger is used appropriately to acknowledge one’s boundaries and integrity; and destructive anger is defensive and rigid and is used to threaten or violate another’s integrity and personal boundaries. These definitions illustrate the multifaceted nature of anger expression. Particular terms are commonly associated with or related to each expression of anger. The term related to purposeful anger is “assertion”; spontaneous anger can be referenced to “hostility”; the association with constructive anger is “passion” and the association with destructive anger can be defined as “rage”. Gorkin (1998) summarizes his position graphically in Figure 1.

Box 1 Purposeful and Constructive Anger	Box 2 Purposeful and Destructive Anger
Box 3 Spontaneous and Constructive Anger	Box 4 Spontaneous and Destructive Anger

	Constructive	Destructive
Purposeful	Assertion	Hostility
Spontaneous	Passion	Rage

Figure 1: The Four Faces of Anger

Although expressions of anger can vary, anger is a normal and healthy emotion that varies in intensity in relation to the inner emotion experienced. The understanding of a particular event or a situation is driven by cognitive interpretations made either

consciously or unconsciously. For example, Gorkin (1998) proposes that these cognitive interpretations result from an interaction between four internal responses. One's "experiential" response involves the emotions felt by the individual, which can range from "mild" to "furious" intensity. The "physiological" response focuses on the level of arousal felt and is measured by physical changes in the body, for example, adrenal release, increased muscle tension, and activation of the autonomic nervous system. The third response involves cognitive processes and how an experience is interpreted. Cognitively, anger is viewed as a violation of the individual's rights, this violation derived from a perceived injustice, injury, invasion, or intentional harm. Finally, the behavioural response denotes the actions taken by an individual to do something about the above perceived injustices, injuries, and invasions (Gorkin, 1998).

2.2.3 Anger versus Other Emotions

It is important to note the differences between terms that on the surface may seem very similar to anger. The term 'aggression' signifies that an action is intended to harm another person, either physically or verbally. This type of response differs from anger in that the goal is intentional harm, whereas anger refers to a set of feelings not necessarily having an intended goal in mind (Berkowitz, 1993). Rage occurs when aggression becomes so extreme that there is a loss of self-control. Hostility refers to a chronic state of anger. Assertiveness is seen as rationally standing up for one's own rights without the intent of hurting another individual or object (Tucker-Ladd, 1997). Frustration is an emotion felt when the outcome of an event or experience differs from the expected outcome. Frustration comes when an expected result does not occur (Berkowitz, 1993).

Many individuals have the inability to differentiate between anger and these other emotional states. Knowing about anger's related states is, in this study, deemed a key rationale for use of a psychoeducational intervention model. Education helps one distinguish the emotions being felt and, therefore, helps an individual learn to react to each situation in a more practical manner.

2.2.4 Problematic Anger

Anger can be assessed by its frequency, intensity, duration, and threshold. When the level of anger becomes problematic, the need for anger management becomes evident (Novaco, 1975). Problematic behaviour can be described as conduct that the general population would consider beyond the scope of what is conventionally deemed acceptable (Olatunji & Lohr, 2004). As the threshold for anger decreases, an individual may become more prone to angry outbursts, which may intensify as time goes on. Intense anger can be psychologically taxing. When this occurs, physical symptoms can become apparent. They can be seen as headaches, stomach pains, backaches, and cardiovascular problems. Behavioural symptoms such as rapid speech, yelling and screaming, sarcasm and cynicism, avoidance of others, and/or reliance on alcohol, drugs, or food are sometimes displayed when an individual is angry (Hollander, 1998).

Anger upsets at least two people: the aggressor and the object of her or his anger. While mild anger can serve many functions, such as motivating change and signaling dissatisfaction, problems arise when anger becomes severe and/or persistent. Severe anger indicates the presence of cognitive factors that make frustrating events appear as

“intolerable, infuriating violations [that cause the individual to] react emotionally and behaviourally to the construed reality” (Lyddon & Jones, 2001, p. 167). Anger can occur when individuals are unable to articulate their feelings and thoughts appropriately or when others fail to meet their needs. Anger results from the individual’s interpretation of an event, and not necessarily the event itself. Problematic anger can result in hurt or punishment, rather than building, protecting, or defending oneself or another. It is a behavioural response that is deemed too frequent, too intense, or disproportionate to the perceived offence (Lyddon & Jones, 2001).

While problematic anger can arise when a person thinks she or he is being attacked without evaluating the situation, anger is not always regarded as an unhealthy emotion. Constructive anger has helped to change the world over time. When reading of prominent people in history, such as Nelson Mandela, Romeo Dallaire, and Rosa Parks, it appears that their constructive anger had a motivating component that helped create awareness of the specific point being made. Therefore, a state of anger is not necessarily problematic when individuals can express their emotions adaptively to affront an injustice.

2.3 Origins of Anger

Over a century of research has been dedicated to deciphering the background and development of emotions, such as anger. Discussions of anger fall into three main areas namely: biological theories, biosocial and psychosocial theories (interaction theories), and social learning theories. Representative theories in each of these three areas are discussed below.

2.3.1 Biological Theories

Theories in this category propose that the origins of anger are biological. Individuals may have a predisposition for anger and angry responses originate from a physical and/or neurological injury that causes a personality shift in the individual (Kassinove & Sukhodolsky, 1995). Although rare, Deffenbacher and McKay (2000) explain that dysregulation in serotonergic and noradrenergic systems can influence some people to overreact with anger and potentially aggressive behaviour. When the arousal system breaks down, anger may become disproportionate to the offence. Physiologically, anger is a state of increased arousal of the autonomic nervous system (Gorkin, 1998).

The emotion of anger stems from three overlapping domains within the brain: brain structure and lateralization, autonomic nervous system responses, and neurotransmitter and hormonal influences. The brain structures found to be influential in the experience of emotion are the amygdala, the hippocampus, and the neocortex (Cox, Stabb, & Bruckner, 1999). Although the neurological mechanisms of anger are beyond the scope of this study, it is important to mention that emotions are induced by the three distinct processes of arousal, activation, and effort, which are directly motivated by action of the above mentioned brain structures (Pribram, 1980).

In 1880, William James and Carl Lange introduced their theory on emotions as the James-Lange Theory of Emotions. According to these researchers, emotions are specific feelings caused by changes in physiological conditions relating to autonomic and motor functions of the human body (de Sousa, 2003). The James-Lange Theory of Emotion has encountered much debate as more knowledge and research has been

discovered on the nature of human emotions. While most biosocial and psychological theories consider the opposite to be true, the James-Lange theory states that a bodily reaction happens before any emotion is felt. Therefore, an appraisal of a situation does not predict an emotional response. The emotional response stems from how the body reacts to the interpretation (Cox et al., 1999). Therefore, when we perceive that we are being treated unjustly, our body reacts to this perception in a physical way, which then creates our awareness of being angry.

Walter Cannon (1929) did not agree entirely with the James-Lange theory due to its inability to distinguish differences between emotions. An increase in heart rate might indicate anxiety, anger, or feelings of love. It is difficult to decipher an emotion derived from a specific physiological response. Therefore, this cannot be what permits us to tell emotions apart. In addition to this opinion, Cannon was the first to describe the “fight or flight” response to stress. Originally termed the “acute stress response”, studies showed that animals react to threats with a general discharge of the sympathetic nervous system. To regulate stress responses among vertebrates and other organisms, the physiological reaction of releasing acetylcholine into the sympathetic nervous system allows an intuitive, spontaneous behaviour towards combat or escaping the provocation.

When used adaptively, anger serves as a natural response to threats and can be a defense against attacks. Berkowitz (1993) explains that all negative feelings generate both fight and flight tendencies. When an unpleasant emotion is felt, our “biological programming” creates an upsurge of reactions, feelings, thoughts, and memories. The resultant behaviour can be to both stay and attack the source of these feelings or to escape or avoid the aversive situation.

While biological determinism theorists state that anger and hostility are innate emotions for humans (Tucker-Ladd, 1997), there is no evidence that humans have inherited this tendency. The origins of any predisposition to fight and/or make war or alternatively to be cooperative and tolerant towards one another cannot be determined genetically. We cannot explain anger and aggression as inherent responses to hostile stimuli.

2.3.2 Interactionist Theories

Many theorists have concluded that both biological and social/psychological factors interact to result in displays and experiences of anger. This thinking resulted in a number of “interactional” theories, with biological and psychological bases, that focus on the origins of anger. Schachter’s Cognitive-Arousal Theory, for example, proposes that in a situation deemed to involve an “anger response”, there is an initial experience that does not differentially trigger any particular emotion or emotional response in an individual. The initial experience, while perhaps intense, is emotionally neutral and needs to be followed by an interpretation of the event and then a consequent reaction, i.e., of “displeasure”, before the “cause” of the reaction, in this case anger, is determined (Cox et al., 1999). From this cognitive-arousal theory, a separate theory emerged when Schachter teamed with Singer.

From this apparent sequence of events, interactionist theories emerged, such as the Two Factor Theory of Emotion proposed by Schachter and Singer (Berkowitz, 1993). This cognitive-arousal theory asserts that specific emotions are not linked to specific bodily reactions and instead, individuals feel angry based on interpretations of the

experience, not because of tense muscles and an increased pulse rate as the James-Lange Theory of Emotions stated. Instead, people feel angry due to the level of arousal they are already experiencing and their preconceptions about the nature of the arousal. The argument asserts that when people become aroused, they look for certain cues to help explain why they feel the way they do (Berkowitz, 1993). The nature of emotions is dependent on the constructs that are already present and, therefore, can be influenced by appraisals of the experience.

Appraisal processes are seen as a foundation of interactionist theories, since anger is not believed to be an automatic reaction. Individuals perceive provocation due to how the characteristics of the situation relate to past experiences they have encountered (Kassinove & Sukhodolsky, 1995). As Lazarus (1991) explains, the process of appraising a situation begins with the “primary appraisal” that involves evaluating the event in terms of its potential to pertain harm or risk to the individual. If the appraisal is deemed positive, then anger is unlikely to be expressed. When individuals perceive that they are being unjustly or intentionally violated, their sense of freedom is being threatened, and anger is expressed. “Secondary appraisal” takes in the individuals’ sense of ability to manage the situation. During this process, individuals determine accountability when attempting to cope with the situation, whether the ability to cope is available physically and psychologically, and finally, any future consequence of their actions (Berkowitz, 1993).

2.3.3 Social Theories

Social theorists believe that angry behaviours are a result of a learning process, and that its nature and occurrence is significantly determined by the social experiences one has. Therefore, our behaviours derive from our observations and experiences (Berkowitz, 1993). Individuals can learn from others, or by previous encounters, that an angry reaction to a perceived injustice may work to rectify the situation to their own benefit. Lazarus (1991) says that higher-order organisms rely less on the reflexive, physiological action that triggers the development of emotion, and more on the intertwining of a “startle response” with both complex social implications and one’s perceptions of the emotionally, arousing event.

Schiraldi and Kerr (2002) conclude that, adaptively, people get angry because they care about what happens to them and to others whom they care about. Each person responds differently depending on how the individual has learned to express her or his anger. How children are raised and the type of experiences they have had factor into their inclinations towards anger and violence. Family values and incidents that occur while growing up play a role in learning how to manage angry feelings, as do media and environmental factors, such as television and movies (Schiraldi & Kerr, 2002).

Albert Bandura’s Social Learning Theory developed from his studies on personality and behaviour. Behaviourism focuses on external research methods that can test observable actions and events (Bandura, 1977). Simplifying this definition can conclude that one’s environment is a significant determiner of one’s behaviour. Bandura’s research led him to add another dimension to behaviourism labeled “reciprocal determinism” where, not only does the environment cause behaviour, but

behaviour affects the environment as well (Boeree, 2006). The response people experience to their anger serves to define the nature and form of their anger.

Named as the “Father” of the cognitivist movement, Bandura added psychological processes to his personality theory in addition to behavioural and environmental factors. These psychological processes included observation learning (modeling) and self-regulation, paired with imagery and language. Results led Bandura to develop his “self-control” and “modeling” therapies that are used to help individuals change their behaviours by altering their thought processes (Boeree, 2006). “Modeling” is defined as observing and then imitating behaviours that people display. These resultant behaviours can be influenced by a number of cognitive, behavioural, or environmental factors (Bandura, 1977), and he asserts that modeling the behaviours of others can influence how individuals will behave when faced with their own situations.

Tavris (1989), in a discussion of Bandura’s theory, suggests that angry emotions are within our control. Within the social learning approach to anger, individuals can learn to uncover the causes of frustration that can lie underneath the expressed emotion of anger. Tavris believes that we use violence because anger and aggression pay off. While other theories simply provide us with excuses for being angry, he proposes that there are two basic ways to learn how to be angry: from observing aggressive models, as stated above, and from receiving and/or expecting payoffs following the aggression. These payoffs can include stopping the aggression of others, getting praise for being aggressive, getting self-reinforcement from the action of being aggressive, and experiencing a reduction in tension (Tucker-Ladd, 1997). Socialization experiences can demonstrate to an individual that many situations are highly insulting and threatening

and, therefore, need to be dealt with forcefully. Problematic anger arises when these negative situations are regularly handled in an aggressive manner (Lyddon & Jones, 2001).

Socialization, the process whereby individuals learn the way of life of their culture, and, therefore, acquire social identity (Corey, 2001). These learning patterns can come from parents' reinforcement of behaviour, experiences with peers, school, religious institutions, the media, and from other cultural norms. The term 'positive socialization' defines anger that is used in a flexible manner and is respectful of the rights of others while provoking resolution to the problem. 'Negative socialization' occurs when individuals are taught that specific experiences are to be viewed as an attack and are highly insulting. When high levels of anger and outbursts are frequent, they can become a normalized way of handling difficulties and end up as a habitual way of responding in general for these individuals (Deffenbacher & McKay, 2000).

There are several frames of mind that an individual may feel prior to the expression of anger. These 'pre-anger' states are important in helping to determine the intensity of the angry response. A person's state prior to the elicitation of anger consists of two elements: personal characteristics and the individual's cognitive-emotional-physical state at that particular time (Averill, 1983). Any anger felt from a similar incident that happened in the past can multiply the level of anger felt at the present time. Kauffman and New (2004) explain that each time an experience triggers the memory of a previous anger-invoking encounter; our level of intelligent thought during that situation diminishes. The input of the new information still occurs, but continues to be mis-stored as the previous experiences. The term used for this action is called "restimulation" and it

proposes that as anger increases, the level of intelligent thought decreases. It is difficult to think clearly when one is angry or in distress. When individuals believe that they have suffered an injustice and/or feel hurt or betrayed, information that enters the brain is not sorted out and organized as it is when they are not upset. When angry, one tends to act on the basis of emotions and not logical thought. Due to this type of thinking, most individuals are not able to compare and contrast new information with the data they already have experienced (Kauffman & New, 2004).

For the purpose of this study, it is crucial to explore the links between a person's constructs and display of anger and one's experience of anger. How one understands and perceives a situation or event can contribute to one's reaction (in this case, anger). When discussing cognition, it is important to differentiate between appraisals and attributions. Cognitive appraisals generally refer to our personal interpretations of a situation to determine its significance on an individual (Cox et al., 1999). Attributions refer to the person's beliefs about the cause of the emotion-arousing event.

These definitions and their relation to anger and other emotional origins are derived from a cognitivist point of view. Berkowitz (1993) followed Bandura's cognitive, psychosocial approach with his own interpretation of emotional constructs. Berkowitz labeled his cognitive theory as the "Cognitive, Appraisal, and Attribution Conceptions" theory. When a situation takes place, an individual is left with an initial reaction of displeasure. The way that an individual appraises the situation and interprets her or his feelings of displeasure will have an effect on the behavioural outcome. Berkowitz believes that a hurt individual becomes angry depending on the rationale of the cause of the displeasure felt (Berkowitz, 1993).

In the past few years, researchers have used a cognitive, social learning approach for deconstructing emotional states and how a person's perception of an event or experience affects how each will react (Solomon, 1980; Thomas, 1991; Damasio, 1999; Scherer, 2001; Nussbaum, 2001). Educating individuals in evaluating their own perceptions of an event and how their interpretations are reflected from past learning experiences can lead them to become empowered to take control over their emotional responses such as anger.

2.4 DSM-IV Diagnosis of Anger

The lack of diagnostic criteria in the DSM-IV does not imply that there are not a substantial number of persons suffering from clinically problematic anger (Lyddon & Jones, 2001). The DSM-IV does not include diagnoses for disorders in which pathological anger is a necessary or sufficient component (American Psychiatric Association, 1994). Anger is seen as a possible characteristic of other diagnoses and not as a problem that stands on its own. For example, Berkowitz (1993) explains that Freud's psychoanalytic view depicts depression as coming from an angry feeling directed inward by the individual. In this theory, a person suffers from depression because she or he is angry. Simultaneously, Berkowitz believes that depressed feelings bring on aggressive behaviours. In this way, the person is angry because she or he has depression.

The absence of any formal diagnosis for 'anger' disorders can be considered as a potential reason why anger problems receive limited study when researched on their own. Because symptoms of anger fall under different diagnoses they are not dealt with directly as the primary problem. Anger is seen as an element in many Axis-I disorders

such as Depression and Post Traumatic Stress Disorder, and Axis-II disorders such as Paranoid, Antisocial, Borderline, and Narcissistic Personality Disorders (Kassinove & Tafrate, 2000). Eckhart and Deffenbacher (1995) proposed three anger disorders that they felt should be in the DSM-IV namely: Adjustment Disorder with Angry Mood, Situational Anger Disorder, and General Anger Disorder. Each of the three proposed disorders includes physiological and cognitive indices for positive diagnosis.

Researchers continue to carry out studies in aim of constructing a specific set of criteria for diagnosing anger (Holloway, 2003).

2.5 Comorbidity with Anger

Consideration has to be given to the dilemma of dual diagnosis when dealing with the topic of anger. Anger is an emotion that can be intensified by situational and environmental experiences. The interconnection between anger and anxiety, anger and depression, or both can be noteworthy. Due to the fact that anger is, in part, a reaction to an underlying cause, the presence of anxiety and/or depression can heighten an individual's sensitivity to react to particular events. For this reason, a person who has depression may believe that an experience is problematic where someone without depression may not notice a problem. Individuals can have different reactions to one event depending on how they perceived the situation.

In addition, symptoms of anxiety and depression can interfere with the success of learning new skills in handling anger. Anxiety can arise when individuals believe that their anger is too overwhelming for them to control (Thomas, 2001). Their feelings of distress may hinder their ability to learn new concepts and techniques.

Substance abuse and personality disorders can have an impact on managing anger. Trying to maintain control over one's emotions in the presence of other factors, such as psychological or physiological ailments, can prove to be overwhelming at times. For example, levels of frustration can be heightened or even exaggerated when substances such as alcohol are involved. In addition, under the influence of alcohol, a person may be more inclined to act aggressively than when sober. Furthermore, anger can be concurrent with other unsettling experiences, such as marriage difficulties, coping with personal identity, or even trying to overcome another long, learned, negative behaviour. This anger can induce trust issues, relationship problems, loss of status or functioning, a shift in moral values, or denial (Thomas, 2001).

2.6 Anger Management Therapy

This research studies the impact of a group anger management therapy program using psychoeducational interventions. Although anger has received less attention in treatment literature than depression and anxiety, there has been considerable study of managing anger using a number of different therapeutic interventions.

2.6.1 Cognitive-Behavioural Therapy and Anger Management

Cognitive-Behavioural Therapy (CBT) has been widely used as an effective technique for anger management and falls under the social theory model. CBT relies on empowering individuals to initiate and then evaluate their own feelings and behaviours. This is done by using techniques to stop irrational thinking, by learning assertive behaviours, and by increasing self-confidence (Tucker-Ladd, 1997). The therapist helps

to engage clients to deal with their problems and to learn new procedures for overcoming conflict and enhancing relationships in their daily lives (Corey, 2001).

Donald Meichenbaum is one of the founders of cognitive-behavioural therapy. He specializes in “Cognitive-Behavioural Modification” (CBM) and “Stress-Inoculation Therapy” (SIT) (Bandura, 1977). According to Meichenbaum, stress arises when individuals are overwhelmed by demands on their routine, but do not have the resources available to cope with these demands (Olatunji & Lohr, 2004). CBM is used to help individuals increase their skills in the areas of communication and coping with stress so that they can respond to stress-invoking situations in an effective and more positive manner. With increased skills, individuals can learn that when dealing with a problem, they have more options to select from than they had previously considered (Corey, 2001). CBM focuses on helping individuals to identify their dysfunctional self-statements and then to change them into positive statements. (See Appendix E). In modifying their behaviours, individuals learn to take notice of how they are thinking, feeling, and behaving in particular situations and gain understanding of the impact these behaviours have on themselves and others around them. From this step, they can begin learning new, adaptive ways of behaving that can improve the outcome of the experience (Corey, 2001).

Donald Meichenbaum was also influential in helping individuals cope with angry emotions by using his Stress-Inoculation Therapy (SIT). SIT was originally developed for use with anxiety disorders. As coping skills are taught, a person is exposed to increasing levels of stress-inducing situations (Meichenbaum & Deffenbacher, 1988). As a type of cognitive-behavioural therapy, SIT aims to change individuals thinking patterns

about themselves and the experiences in their lives. SIT uses cognitive-behavioural modification to educate and teach skills to help individuals relax their bodies physically and, subsequently, slow down any racing thoughts. Examples of exercises that can be used in therapy are progressive muscle relaxation, breathing control exercises, role-playing, assertiveness training, listening skills, and positive thinking and self-talk exercises.

The first stage of SIT involves helping individuals interpret information as it comes in and to monitor their own behaviours in response. The second stage teaches new coping skills for managing stressful situations. Individuals are taught different techniques of managing stress, such as breathing exercises and muscle relaxation techniques to help increase control over emotions. Information is given on handling different aspects of a social interaction and problem solving skills. Finally, the third stage takes the new information learned in the previous two stages and applies the skills into daily like experiences (Tucker-Ladd, 1997).

Novaco (1975) first studied anger and the effects of anger management therapy on individuals coping with and relieving their anger symptoms. According to Novaco (1977), anger is a learned emotional response to adverse situations. This belief led him to develop his “Anger Management Therapy” (AMT) based on Meichenbaum’s Stress Inoculation Training (SIT). Novaco’s AMT also included three treatment phases: education, acquisition, and application. The “education” phase provides clients with information about anger and aspects of their anger dysfunction. The “acquisition” phase teaches the clients improved methods of coping with their anger and the “application”

phase gives the clients an opportunity to incorporate these newly learned techniques in a number of anger-invoking situations (Olatunji & Lohr, 2004).

Novaco has continued to study the effects of anger on a number of subject areas, and others have joined him in pursuit of the most effective psychosocial therapy intervention in managing anger. Techniques used in AMT include relaxation training, progressive muscle relaxation, systematic desensitization, meditation, cognitive restructuring, social skills training, and education (Olatunji & Lohr, 2004).

2.7 Psychoeducational Therapy

Psychoeducational therapy involves empowering clients with knowledge about their behaviours with the objective of changing how they behave. A fundamental assumption of psychoeducation is that our concepts, interpretations, and views underline our behaviours. Using an educational definition, what we do is defined by what we know. Psychoeducational therapy involves direct instruction on the social constructs (values, rights, and expectations) and foundations of the problem at hand (i.e. anger). The basic assumption of psychoeducational therapy involves an understanding of the behaviour and then learning new ways in problem solving (Levant, 1986). Joseph Pratt, M.D, is credited as being the founder of group psychotherapy. His technique was primarily educational in nature, using knowledge-based development and skill-building procedures to educate his patients on their illnesses (Siegmann & Bower, n.d.). Knowing about the nature and foundation of behaviours can help one effectively communicate, listen, make decisions, and solve problems (Anderson, Boris, & Kleckham, 2000).

Individuals learning to take control over their behaviours are instructed on how to manage irrational thoughts and learn prosocial responses to how they feel. Prosocial responses are communications that are deemed as more acceptable ways of expressing how a person feels in place of, for example, an angry outburst. Overall, the psychoeducational approach involves educating people in a number of psychological strategies, including cognitive behavioural skills training, relaxation techniques, and stress management. Psychoeducational therapy is advantageous for instructing about anger and anger treatments offered, improving self-care behaviours, and increasing communication skills (Coon, Thompson, Steffen, Sorocco, & Gallagher-Thompson, 2003).

Lyddon and Jones (2001) say that most behavioural coping and social skills approaches are highly structured with an ordered skill-training format directed by the therapist. First, the problematic behaviours are identified and new, more adaptive behaviours are learned. Then, these effective, new behaviours are modeled and rehearsed in a controlled setting with the therapist or other members, if in a group setting, offer feedback and discussion. Once learned, the new skills are practiced using specific situations relevant to each individual. As these therapeutic skills become more familiar they can be applied in the real world. Given that most anger occurs in an interpersonal situation, knowledge in communication, negotiation, and feedback skills are very likely to be relevant to each member in the anger management group.

Psychoeducational therapy shares the cognitive-behavioural view that problematic emotions, such as anger, result from illogical thinking and unrealistic appraisal of events, otherwise known as cognitive distortions (Beck, 1971). The concept

of a cognitive distortion highlights the importance of perceptions, assumptions and judgments in coping with different situations. Some examples include jumping to conclusions, over generalizing, all-or-nothing thinking, emotional reasoning, and 'should' statements (Burns, 1989).

Psychoeducational therapy also teaches the use of visualization, a technique that involves imagining mental images generated by the client or by the therapist to achieve a goal of physiological and psychological relaxation (Schiraldi & Kerr, 2002).

Visualization allows the therapist to implement a specific outcome; for example, reminding the clients that achieving relaxed state allows increased cognition and control over their emotions.

Astin, Shapiro, Eisenberg, and Forsys (2003) explain that relaxation techniques are used in conjunction with a number of therapies. They point out that imagery is often included in meditation and relaxation and all of these techniques are related to psychoeducational and cognitive-behavioural therapy. The strategies used educate individuals in handling their thoughts and feelings in an effective manner. In turn, it is intended that stress levels will decrease and relationships with others will improve.

2.8 Group Therapy

Group therapy typically involves a meeting of two or more people for a common therapeutic purpose to achieve a common goal (Tucker-Ladd, 1997). The individuals participating in a group tend to be experiencing a similar problem and it is intended that concepts, self-knowledge, and skills acquired will be implemented outside of the sessions. Yalom (1995) identifies the nature and procedures of group therapy, some of

which include the instilling of hope in the individual, illustrating to the person the universality of her or his problem, the imparting of information and how to use the new information more successfully, fostering altruism, encouraging the development of new social techniques, and improving interpersonal learning. He also identifies the benefits of group cohesiveness itself. Interpersonal interaction is crucial in group therapy, especially to enhance group cohesiveness.

The aims of group therapy typically are to help overcome emotional difficulties and to encourage the personal development of the participants in the group. Support is a key feature and members are commonly relieved to know that they are not alone with their problem and that there are others who are experiencing a similar difficulty (Yalom, 1995). Participants typically react to other individuals in a group by giving support, feedback, or criticism. While each member in a group is experiencing her or his own stresses, there is power and comfort in knowing that there is support from peers. Because group members can be disposed to blaming others for their own problems, group therapy can motivate the participants to accept responsibility for helping themselves (Anderson et. al, 2000). Typically, the use of positive feedback by group members and the therapist can give the other members the sense of being supported and accepted by the entire group. Knowing that the therapist and other members are not critical of what a group member may share can enhance the cooperation of all members involved and, in turn, increase the level of trust and confidence within the group. The use of group therapy can motivate the members in a number of ways such as influencing other members to speak out or to think about a situation in a different perspective. The

group experience can help members become more willing to listen to one another and disclose information about their personal experiences.

Group therapy promotes the use of a 'here and now' focus. While the group experience imitates reality, in this microcosm, members are protected from the outside world and, hence, can acquire skills and can practice in a controlled environment. This "laboratory effect" allows a participant to practice new methods of behaviour that may be more constructive and effective. Group members are able to practice new techniques with other individuals in the group rather than through using an imaginary role-play (Thomas, 2001), as is often the case. In this non-threatening environment, each person can try different techniques to see what works best. This controlled environment can maximize the strength of the intervention (Burlingame, Furhiman, and Johnson, 2002).

2.8.1 Benefits of Group Therapy

In general, there are a number of benefits from attending psychoeducational group therapy. The first stems from the education and skills offered to the group members to help improve their levels of functioning. A second reason is that the use of group therapy, especially group psychoeducational therapy, aids in diminishing any stigma felt from receiving mental health services. The individuals involved can describe themselves as going to a group class rather than a therapy session. Third, group therapy allows the group members the opportunity to develop positive relationship skills. Finally, group therapy increases the accessibility to potential clients due to decreased wait times compared with individual therapy. Not only do the clients gain from shorter waiting lists, but also the referral sources and the therapists leading the groups can save

time and energy by treating more than one individual at a time (Yalom, 1995). This is significant where resources are few and there are limited clinicians available.

Individuals deemed appropriate for group therapy are those considered to be at a stage in their therapy where they can benefit from being around others with similar issues. Group work is beneficial when an individual desires a more in-depth focus on the experiences created by the problem. When a participant wishes to overcome feelings associated with social isolation, shame, and/or self-depreciation that may occur alongside the problem, group work may be the best solution to mend these disrupted interpersonal relationships (Klein & Schermer, 2000). The group members can help each other lessen guilt and correct each other's distortions.

2.8.2 Determining Group Parameters

There are a number of factors that can influence the make-up of a group. Group therapists must determine restrictions and limitations before screening the potential group members. The first is determining the time frame allotted for the group. A time-limited group is focused with more structure and support compared to open-ended groups. Participants that are in earlier stages of their treatment tend to gain from belonging to groups with structured sessions and defined topics to discuss (Janis, 1983). In this way, the group members do not feel pressured to discuss their own circumstances so early in their treatment, but still learn about their own behaviours and how to manage them. People whom are in the early stages of their treatment tend to benefit more from associating with those at a similar level. This helps to facilitate bonding and the cohesion of the group members (Klein & Schermer, 2000). A restricted enrollment tends

to cause less disruption, which is helpful for short-term therapy. Furthermore, since all members get to know each other well within the group, the level of trust and safety is likely more secure than with an open enrollment.

An open-ended group, that contains an unlimited number of sessions, is designed primarily for members in later stages of their treatment who have a high level of functioning (Klein & Schermer, 2000). With so many sessions, a longer-term group usually has an open attendance policy, allowing participants to join at any time and at different levels of their treatment.

It is crucial that group cohesion be utilized with group therapy. Individuals tend to feel closer to others who have similar values, backgrounds, and attitudes as their own (Klein & Schermer, 2000). It is necessary when planning group parameters that these factors are taken into consideration. Once the type of group has been defined and the procedure for intervention is determined, the therapists can begin the screening process for selecting the appropriate group members.

2.8.3 Short-Term Therapy

Short-term therapy can be as successful as long-term therapy as it is more goal-orientated, more structured, and more directive (Barry, 1999). Having time-limited therapy is also a potentially cost effective alternative to individual therapy, medical care, and perhaps our judicial system. In addition, short-term therapy can positively affect the society as a whole. Abbass (2002) found that intensive short-term psychotherapy on 89 patients seen in Vancouver, Canada, increased the number of returns to work, reduced healthcare utilization, and medication stopping. A year's worth of therapy

(approximately fourteen hours of therapy per person) accounted for a \$400,000 dollar cost reduction to the society.

There are a number of issues that need to be addressed for short-term therapy to be effective in increasing therapeutic benefits (Corey, 2001). Short-term therapy groups usually consist of eight to fifteen sessions. This time limit makes psychoeducational group therapy very attractive in a managed care environment since the therapist is highly active in the process (Barry, 1999).

In addition, although the composition of the members within a group may vary, Flower and Booraem (1991) found that greater changes were observed in individuals attending a structured group process rather than an unstructured group. This success was enhanced when the group use short-term therapy rather than meeting over a long period of time.

2.9 Psychoeducational Group Therapy for Anger Management

The use of psychoeducational therapy offers the group members an opportunity to learn how their anger affects them physically, mentally, and socially. From there, they can be taught new techniques of controlling their anger and thinking about their feelings before acting on them. Treating anger using psychoeducational therapy has been little studied. Pekkala and Merinder(2001) say that the psychoeducational therapeutic approach involves coaching a person with a disorder in subject areas that serve the goals of treatment and rehabilitation.

Psychoeducational group therapy usually focuses on common areas of concern such as anger, difficult relationships, stress management, and others. Parts of Alcoholics

Anonymous, Narcotic Anonymous, Al-Anon, and other therapeutic communities are based on the theory that people can control a problem better if they can understand it (Pekkala & Merinder, 2001). Once a problem is recognized, new problem solving techniques are taught as to exert control over a situation. Psychoeducational group therapy is beneficial in teaching one how to accept and manage one's anger. It instructs how to change unproductive behaviours and offers supports during this change from the group therapists and other group members experiencing similar problems. Another value of psychoeducational group therapy lies in its non-confrontational approach. Members of the group can discuss their issues and concerns in a non -personal way while focusing on the educational materials (Anderson et. al, 2000).

Pilet (2000) evaluated whether a systematic implementation of a psychoeducational anger management intervention would have a positive impact on anger levels. Pilet assessed a court ordered, domestically violent, male population using the State Trait Anger Expression Inventory (STAXI) instrument. This assessment tool is made up of 44 questions distributed under five subscales. Its purpose is to measure both the experience of anger and its expression (Spielberger, 1988). One hundred and eighty two men volunteered to take the STAXI and complete a demographic questionnaire before and after completing the psychoeducational anger management sessions. The results indicated that the experimental group exhibited significant changes on all five STAXI subscales. None of these changes were significantly linked to the men's level of education, age, or ethnicity and the combination of participants of differing education levels, age, and/or ethnicity did not influence STAXI anger levels. Based on the STAXI results, Pilet concluded that a psychoeducational anger management program could

significantly reduce anger by using a mix of cognitive and cognitive-behavioural techniques.

Psychoeducational therapy has received support from Rimm, Hill, Brown, and Stewart (1974) in their work on anger management with male community volunteers. They found that assertiveness training might provide an effective means for dealing with anger that typically leads to antisocial aggression. Deffenbacher, Thwaites, Wallace, and Oetting (1994) based their intervention on Beck's Cognitive Therapy approach by encouraging their clients to identify and explore effective behaviours for coping with anger. New strategies were developed and rehearsed until ready to be tested in a real life setting. According to Deffenbacher et al, (1994) this method is just as effective as cognitive or combined cognitive and relaxation treatments.

McDougal, Barnett, Ashurst, and Willis (1987) reported on the effects of a six-week anger management program at a youth custody center. The researchers found a reduction in disciplinary reports detailing incidents at the center. This suggests an improvement in anger control. The only noted complaint by the youth at the center was that the program was too short. In a study completed by Taylor, Novaco, Gillmer, and Thorne (2002), cognitive-behavioural treatment of anger with a group of offenders having a learning disability had a significant effect on decreasing the participants' self reported anger levels. Burns, Bird, Leach, and Huggins (2003) stated that although much research in the past has shown improved anger levels after intervention, the foci of these studies were on the self-report measures used rather than the actual program used. Several programs were lacking a theoretical basis and did not examine the effects of the intervention used on the cultural society where the system was being operated.

As with any therapy, the psychoeducational group cannot work if the group members are not motivated to change (Yalom, 1995). Another factor that may interfere with the success of increasing anger management is a concentration on the topic of anger without looking into possible related mental illnesses.

2.10 Screening Process

Before any group therapy can be implemented, the group therapists must take time to determine the criteria that will help define who can attend the group sessions as discussed above, (see “Defining Group Parameters”). Once the parameters are defined, the group therapists need to decide how to screen for the potential group participants. Screening for potential members is done after the structure, presentation layout, and intervention strategy has been determined. The purpose of the screening interview allows group therapists to gather information and data from the potential group member. The collected information aids in determining potential problems and diagnosing challenges that may affect the appropriateness of candidates, as well as determining whether the individual will add to the success of the group.

The screening process allows the group therapists to ensure a stronger commitment from the group members since they had to meet certain requirements to get into the group. As well, the therapists can explain the treatment goals of the group and review the policies (such as those relating to absenteeism and drug use) to which the members will be expected to adhere. Using the information gathered from the potential group candidates can help the therapists decide if potential clients are likely to benefit from the planned intervention. Furthermore, potential group members have the

opportunity to gather information on what is expected of them and the chance to prepare for what to expect from the group sessions, if selected to attend (Klein & Schermer, 2000).

Diverse information can be collected during the screening process to help get an overall impression of the individual. Some data typically gathered includes the nature of the individuals' problems and how they are functioning with their day-to-day activities. In-depth probing can be used to determine the coping style of the individuals and possible problems associated with these styles of behaviour. Educational and vocational background information is gathered from each person, as well as any legal and medical history. When discussing the medical history and issues each potential member has, focus is placed on any substance abuse and current or past physical and mental illnesses. This information is important in examining the individual's concurrent issues that may have an impact on the person's progress or the progress of the group as a whole.

Potential group members can also be asked about their past relationships and the quality of the relationship each may be involved in at the time of the screening interviews. These relationships, past and present, can be with family members, spouses, partners, friends, and any children. Once this information is collected, the individuals can be asked to discuss the goals they wish to achieve by attending the group sessions.

As information is gathered from the screened candidates, the therapists can review the data to determine the appropriateness of the applicants. During and after the screening interview, the therapists may examine whether they feel the prospective individuals are ready to attend group therapy and if their goals for treatment are feasible and realistic. The screened individuals' capacities for empathy and patience can also be

evaluated along side their ability to reflect on lessons learned and subject matter. The therapists can get a strong idea of how the clients view their healing process. Most importantly, the therapists have the responsibility to try and decipher the individuals' motivation for change, their impulse control, and their ability to be aware of their behaviours (Klein & Schermer, 2000).

Before accepting the potential member to join the group, the therapists need to explore three factors relating to the clients' ability: Ego strength, level of affect, and tolerance to anxiety (Klein & Schermer, 2000). The individuals must be able to have confidence in overcoming their anger. If the therapists do not feel that a person is at a stage of moving ahead to overcome problem behaviours, then the person is most likely not ready to attend the group sessions. Having the capacity to handle affect means that the members should be able to reasonable handle any distress felt from the changing behaviours brought on by the new knowledge gained through the sessions. Finally, since the group sessions are intended to benefit its members, any debilitating anxiety may decrease an individual's ability to improve in coping skills instead of improving on these skills (Klein & Schermer, 2000).

When therapists seek extensive information from each person being screened, the process may take more than one interview session. The benefit of having more than one screening session is that individuals who are not committed to attending all sessions may not take the time or effort to return for further interviewing. This can protect the entire group process from premature dropouts (Klein & Schermer, 2000).

Therapists should provide prospective members information on the content of the group sessions and the therapeutic interventions that will be used. They also should

explain the policies that must be enforced when attending these sessions. The main policies revolve around the rules of confidentiality including not sharing information from within the group with persons outside of the group. This includes not discussing events from the sessions with other group members outside of the group sessions. The therapists should also take time to enforce any rules and regulations on attendance and possible fees for attending or even missing sessions (Klein & Schermer, 2000).

2.11 The Therapists' Role

One benefit of group therapy is that the group may have more than one therapist, leader, or therapist. When there is shared leadership, the therapists can help each other in explaining techniques and managing role-playing scenarios. There is a greater opportunity in making sure all members understand what is being discussed and that no one feels left out of the conversation. While one therapist is talking, the other can observe the group members.

Therapists can share in creating a supportive environment, allowing the group members to feel comfortable and in helping them share their feelings and ideas on specific topics. Using the modeling techniques described by Meichenbaum (1996) and Novaco (1975), therapists can encourage group members to take an active part of the sessions. They can offer feedback to the group members that aims to be constructive and leads the group members' focus to areas where change is desirable. In this way, the personal strength and confidence in the members can be increased as more information is learned (Siegmann & Bower, n.d.).

In order for group therapy to attain the maximum benefits and success, the group members must feel safe to express their feelings and personal experiences (Anderson et al., 2000). For this reason, the therapists require completion of specific tasks when committing to group therapy. The therapist is responsible for constructing and reinforcing rules and norms for the group members. In addition, observation of transference should be noted and addressed.

According to Janis (1983), group therapists aim to achieve three specific objectives for their group. The first is to help the group members learn to make their own suitable decisions when dealing with their anger. The second is to instruct the group with methods to help prevent any possible conflicts that can occur once the group sessions come to an end. The third objective is to increase the awareness of anger in each individual member. Through meeting these objectives, the group members will be better able to alter their behaviours before displaying any unwanted emotions.

In a psychoeducational role, the therapists instruct the group members about the topic at hand and about skills to increase their level of coping. Although psychoeducational therapy focuses on the course materials, the therapists may share examples of behaviours from their own experiences.

When in traditional process therapy, the role of the therapists involves helping the group participants facilitate change in developing their strengths with listening, support, and feedback skills. The therapists redirect the clients from an instructional atmosphere to one where they can learn to emphasize on positive aspects in their lives and their personal strengths (Siegmann & Bower, n.d.).

Chapter Three – Methodology

Dr. Hassan Khalili was awarded funding in 2005 by the same mental health facility used as location for this therapeutic intervention. Dr. Khalili created a proposal for leading a group therapeutic intervention for outpatient clients requiring anger management services. Since this was the first opportunity to offer anger management in a group setting, after researching the literature, Dr. Khalili conceptualized and outlined the intervention using a psychoeducational therapeutic approach. The design and implementation phase of the study took approximately three months and were carried out by Dr. Khalili and the researcher. An initial version of this program was offered about four months prior to the offering focuses upon in this study. The specific psychoeducational program used in this study is a revised version of the above intervention. This revision reflects the initial offering in the organization of each session and the activities developed by the researcher. Chapter Four describes the complete program in detail.

The researcher facilitated Dr. Khalili in leading the initial offering and in the sessions focused upon in this research. It was decided to assess the effectiveness of the intervention strategy by collecting various types of data on an ongoing basis. This was achieved through recording detailed session notes, collecting anecdotal observations and thematic data noted by the group leaders on the events of each session, collecting qualitative data from meetings with the participants, and through the use of a specially designed questionnaire described below. The researcher, using information on the initial

anger management group, input from other anger inventories, and an extensive review of the literature, developed this questionnaire specifically for these participants.

To determine if this intervention was successful in helping the participants improve their anger management skills, a methodology was designed which entailed gathering various types of data. A single case cohort methodology was used to collect data on the individual group members. The design took into consideration the screening and interviewing process to be used and the nature of selecting the sample of participants. It also addressed the questionnaire, the collection of concurrent data from and about sessions, and tools to be used for the analysis of the collected data. The rationale for usage of the various data gathering strategies utilized in this study are discussed below.

3.1 Single Case Cohort Studies

This study can be characterized as a single case cohort study. There was one group studied: the members of the anger management psychoeducational therapy group. There was no control group used to receive an alternative treatment. A single case cohort study is recommended as an appropriate design where the purpose of the study is to examine the effect of a particular treatment on a specific group. This design allows a researcher to follow a group of participants over time to determine the general outcome of the study (Burns, Bird, Leach, & Huggins, 2003). Although a control group can enable a researcher to eliminate a number of internal factors threatening to the validity of a study, it can also create new problems such as selection biases and social threats (Martin, 1997). Placing an individual with problematic anger in a control group that

receives no treatment can be socially threatening as well as an ethical concern for the researcher. Problems can arise if an angry individual in the researcher's control group lashes out and causes disruption and /or disturbance to the society or her or himself. The threat of this possibly occurring was deemed to be much to risk solely for the purpose of this study. In addition, maintaining a control group can become expensive and perhaps be inefficient for the researcher. For ethical, as well as practical reasons, this methodology was deemed appropriate.

Single case cohort studies allow a direct opportunity for one to gain an indication of the possible effects an intervention has on a participant. Individual differences can be highlighted when the group is smaller and has a clear and well-defined focus, as was the case in this anger management study. Studies using a large number of participants potentially can mask individual differences. As used here, the research is characterized as an example of 'practice-based evidence' where the focus is on collecting data from a bottom-up procedure (Burns et. al, 2003).

Caution needs to be exercised in making any interpretation of the broader nature of any such impact. Anger is a subjective emotion whose interpretation may vary from person to person. One person's definition and experience of being angry may not be as intense as another. Being aware of these differences supports the position that self-reporting instrumentation for evaluating levels of anger for every individual is justified (Novaco, 1995). Therefore, having a control group for this study in particular would not necessarily be required or beneficial.

3.2 The Screening Interviewing Process

The interviews took place at the same mental health facility where the sessions were going to be held. The psychologist created the interview procedure used based on previous interview methods used for other groups he has led in the past (See Appendix C). Information required of the potential members included personal family history, such as where they grew up, what type of family environment they grew up in, and information of the behaviours and habits of other family members. These behaviours and habits included how family members handled their own anger, any addictions or illnesses each was dealing with, and the relationships between the family members and the potential group member. Educational and work experience, legal and medical history, and their willingness to attend each group session and comply with standard group confidentiality rules were also discussed. The referred clients were asked about their understanding of the group process and what they thought about their own anger and how it has impacted their lives. Note was taken of destructive methods of reducing anger (for example, alcohol and other substance abuse, gambling, and eating) and the individuals were also asked about co- morbidity issues that might have contributed to their anger, for example, alcoholism or depression. Each interview took from one hour to one hour an 30 minutes to complete.

Individuals were selected primarily on the information they offered about their own anger and on their motivation to overcome their anger issues. The therapists paid considerable attention to group dynamics as interpersonal relationships between group members can enhance or diminish the effectiveness of group therapy (Yalom, 1995). Therefore, the group members were screened for compatibility in a group session and

willingness to communicate and express themselves. For example, an individual with a thought disorder was not considered appropriate for this group since such a comorbid disorder could cause disturbance to the group process.

3.3 Description of the Sample Group

This study analyzed data collected from a therapeutic group run at a mental health facility. Prior to the running of this group, participants were informed that, because the group was of a pilot nature, with their permission, information collected from them would be analyzed and subsequently used for research purposes. Confidentiality was ensured and each person was informed that the use of their data would not take place without their written permission.

To identify individuals suitable to participate in this anger management intervention and to determine group compatibility, the group therapists devised a screening interview process. (See Appendix C). To be included in the sample, all participants were referred from an external source, such as their family doctor, psychiatrist, registered nurse, or a social worker. Also, no individual could attend these sessions while admitted to a hospital or serving times at a penitentiary. When the researcher received the referral, each potential client was called to schedule an individual appointment with the principal therapist and the researcher.

Initially nine participants, from a list of fourteen applicants who were interviewed, were invited to join the anger management sessions. The age of the members ranged from 27 years old to 45 years old. Two females and seven males participated in the group. One male, who did not feel he needed anger management at

the time of the sessions, decided not to return after the first session and a second male, who was absent for three sessions in a row, was asked to defer his attendance and await the next anger management sessions, if available. The final data in this research is obtained from the seven participants whom completed the program.

3.4 The Therapeutic Model

The intervention used followed a psychoeducational approach. Emphasis was placed on education and skill development while members shared personal information that was beneficial to the group's overall learning. Psychoeducational therapy is distinctive in that it utilizes the therapist in a teaching role instead of the clients governing the conversation (Anderson et al., 2000). The group therapists educated clients to increase their knowledge of and independence from their anger. The first part of the sessions were dedicated to educating the group members about anger and its components while the remaining parts were devoted to process therapy, which encouraged an in-depth discussion on how the materials pertained to each participant. Although each session had a predetermined layout, there was flexibility in that there was an opportunity for individual discussion and skill-building activities dedicated to each individual's personal troubles (Siegmann & Bower, n.d.).

The psychoeducational group anger management sessions began by describing physical implications of being angry such as tensed muscles, increased heart rate, and blood pressure. Once the physical symptoms were explained, the therapist moved on to relaxation techniques, cognitive thinking distortions, and improved coping mechanisms for increasing anger management. As the group members became more comfortable

with each other, they were asked to share situations in their own lives that related to the information they were learning. The group members listened to each other's stories of angry moments and how they were managed, and then offered feedback and support to one another. Chapter 4 provides detail to the subject matter presented by the therapist and researcher during each session.

For members who were unable to attend a session, an opportunity was provided to attend a private meeting in order to catch up on information given out during the previous session. The group researcher offered these sessions. Prearranged meetings were held an hour before the group session was to begin so that the researcher could talk with the member about what information she or he missed or offer individual counselling pertaining to each person's conflict with anger issues. The chief focus of these individual sessions was to inform the individual of information she or he would need in order to be prepared for the next session.

3.5 The Questionnaires

Novaco (1995) states that anger is a subjective experience that is best measured by self-reporting. It is felt that other measures of assessing change typically would under-report this type of data. For this reason, and to gain information on the effectiveness of this intervention, a self-reported questionnaire was used. This instrument was created by the researcher and given to each group participant (Refer to Appendix A). The group members were asked to complete the questionnaire during the first session, before the intervention began, and then again during the last session, after 8 weeks of anger management sessions were completed. After completion of the group,

participants were told of the research value of this pilot project and were asked to sign a consent form if they were willing to have the information they offered be used in a research study (see Appendix B).

The questionnaire used was specifically created to gather information on individuals in the group and their reports on personal anger traits. It was based on anger trait measures identified in the literature and on a number of instruments assessing anger. The researcher used the Beck Depression Inventory (Beck, Ward, Mendelson, Mock, & Erbaugh, 1961), the Beck Anxiety Inventory (Beck, Epstein, Brown, & Steer, 1988), as well as items from Novaco's Anger Inventory (1975) and Spielberger's State-Trait Anger Expression Inventory (1988) as a basis for the instrument. Many of the items used in this questionnaire were also derived from comments made by members of the previous anger management group psychoeducational therapy that took place prior to these sessions.

Several experts were asked to review early drafts of the questionnaire and to comment on any improvements that could enhance the clarity and content of the instrument. The resultant questionnaire collected information on each group member's current subjective levels of depression, anxiety, and anger. In total, there were 79 items in the instrument as well as an open-ended question that asked respondents to comment on anything else they wished to express to the researcher. The seventy-nine items were divided: twenty items pertained to anxiety, twelve items pertained to depression, and the remaining forty-seven items focused on anger. Items pertaining to depression and anxiety were used to help evaluate if anger has effect on these symptoms or, alternatively, if these symptoms aided in producing anger. The items used under the anger inventory section of the questionnaire fell into three categories:

injustice/unfairness, frustration/clumsiness, and physical offences. Numerous items were used in this questionnaire, a few from each of the three categories, so that a variety of angry situations could be sampled. For example, while one member of the psychoeducational therapy group might get angry while intoxicated, another member might feel angry when frustrated by a loved one. These examples both lead to angry responses, but fall under different categories of provocation.

Respondents were asked to rate each item on a scale of 1 to 5 (1 being not at all, 5 being always) the degree to which each statement relates to the respondent. The anger items in the questionnaire consisted of a brief description of a situation that might be expected to provoke anger. Robbins (2000) noted that when retesting with a similar type scale one month after initially testing the scale scores were consistent. It was thus felt that the scale would reasonable assess trait anger rather than temporary angry feelings.

3.6 The Intervention

The group anger management sessions were carried out over 8 weeks, with one session per week. The sessions were held at a mental health facility in a small conference room for two hours. The conference room contained tables that were positioned in a horseshoe pattern around the room. The chairs were on the outside edges of the tables so that participants could see each other and the therapists had room to walk around the center of the room to access each person.

The eight sessions were organized in a manner that facilitated participants' experience to gain group cohesiveness and improve their skills in managing anger. The first session stood apart from the proceeding six sessions in that group members spent

time introducing themselves to the others. The therapist and researcher introduced themselves, their educational backgrounds, and experience working with angry individuals. They then proceeded to explain the rules and regulations that consisted of confidentiality requirements and respect for each individual during and outside the sessions. Abstaining from substance use and alcohol abuse was asked of each participant throughout the two months, and, importantly, that no group member could participate in the session while intoxicated. During the first session, the researcher explained the importance of the questionnaire for increased analysis of the participants' improvement from the program and, also, that the investigation would help determine the benefits and usefulness of this intervention for future clients. The group members were instructed on how to complete the questionnaire and told that their participation was voluntary and would remain confidential. The remaining time in the session was dedicated to starting the psychoeducational instruction on anger.

The second to seventh sessions differed from the first session in that no questionnaire was administered and emphasis was placed on the psychoeducational intervention in managing the members' anger. The therapist was absent for the first 30 minutes of each meeting. In his absence, the researcher started each session by asking members how their week had been and if they were able to monitor any situations of anger. Before any discussion took place, the assistant restated the importance of confidentiality within the group, as the possibility is always there that members will meet up outside of the group sessions. Nothing heard within the group was to be taken outside of the sessions and respect for each other was mandatory. As specific techniques and coping mechanisms were introduced each week, the researcher would take note of

individuals' comments related to their learning or their application of each new techniques. When the therapist arrived, he began the therapeutic part of the session. The layout of each session is examined in detail in Chapter Four.

The eighth session, as with the previous six sessions, was started by the researcher who gave out the same questionnaire that was administered during the first session, and the group members were asked again to complete it with the same directions as in the first session. The researcher reminded the group member that completion of the questionnaire was still voluntary and that all information gathered would remain confidential without their permission for use. Once all questionnaires were collected, the last session commenced.

Each session, with exception of completing the questionnaires, was broken down into three sections; one part being educational and the other two parts were used to help process information learned. An in-depth explanation of topics covered in each session is given in Chapter 4.

3.7 Analysis of Data Collected

The dependent variable was the effect structured anger management group psychoeducational therapy had on the recipients' anger. This was measured using the questionnaires given to all members of the group, anecdotal comments noted from the group members, and clinical observations made by the group therapists. All questionnaires were analyzed to determine if there were significant differences between responses offered in the first and last sessions. If the results of the questionnaire given out during the last session illustrated increased awareness and management of anger traits

and tendencies compared to the results in the first questionnaire, this would be considered to affirm the effectiveness of the anger management group sessions. Descriptive statistics were calculated to test for significance between the two administrations of the questionnaire, one before the intervention and then again, after the intervention took place.

Two types of qualitative data were collected on the anger management sessions. Indirect data, such as attendance of participants and horizontal relationships between group members was gathered. Anecdotal data was also collected during each of the sessions. This data was in the form of notes the researcher recorded on the experiences that group members shared during the sessions. The researcher and the therapist recorded observations of how members of the group seemed to be improving their skills in anger management. This data was collected during the sessions and discussed after each session between the therapist and the researcher. Notes on this debriefing were collected. The debriefing activity is a normal process used after group sessions for the therapists to summarize the events during that session and to record any transference or counter transference felt, possible conflicting issues, and the progress of the group as a whole.

Chapter Four - Intervention Methodology

The model used for each session followed a psychoeducational therapeutic approach with a “traditional” psychotherapy component in each session. The concepts used were based on three distinct criteria: a psychoeducational therapeutic model devised by the therapist and researcher, the knowledge of anger outlined in the literature included in Chapter Two, and the clinical experiences of the therapist and researcher. These criteria make up the foundation of virtually every educational curriculum.

4.1 Rationale for the Therapeutic Technique

The primary therapist of this anger management group was a psychologist with clinical experience in a hospital setting and private practice for over twenty years. He has researched anger and its components over the last few years and has extensive experience giving anger management workshops to hospital staff members, conflict-resolution workshops in a number of work settings, and individual therapy focused on addressing anger issues. Using approaches developed in his layout from his anger management workshops, he developed the model used for these group sessions. The group intervention focused on in this study, which is deemed to be of a pilot nature, was based on these workshops and anger management sessions were offered only once before. The same therapist led the sessions from the previous group with facilitation from the researcher. The goal was for the therapist to test the success of his format. It was also intended that this study would foster further improvement and modification of

the intervention. The only data collected from the previous group of participants consisted of clinical observations made by the therapist and researcher on the effects of the curriculum as the sessions progressed. The organization, clarity, and content of the materials originally used were recorded to strengthen the curriculum given to this group being studied and, in turn, to increase the confidence in the layout and focus of information provided during these sessions.

4.2 Session Outline

Each session consisted of three parts intertwining the psychoeducational and psychotherapeutic portions into a two-hour session. The first part of each session began with a review of the regulations on confidentiality and respect for all members in the group. The participants were asked to share any events that occurred since the previous session concerning their anger and/or the use of techniques taught. The participants started processing by discussing events of the week, feelings about previously taught strategies, and the effectiveness of each strategy. The first two sessions included warm-up and rapport building activities presented by the researcher to gain comfort and a friendly atmosphere within the group. Later sessions used different types of activities for maintaining group cohesion. This psychotherapeutic portion of each session was used to get the group members to feel comfortable with each other again after having a week apart. Also, examining events that happened to the group members during the week, allowed each individual the opportunity to process these events and potentially to uncover any feelings, reactions, and underlying distortions that might have affected the person's behaviour.

The second portion of the session started when the therapist arrived. At this point, a psychoeducational concept of anger was taught to the group. These concepts were pre-selected when the layout of this therapeutic intervention was designed. Conceptual information about anger including background of anger, anger processes, rational for and against anger, types of aggression, physical and mental influences, and more was offered to the group members. Handouts and visual materials were used to enhance learning and understanding amongst the group members.

Time was then dedicated to demonstrating and rehearsing new strategies for handling anger. After each concept or topic related to anger was explained to the participants and new knowledge was acquired to understand their anger, strategies were taught to the members to help them develop new techniques to deal with and express their anger more effectively. Once learned, these techniques were practiced using a variety of methods. These included role-playing scenarios, games, visualization, and question and answer periods. Rehearsing during the sessions allowed the group members the opportunity of experiencing these alternative ways of expressing their anger in a controlled environment before using them in their daily lives.

The session ended with another psychotherapeutic component allowing the therapist and researcher to sum up what was taught during the session. Members had an opportunity to discuss the topics examined throughout the sessions and to discuss how the learned materials may be helpful to them in their personal lives. The group members took the time offered to talk about how their skills had developed since the group sessions began. In this way, group members were offered an opportunity to take what had been taught and apply it to circumstances in their lives that they were having

difficulties coping with at that moment. The group participants also found it helpful to get feedback and encouragement from the others who were experiencing similar frustrations and conflicts.

4.2.1 Rationale for the Procedure Used

The rationale for using this structure of each group session was threefold. Firstly, this psychoeducational-psychotherapeutic technique stemmed from the success of this particular methodology from the psychologist's years of research, his anger management workshops, and the first anger management psychoeducational group that took place a few months earlier. The evidence of success from the prior anger management group intervention helped guide the researcher when devising the questionnaire used on the participants in this study. The information gathered from the therapist and clinical notes taken from the first group sessions allowed the therapist and researcher to modify the layout of the overall program and the individual sessions to enhance the potential benefit of this group. Some questions in the questionnaire created by the researcher were formulated from using the above-mentioned information.

Secondly, as stated, each session was divided into three parts. These parts are titled as: *Psychotherapeutic 1*, *Psychoeducational*, and *Psychotherapeutic 2*. Each session started with a psychotherapy component, followed by the educational lessons, and ending with another psychotherapy section. Linking together the psychotherapeutic interventions with the psychoeducational lessons of the session was intended to allow the group members to learn new information and then examine how this information would be used to help mend problems in each individual's life. The psychotherapeutic sections

of the session were separated by the psychoeducational section as to enhance the flow of the session and allow the opportunity for the members to discuss their personal experiences both before and after learning new materials.

Thirdly, each section within the session contributed to the overall impact desired from each session. The warm up portion of the session allowed the group members to become aware of how their anger management was improving each week. Conceptually, they were also able to see how past sessions had helped them to use new techniques in dealing with a specific anger provoking situation. This first part of the session allowed members to re-acquaint themselves (after spending a week a part) and become comfortable again with sharing information with each other. The opportunity to chat with each other gave each participant time to relax in the environment and rehearse their vocalization skills, as well as share their experiences over the past week.

4.3. Session Layout

This section discusses the procedure of each session in depth. Each session will be discussed using the same layout as above, separating the session into its three components, labeled *Psychotherapeutic 1*, *Psychoeducational*, and *Psychotherapeutic 2*.

4.3.1 Session One

Psychotherapeutic 1: As each member of the group arrived, they chose their own seats in the conference room, distancing themselves from one another. The questionnaires were given out and the instructions and confidentiality were explained while letting each participant know that their participation was voluntary. Once all

questionnaires were completed, they were returned to the researcher and she began the session by having everyone introduce and say one thing about her or himself. The members were then asked to pair off and an activity was given out to help the members get to know each other. Each pair was to ask each other questions from the handout given and then when the group reconvened, they were to describe their partner to the rest of the group (See Appendix D). This activity was used to help the group participants actively get to know each other and become comfortable with one another.

Psychoeducational: When the lead therapist arrived, another handout was given to the group. They were asked to get into different groups of two or three and were asked to discuss and write down what they wanted to get from these sessions. The handout entitled, “My Goals for this Group” asked the group members to think of the objectives and goals they would like to achieve over the next eight sessions. Members were given time to discuss their goals, the therapists asked them to read out their responses while the researcher wrote them down on the chalkboard.

Once the objectives of these sessions were determined, the therapist began instruction by describing three types of anger that an individual can have: bad, good, and passive-aggressive. There is ‘bad’ anger that seems uncontrollable and negative, ‘good’ anger that is used for competitiveness and motivation, and ‘passive-aggressive’ anger. The therapist said that we all have used the three types of anger and in later sessions, we will discuss each in detail. From here, the therapist went on to explain that there are emotions that we sometimes hide by using anger instead. For example, sometimes anger is used to disguise any feelings of guilt or hurt that we might have. Showing anger might

make us appear like we were never hurt or felt bad by the event and, therefore, we come across as strong instead of weak.

Anger can also be expressed in two ways, either as “inbursts” or “outbursts”. “Inbursts” are seen when angry feelings are held in and not expressed outside of the individual’s mind. This anger can eventually come out in physical ailments such as high blood pressure, increased heart rate, and other cardiovascular problems.

“Outbursts” are expressed in any of the three methods mentioned before, either as ‘good’, ‘bad’, or ‘passive-aggressive’. This anger that is expressed can be magnified if there is old, unfinished anger that had not been dealt with in the past. In this way, the anger that is felt might not have been caused by the direct event that took place, but perhaps from feelings of anger from a similar event that happened in the past.

The therapist talked about how to monitor anger by looking for four particular triggers. These were auditory, visual, physical, and internal. The first trigger is auditory. Some use of language can automatically put us on edge just by hearing them. For example, the use of swear words on an individual tends to provoke anger more so than talking calmly about the situation. Other auditory triggers that can provoke anger are any words or noises that become associated to a negative feeling. For example, a loud car horn can trigger an angry feeling. The therapist gave an example of a couple that he saw in practice. The husband swore on a regular basis and the couple’s children decided not to let their parents see their grandchildren unless he could modify his language. Although the swear words were not intended as offensive, but rather an addition to speech, their children finally became angry enough to leave. The therapist asked the

group members how they would feel if someone told them to “shut up” or ‘go to hell”. These words are meant to be offensive, even if not intended in an offensive manner.

The second triggers to look for are visual triggers. Examples of this are if you see someone attempting to steal from your wallet or if you see your child’s messy room even though you told her or him to clean it days ago. These visual cues can provoke feelings of anger. The third trigger is of a physical nature. When a basic need is not being met, one can tend to get angry. For instance, imagine that you were very hungry after not eating all day and you decided to go to a fast food restaurant only to find that you were at the end of a long lineup. Because the feeling of hunger already was upsetting to you, the long line up could serve to further aggravate these feelings. The final trigger is an internal one. These internal triggers are experiences that we have been subjected to or simply believe inside our thoughts. The prime examples of these triggers relate to our level of self-esteem, our interpretation of past memories, and how we decipher events that happen around us.

After explaining in more detail items that can trigger anger in us, the therapist went on to illustrate the definition of anger and how it relates to how we act. According to the therapist, anger becomes a problem when whatever situation or feeling enters our head goes straight to anger. When this happens, the individual loses control over the situation. To lose control, the brain forfeits power over the individual and all intelligence is gone. Every time intelligent thought decreases, anger gains control and increases. The therapist described this in length and went further to explain the difference between intellectual intelligence and emotional intelligence. Emotional intelligence is what influences control over some situations rather than others. The therapist ended this

psychoeducational section by explaining that there is a difference between being angry and acting angry. We can act angry and still have control over the situation. In this way, we can manipulate change, but we are still able to think clearly and act rationally throughout the situation.

The therapist explained to the group members how to monitor their anger by taking notice of the triggers discussed earlier in the session. He asked the group members to monitor what triggers them to become angry and how long it takes to reach the level of anger. The members did not need to try to process what is happening to them when they get angry or think about how to control it, but to take note of what happened to get them to that point of anger. They were asked to monitor their anger for the rest of the week until the next session.

Psychotherapeutic 2: This final portion of the session was used to discuss what had been learned and how it could be applied to each individual. This time was also used to discuss more personally how each individual was affected by their anger and how it had influenced their personal lives and other people affected by her or him. The group members were offered the chance to open up and talk about their triggers. The therapist ended the session by leaving the group members with a question: “Although we keep justifying our anger, what do we really feel afterwards? Is the anger truly justified?”

4.3.2 Session Two

Psychotherapeutic 1: The session started by the researcher asking everyone to reintroduce themselves to the rest of the group. Then they were asked to close their eyes while she read a short passage. They were asked to visualize the situation taking place.

The passage was a funny relaxation exercise that was intended to make everyone laugh and get comfortable with each other again after being a part for a week. The second exercise used to re-acquaint the group was an activity entitled, "If You Could Meet One Person". The researcher asked the group members, "If they could meet one person, dead or alive, who would they want to meet the most?" After these exercises were completed, the researcher asked the group members to talk about how their week was since the last session and if they had encountered any angry scenarios. The members were asked to describe what happened to make them angry, how they handled the situation, and how they felt after things calmed down.

Psychoeducational: The therapist began this educational part of the session by reviewing what it means to monitor anger and the different triggers that can provoke anger. The therapist told the group, "If we learn to refine our thinking, half the battle is over." This helped the members see that not everything triggers her or him to be angry. From there, the therapist asked the group members to think of some feelings that are related to anger. For example, sometimes when a person feels hurt by someone, she or he may decide to show the feeling of being hurt as being angry instead. Other feelings related to anger are frustration, guilt, depression, anxiety, and fear. According to the therapist, the emotion of anger always comes in combination with another feeling. At the same time, anger tends to emerge when the reaction we experience differs from the one that is expected. The therapist gave an example of someone telling a person to, "Shut up!" If the words came from a 2-year-old infant, the person may not have felt hurt by it, since the child really did not understand what she or he was saying. If a 92-year-old man told you to, "Shut up!" you probably would not get upset for similar reasons. It is when

a person in a comparable age bracket says these words would you get offended and then angry. What we expect from the experience will help determine our reactions.

The next topic on anger dealt with the physical implications that precede angry reactions or are caused by them. There are many physical ailments that can be caused by problematic anger. These include high blood pressure, increased heart rate, other cardiovascular problems, stomach ulcers, decreased immune system, and headaches. The group was asked to add other physical symptoms that they feel when they are angry. The therapist then talked about physical conditions that can increase the likeliness of an angry reaction. Hunger, as mentioned earlier, can be one of these conditions. Another can be when an individual is tired. The therapist explained that he tends to get very tired between 4:00 p.m. and 6:00 p.m. During this time period, the therapist said that he is more likely to snap at his family since he already is feeling sluggish. Increased levels of stress can preoccupy a person and make a person feel more aggravated than normal. These feelings of frustration then can produce an angry reaction that probably would not have occurred otherwise.

The final topics the therapist discussed for this session were two temporary strategies used to help cope with anger. These were the use of escape and avoidance. Escaping anger means to temporarily walk away from the actual situation by taking a 'time-out' to allow an opportunity to cool down and relax. This can be done by taking a walk, going to the gym, watching television, or even talking to someone not involved in the anger-provoking situation. By doing something else instead of reacting immediately to the anger, the individual can have time to calm down and think logically before re-addressing the situation. The use of the avoidance method means that the individual

should try to stay away from situations that tend to provoke anger. For example, if an individual knows that she or he tends to get angry when having to wait in line at the supermarket, then this person should plan to go grocery shopping at a time when the store is least busy, either late at night or early in the morning. By doing so, the person then avoids having to wait in a long line to pay for the groceries and, therefore, might avoid getting angry.

A great deal of materials was presented during this session. The therapists' main concern was that the group members understood the need to be motivated to change their behaviours, otherwise, their problematic anger would continue to be an issue in their lives. The therapist gave each member a handout entitled, "Increasing Motivation" and gave a brief description of what the article entailed. The group members were asked to read this handout before next week's session and to continue to monitor their anger as they did over the past week.

Psychotherapeutic 2: The highlights of the session were summarized and members of the group were given the opportunity to ask questions. They were to use this time to confirm their understanding of the information taught during this session.

4.3.3 Session Three

Psychotherapeutic 1: Members were asked to discuss how their week was in relation to their anger. Group members were asked of their understanding of the handout given last session and if they have any questions relating to increasing their motivation. Members were also asked if they have any questions on anything in particular that they have learned so far from these sessions. The conversation was then to focus on any

angry situations group members had encountered over the past week and if they were able to incorporate any of the techniques they had learned over the last two sessions. Discussion ensued until the therapist arrived.

Psychoeducational: The therapist started this session by explaining the incorporation of both physical and mental processes that are involved when an individual gets angry. Physically, the body gets in 'fight or flight' mode. This is a biological term used to explain how from the beginning of time, humans have acquired the ability to prepare their bodies when they feel they are in danger. The human body changes in preparation to fight off the danger or to run from the danger, depending on the situation. In doing so, the body's sympathetic nervous system adapts by increasing blood flow to the heart, dilating pupils, and increasing adrenaline levels so that the individual can use all the strength she or he has. Even though humans now are not as likely to be involved in situations where they are in imminent danger of being killed, the body still reacts as if it is in danger when we feel threatened. Therefore, when a person is angry, the same bodily changes take place. At the same time, mental processes are occurring while these physical changes take place. The angrier an individual becomes, the less she or he is able to think rationally. Both the physical and mental processes that occur when one is angry can enhance or undermine the person's ability to react calmly.

After time, a person can get used to acting a certain way when upset and, therefore, instead of thinking about the appropriate reaction to the situation an individual will just use the same methods used in the past. The therapist explained this phenomena as a subconscious process that people get used to using. For example, when most people are writing, driving, or dancing, they are not thinking consciously about the precise

process of each event. One can drive from point A to point B and on reaching the final destination not be aware of how she or he arrived there. The person just drove there without thinking about it. Angry reactions become an automatic behaviour that ignores the intensity of the situation. The task for the group members was to get anger out of automation and the best method to do so is to learn and practice new techniques of dealing with an anger-provoking situation. The therapist told the group that learning to drive in England, where people drive on the left hand side of the road, is a good way of getting out of the automation of driving on the right hand side, as in the Western world.

This educational section began by handing an article entitled, “Tuning In To Your Body” (See Appendix E). The handout focused on teaching how to physically relax all muscles of the body. By intentionally relaxing muscles, one muscle group at a time, the physical symptoms that come with anger should also decrease. The main objective that the therapist had for this section was to teach the group members a few techniques that they can use immediately when they become angry.

The first exercise the therapist taught to the group was called the “5-5-5-5 method” (as explained by Dr. Khalili). The objective of this exercise is to control breathing and keep it steady even though you are angry. First, the group was asked to take a deep breath in slowly counting to five. Then they were asked to hold that breath for a count of five and then slowly release that breath for a count of five. This represents three of the fives in the title and the fourth five denotes the number of times the exercise should be carried out. The second exercise taught to the group members was another relaxation technique, but dealt directly with the “Tuning In To Your Body” handout (as above). In preparation for this session, the therapist had recorded a progressive muscle

relaxation procedure on cassette to play for the group. He based his technique on recordings he had created in the past for a number of patients suffering from different ailments. The participants were asked to get in a comfortable position, close their eyes, and just follow the instructions. The researcher turned on the cassette and the members tensed and relaxed different muscle groups for approximately 20 minutes. After the exercise was completed, the therapist told the group that these methods were not solely used to decrease levels of anger, but for many circumstances in life. Examples included stress management, sleep aids, anxiety, and for many other areas in life.

Psychotherapeutic 2: This session ended in the same fashion as the previous sessions by asking the members if there are any questions and the therapist paraphrased the contents of the session. It was intended that the group would use this time to comment on their feelings toward the group and if they felt progress in managing their anger.

4.3.4 Session Four

Psychotherapeutic 1: The session began by asking the members how they had been since the last session and if they had any episodes of anger they would like to share with the rest of the group. The members were asked if they had any questions about the “Tuning In To Your Body” handout from last session and if they had practiced using the progressive muscle technique and the “5-5-5-5 method” breathing exercise. The researcher asked everyone to get in a comfortable position and then played the progressive muscle relaxation tape created by the therapist.

Psychoeducational: This session focused on the mental processes that influence our perceptions of events we experience. How we cognitively interpret a situation affects how we will react. This session was dedicated to learning about cognitive distortions: what they are, how we use them, and how to be aware of them. The therapist and researcher wrote down six cognitive distortions on the chalkboard and gave a handout on cognitive distortions to each member (See APPENDIX D). The terms cognition and cognitive distortions were defined to the group members. It was explained that cognition is how we process things that happen around us. So a cognitive distortion is interpreting an event in an unintended manner. In distorting how the event was meant to occur, an individual incites negative emotions instead of taking the situation for what it was intended to be. There are many examples of how a person can incorporate a cognitive distortion to create an angry feeling. The six cognitive distortions explained during this session were:

1. Blaming
2. Catastrophizing or Magnifying
3. Labeling
4. Jumping to Conclusions or Misattribution
5. Over-generalizing
6. Demanding/ Commanding

The first cognitive distortion described was 'blame'. When blaming, an individual is holding oneself or another responsible for an outcome that was not completely under the individual's or other person's control. For example, if an individual's parents decided to

divorce, then the child may blame her or himself for the divorce, even though she or he is not at fault. Another cognitive distortion was called 'catastrophizing'. When catastrophizing, a person blows the expected consequences way out of proportion in a negative manner. An example of this could be a woman who was turned down for a job. By catastrophizing, she decided that her life was ruined, she would never get a job, and she would lose all of her friends.

Labeling was a cognitive distortion that allows an individual to call her or himself or another person a bad name when displeased with a behaviour. Calling someone lazy, incompetent, or stupid are examples of labeling. Jumping to conclusions, or misattribution, was another cognitive distortion. There were two ways mentioned in which a person can jump to conclusions. The first way was by 'mind reading', which means to assume other people's thoughts and motives. When looking back at the example of the woman who didn't get the job, perhaps she felt that the reason she didn't get the job was because of her physical appearance, and not just because the job had been filled. The second way to 'jump to conclusions' is by 'forecasting' negative events that will happen in the future. An example of this is after an individual finished an exam, the person assumes she or he failed it, and therefore, will never get into college.

The fifth cognitive distortion explained by the therapist was called 'overgeneralization'. Overgeneralizing includes making self-critical or other critical statements that include terms such as never, nothing, everything or always. A person can feel negative about herself after breaking up with her boyfriend by thinking that she will never ever find another man who will love her and that she will always be alone. The final cognitive distortion discussed was called 'demanding/commanding'. This form of

judging allows a person to use words such as ‘should’ and ‘must’ when confronting her or himself or others. By saying that a person “should’ have finished the task by now”, or saying that “I should have known better” implies a negative feeling of failure.

Knowing and understanding the different cognitive distortions can help an individual know if the feelings each is having are rational. Learning the cognitive distortions means learning how to stay away from certain modes of speech that can be hurtful to the self and others. The researcher gave examples of different situations and then asked the group members to decide what cognitive distortions were being used. Then, once the distortions were determined, then the group members were asked to reword the situations so that there were no distortions.

The therapist used this part of the section to introduce role- playing techniques with the group members. Each member was asked to think of situations where each was most likely to get angry. Once the members thought about their own situations, the researcher asked them to describe the provocation and then each was asked to act out the scenario one at a time with the therapist or researcher acting as the instigator.

Psychotherapeutic 2: This session finished off in the same manner as the other sessions. Group members asked questions about the role playing exercises and discussed the individual experiences that each has when dealing with their own anger.

4.3.5 Session Five

Psychotherapeutic 1: The session started with asking the group members to discuss any angry incidents that happened over the past week and how each situation was handled. When the therapist arrived, he held a ball of yarn in his hand and said that they

were going to play a game. Holding on to the end of wool, the therapist threw the ball of yarn to a person in the group and then said something nice about that person. Then that person held on to the piece of the wool and threw the ball to another person and was instructed to say something nice about that person. As the yarn was tossed from person to person, the ball got smaller and smaller, but the pattern of wool held the group members together.

Psychoeducational: The researcher introduced the topic of relaxation induction techniques to the group. This process was somewhat like the progressive muscle technique completed in a previous session except that visualization played a large role in being able to relax. Instead of just relaxing the physical body, emphasis was placed on being able to imagine yourself in a situation where you feel completely content. Taking deep breaths and relaxing the physical body allow the individual to get into a state of mind that lets the person imagine her or himself in a place that is completely relaxing. By learning how to visualize oneself in a peaceful environment, the individual could put this to use when she or he feels angry or in a stressful situation.

The researcher asked the group members to get in a comfortable position and then she played the relaxation induction tape that was previously recorded for this session. This relaxation induction technique was recorded using the researcher's voice. She researched a number of relaxation passages made available on the Internet to help write this technique recorded particularly for this anger management group. After the tape finished, the group members were given the opportunity to discuss what they thought of the relaxation technique and if it was helpful.

The therapist then gave out a handout with coping skills for handling anger-invoking situations. The group went over each one together and was asked to pick two or three that they would find the most helpful in specific situations.

The researcher constructed role-playing scenarios before the session began so that each situation dealt with a specific problem that a group member actually was facing. A few scenarios were devised for each member and the rest of the session was spent completing these.

Psychotherapeutic 2: The session ended with processing what was learned throughout this session and how each member felt about her or his process with the role-playing scenarios.

4.3.6 Session Six

Psychotherapeutic 1: The session began much the same as previous sessions. The members talked about any incidents that took place over the past week and how they were handled. The group members were then asked how they were feeling in respect to their angry reactions compared to before they began these psychoeducational therapy sessions.

Psychoeducational: An article on the different ways men and women communicate was handed out to the group members and was discussed thoroughly. Much emphasis was placed on how the interpretation of different phrases can affect men and woman differently. Knowing that communication styles between the sexes are so different allowed the group members to realize that maybe they need to change the way they correspond with others so that they can be properly understood. The researcher

asked the group to think of some benefits of effective communication with others. She then spoke of the advantages of mutual respect, reducing tension, increasing self-confidence, and generating more options for problem solving.

The first step in effective communication is to learn how to manage interactions when communicating. To do so, one has to be specific in relating problems to the other person and focus solely on the problem at hand, not all past difficulties that have come up. The goal is to listen intently to the concerns of the other person and identify each other's needs. From here, the individual can move ahead to problem solving by taking the time to identify the specific problem, analyze the needs of those who will be affected, and brain storm to generate any possible solutions. Although this may seem time consuming, with practice, this technique becomes routine and the outcomes will indicate the successfulness of one's efforts.

Four components of effective communication were explained to the group members: "I" statements, active listening, reflection, and non-verbal communication. "I" statements improve communication by being able to rephrase statements into more assertive statements that are not blaming or confrontational. The researcher asked the group members to reword a number of statements into "I" statements. For example, instead of saying, "The dishes are still not done. You are so lazy!" the group members could say, "When I see that the dishes are not done when I get home, I feel tired because I know that it is another thing that I have to do before I can relax." Using this language takes the sense of accusation away from the conversation and may help to initiate a discussion to come up with a solution.

Active listening is used to show that attention is being paid to what the other person is saying. By actively listening, not only is the verbal message being communicated, but also the emotional message that is attached. When actively listening to another person, one should be able to restate the given message in the person's own words to show real understanding. The researcher gave some examples of this and asked the group members to restate the researcher's words to show understanding.

Reflection means to demonstrate interest and understanding of what is being said. Giving feedback on the verbal and emotional message using "I" statements shows the other person that you truly are trying to understand how she or he feels. For example, reflecting back what a partner says can be done by saying, "I think that you are frustrated by my behaviour over the past few days. I can even hear it in your voice." The group practiced reflecting the researcher's messages when she gave examples.

The fourth component of effective listening is learning to recognize nonverbal communication. Facial expressions, how one is sitting/standing, and eye contact are some methods in deciphering nonverbal communication. The researcher gave examples of nonverbal positions that can help determine how a person is feeling. For example, someone standing with her arms crossed over her chest, head down, and avoiding eye contact can imply that she is not happy about something.

Some role-playing techniques were practiced and different communication styles were implemented so that the group members got a feel for how the same message could be stated in a number of different ways. Members practiced using effective and ineffective techniques to help see the difference in resultant feelings and behaviours. The group members were then asked to take turns playing the role of the therapist. Other

group members came to the acting therapist with a particular issue concerning their anger and the person playing the role of therapist had to help them in the most effective manner.

Psychotherapeutic 2: This section was dedicated to reviewing communication styles and answering the group members' questions that related to that topic or any other topic that has been discussed over the past six sessions. Once all participants had the opportunity to comment on the issues that related to them, the therapist decided to bring up the topic of group termination, since next week marked the second last session of this group psychoeducational therapy. Although potentially upsetting, the therapist asked the group members to take into account that the group was soon coming to an end and that they should all think about what they would like to do to celebrate the end of the group. The therapist said that he would set aside some time next session to discuss whether the group members were interested in doing something special to mark the end of the group.

4.3.7 Session Seven

Psychotherapeutic 1: Members discussed any techniques they had used over the past week to help cope with their anger. Some group members offered their stories, but the majority of this processing time was spent on the topic of the group coming to an end and how it affected each individual. A number of ideas were introduced into the discussion on how to mark the end of the group sessions, and the majority of the members decided that they wanted to have a potluck during the last session and just talk with each other about what they have accomplished by participating in the group. The process section of this session overlapped into the psychoeducational section as the

group members were having difficulty in accepting the termination of the group therapy program. When the therapist arrived, the questions concerning termination continued. Some concerns involved how to contact the therapist or researcher after the sessions ended or what to do if old habits returned. The therapist and researcher offered a number of external resources that each member could rely on for help concerning their anger. It was also mentioned that the members could return to their referral source for more help and guidance in this area.

Psychoeducational: The psychoeducational part of this session revolved around summarizing all topics that were discussed, developed, and rehearsed over the past seven weeks. The therapist spent most of the time answering questions that concerned the group members and tips on how to keep using the techniques taught throughout the sessions. At the end of this section, the therapist gave everyone a sheet of paper and a pencil. Each member was asked to draw a pig in whatever way they choose. They were not allowed to look at anyone else's pig and they were just to draw a pig in whatever way they thought of. After everyone in the group had finished drawing their pigs, the therapist explained how each characteristic of the pig could be considered to represent some characteristic of the person who drew it. For example, if the pig had a long snout, then the person that drew the snout was considered to be a nosy person. The therapist said that he enjoyed using this game for a fun activity to make the group laugh and break up the serious nature of a conversation.

The therapist used this time to talk about the responsibilities that each of the group members have for their own thoughts and actions both towards themselves and towards others. Since we have no control over other people, the most we can do is take

control of our own behaviours. The therapist told the group that to take control over our own actions, each individual needed to be aware of how she or he was feeling at all times. When a situation automatically makes a person feel uncomfortable, then it is up to that person to take control and ask what about the situation is upsetting and why it is raising these particular emotions. Understanding why we behave the way we do in a situation can help us to behave more appropriately to rectify the problem.

Psychotherapeutic 2: This session finished with the group talking more about how the group was headed to the last session and how each felt about termination. Time was to be spent on how the members felt about ending this therapy and how they would motivate themselves to keep using the techniques taught.

4.3.8 Session Eight

Psychotherapeutic 1: The same questionnaire that was given out to the group participants in the first session was re-administered. The group members were asked to follow the same instructions as the first time and answer as honestly as possible. The researcher reiterated that completing this questionnaire was voluntary and their answers would be held in confidentiality. If they did not want to complete the questionnaire, then they did not have to do so.

Psychoeducational: The therapist spend some time talking about coping mechanisms for handling everyday stress, especially anger. The focus of this discussion was to inform the group members that just because the sessions have come to an end, the group members still must continue working on their anger management. The therapist then asked each member to talk about the pros and cons of the group sessions and the use

of psychoeducational therapy in helping them with anger management. Each member was to offer advice on how to improve the sessions. The researcher then asked the group members to tell of the technique that they found the most useful and will remember. She took notes on the information provided by the group members.

This section was dedicated to an activity that the group members could take home with them. Each member had his or her name on the top of a piece of paper prepared in advance by the researcher. The papers were passed around from person to person and each member of the group had to write something nice about the person whose name was on the top of the page. At the end of this activity, the pages were given to its rightful owner and the members got to see what nice thoughts the rest of the group had about them.

Psychotherapeutic 2: The session ended with the group being given the opportunity to talk freely to each other about many different topics. This was allowed to help the group members to close the session, and the entire therapeutic experience, on a positive note. The therapist reiterated the importance of confidentiality and how they are committed to this pledge even though the group has ended.

Chapter Five - Results

5.1 Introduction

This section presents an analysis of all the data gathered from participants in this psychoeducational anger management group. The objective was to investigate the effectiveness of this therapeutic intervention on outpatient participants. The following questions were studied:

1. Does the content of a psychoeducational therapeutic intervention program prove effective as a means of addressing anger management problems?
2. Is this intervention effective with a voluntary outpatient population?
3. Can the effectiveness of this intervention be assessed using an instrument developed by the researcher?
4. What is the overall satisfaction level participants experienced as a result of this type of intervention?
5. Do participants experience a perceived increase in their anger management skills as a result of this intervention?

5.2 Screening Results

The screening interview process, used to determine the appropriateness of individuals joining the group, took approximately three weeks to complete. The therapist and the researcher together met with all potential group members, except for two individuals whom only the researcher interviewed. The same format was used for each

interview (See Appendix A) and after each interview was completed, the therapist and the researcher discussed the information given by the individual and whether or not she or he would be a suitable addition to the group. Each interview took approximately an hour and a half to complete. Two group members were asked to attend an additional screening interview since the therapist and the researcher were unable to make a decision on their fitness after only one session. The therapist and researcher spent about 30 minutes reviewing each of the potential members.

The initial interviews with the potential group members tended to move smoothly as the therapist and researcher asked questions about the person's personal history and experiences with anger. Of the fourteen people interviewed, nine were chosen to attend the group sessions. Seven men and two women were invited to join the group, their ages ranging from 27 to 45 years old. Five members had a prior legal record of assault and four had drug or alcohol addictions. All nine members stated that they were suffering from depression and/or anxiety, and five of them were taking medication to help keep their symptoms under control. Of the nine members screened, five were referred to anger management therapy by a professional and the other four members were self-referred and asked to take part in these sessions.

The educational level of the members varied from a grade ten education to an undergraduate university degree. In addition, all members were working full time with an exception of two: one on social services and the other a seasonal worker.

5.3 Quantitative Results of the Questionnaires

The questions on the instrument were categorized as falling into three areas: anxiety, depression, and anger. Only the scores of those members who completed the intervention, hence, completed the questionnaire given during the last session were used in the results. Before analysis was undertaken, missing data from items on the questionnaires were taken into account. Fortunately, most questions were answered by each of the members of the group. Given that the scales had a large number of questions, leaving out one item, would stop the scale from being computed for an individual. Therefore, a decision was made to impute the few missing values. This procedure is more acceptable than not using the data from those who have left out answers to questions. This method of imputation was felt to be acceptable since only one or two items were left out of each of the scales (SPSS MVA, 2006). The scores were then analyzed using Cronbach's alpha to examine the reliability, and finally, two-tailed t-tests for paired samples were performed to determine whether the results obtained from the questionnaires showed statistically significant decreases in the participants' levels of anxiety, depression, and anger.

Once the missing data was filled in, the items were tested for internal consistency to ensure that the items were related to one another (Cronbach, 1951).

Table 1: Descriptives for Cronbach's Alpha for each Scale and Testing.

	N	Number of items	Pretest alpha	Mean	Standard deviation	Posttest alpha	Mean	Standard deviation
Anxiety scale	7	20	.90	49.7	17.0	.84	32.4	8.1
Depression scale	7	12	.84	30.4	10.3	.64	19.4	3.8
Anger scale*	6	47	.89	168.8	22.2	.92	122.0	21.3

Note: Individual items in the scales ranged from 1 for not at all to 5 for very much. Anxiety scale scores could range from a low of 20 (No anxiety) to a high of 100 (High anxiety). Depression scale scores could range from a low of 12 (No depression) to a high of 60 (High levels of depression). Anger scale scores could range from a low of 47 (No anger) to a high of 235 (High levels of anger).

*Note: One individual had too much missing data on this scale to impute a value.

Table 1 shows these results. The pretest alpha's all show high reliabilities, with alpha values over .80. For the posttest, two of the reliabilities were once again found to be high with results over .80. It should be noted that the internal consistency for the depression scale went down to .64, which is still acceptable in exploratory research (Nunnally, 1978).

Table 2: Paired t-test Scores for each Scale.

	Mean difference	t-value	d.f.	Significance two-tailed
Anxiety scale	17.3	2.77	6	.03
Depression scale	11.0	2.64	6	.04
Anger scale	46.8	3.46	5	.02

Paired sample t-tests were then performed to see if the scale scores decreased as a result of the treatment. Table 2 shows that all three scales were significant at $p < .05$. For the anxiety scale the mean score went from 49.7 to 32.4 for a mean difference of

17.3, $t(6) = 2.77$, $p = .03$. The depression scale mean score went from 30.4 to 19.4 for a mean difference of 11.0, $t(6) = 2.64$, $p = .04$. Finally, the anger scale mean score went from 168.8 to 122.0 for a mean difference of 46.8, $t(5) = 3.46$, $p = .02$.

Figure 2: Pre and post test scores for the anxiety scale

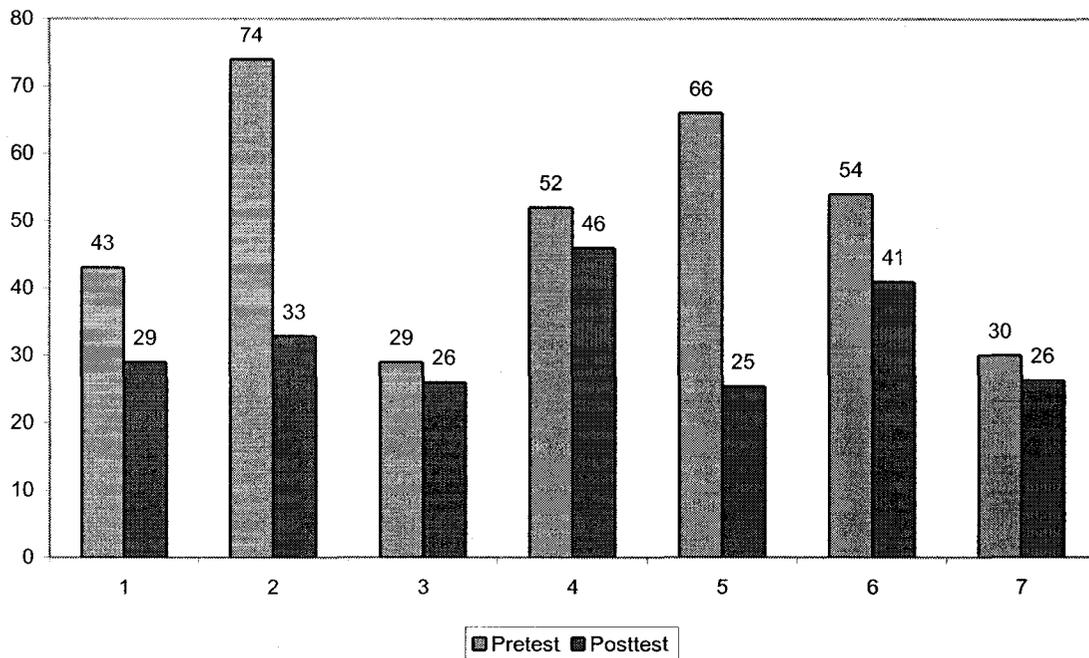


Figure Two shows the anxiety test scores obtained from the seven participants who completed the questionnaire pre and post the intervention. Participants 2 and 5 appear to have the greatest decline in anxiety levels when looking at the table.

Figure 3: Pre and posttest depression scale scores

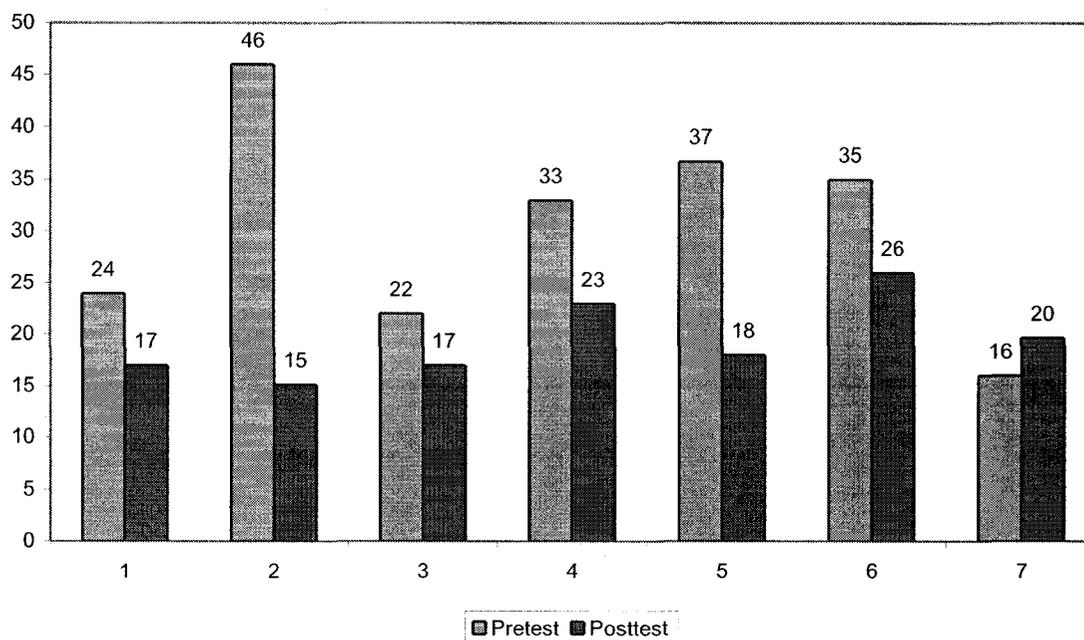


Figure Three shows the depression scale scores obtained from all seven individuals who completed the questionnaire pre and post the intervention. It appears that participant 2 found the greatest decrease in the level of depression perceived. Participant 7 seems to have had a slight increase in the level of depression felt after completing the intervention.

Figure 4: Pre and posttest anger scale scores

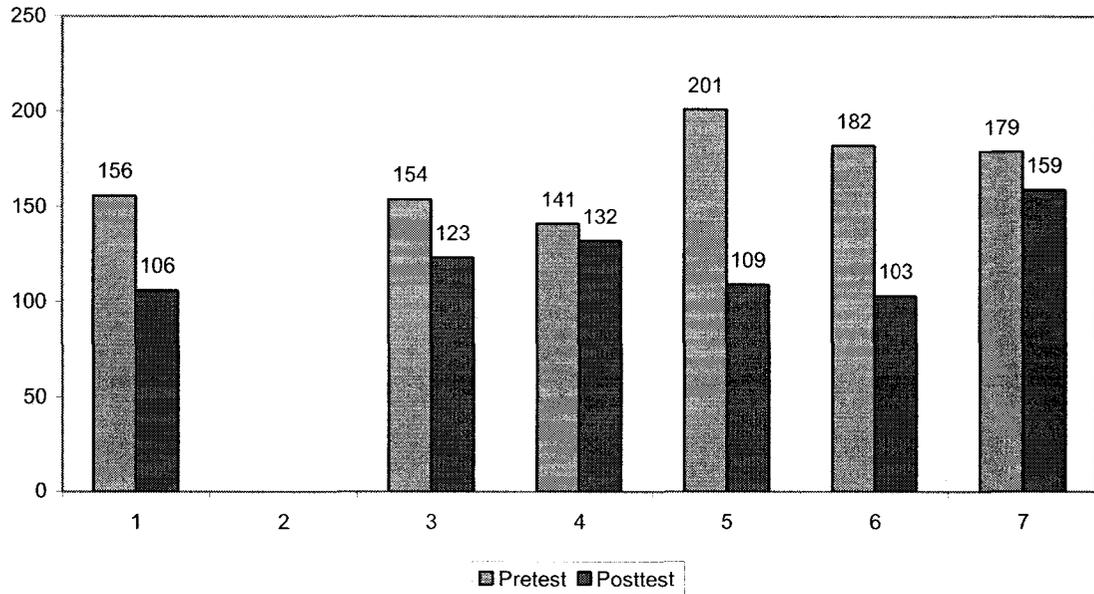


Figure Four shows the anger scores obtained from six of the participants who completed the questionnaire pre and post the intervention. Participant 2 was intentionally left out of this anger analysis due to the number of items on the questionnaire left out. The table shows a decrease in the levels of anger perceived by the six of the participants analyzed.

5.4 Clinical Observations from the Group Sessions

This section provides observations noted throughout the sessions by both the researcher and therapist. These observations include thoughts on the interactions that took place amongst the group members as well as interpretations of the success of each individual member and from the group itself. Interactions that took place between group members were monitored by the therapist and researcher and then discussed after each

session ended. Observations and records were taken of conversations and conflicts that took place as well as any events deemed clinically relevant that occurred as the group participants participated in dealing with into their own problematic anger.

5.4.1 Session One

There were seven members present at this session. The tables were set up as previously described, in the shape of a horseshoe and the members chose to sit in chairs with ample space between each other. One man stood out in the group because he recently was in a fistfight and had two black eyes. No one in the group asked him about it and he did not offer any explanation although he revealed the story to the researcher during the screening interview.

From the start of the session, members appeared to be comfortable and most members readily began to discuss their own anger issues. Although each member in the group came from a different background and life experience, the similarities in how each dealt with his or her anger was noted. The group members decided on their own to briefly explain their personal reasons for attending these group sessions when they were asked to introduce and say one thing about themselves. One group member swore quite often throughout the session. These words were not directed at anyone else in the group, but were used as a regular component of his language. The rest of the members tended to find his use of language to be funny, but the researcher and therapist could see how his comments could create anger in him and others, even if his intention was to be humorous.

Another group member at the end of the session decided that he did not really need to be in anger management therapy. During the screening interview he explained that he only has problematic anger when he is with his girlfriend. At that point of time, he did not have a girlfriend; therefore, felt he did not need to take part in the sessions. The researcher explained to this member that he could learn how to manage his anger before he gets into a situation where it tends to flare. He did not seem convinced.

The group participants were asked during this session to consider any questions they want answered through taking part in this psychoeducational group therapy. The goals defined were as listed:

- Get control over anger.
- Get rid of anger.
- Get back a sense of self.
- What are different experiences that provoke anger?
- Learn how to control our thoughts.
- Learn how to recognize what makes us angry.
- Understand the causes of anger.
- Learn to be assertive.
- Learn how to manage stress.
- Learn ways to deal with difficult people.

When discussing the different types of triggers, one member talked about how people around him knew “how to push his buttons” and how they used this knowledge against him. Another member said that she gets angry when other people tell her to

“calm down” or “chill out”. Some members knew that they got angry as soon as they were called liars or they believed that someone was lying to them. The therapist asked the members what they do to help decrease their anger. One member said that he likes to go to work and complete construction projects. This way, he can take out his anger physically and be productive at the same time. Other responses spoke of taking the dogs for a walk, crying, getting some fresh air, and just letting time take its course.

5.4.2 Session Two

Eight members were present in this session as a new member was screened and consequently added since last week. The icebreakers used at the beginning of this session seemed to work well to reacquaint the group members. The exercise that asked the participants to tell of a person they would like to meet if they could meet anyone in the world dead or alive created a lively conversation amongst the group. Tension that appeared to be present on arrival appeared to quickly dissipate as the group members laughed about the people they would like to meet. Oprah Winfrey was popular with the women in the group and the men tended to choose people from their past, such as grandparents or parents.

The group participant who had the black eyes the previous week looked worse this week. His swollen eyes shone brightly and he looked unpleasant and gloomy. His lack of participation was evident and he appeared bored with the conversation. He did not seem to have patience with the format of the group and tended to complain under his breath about the subject matter. The therapist decided after this session to ask him to

come early next week for an individual session to discuss his thoughts on and/or his needs from this group therapy.

When the therapist reviewed the content related to the triggers that had been taught the previous week, one of the group members enquired as to what should he do when he is triggered by everything? The therapist replied by stating that he cannot see him being angry twenty-four hours a day. This comment helped the member realize that there are times when he is not angry. This conversation was enlightening for the group as it helped members to understand that they are in control of their anger. They were encouraged to realize that they can choose what makes them angry and what they can ignore. The realization of this fact is important when learning how to manage anger. The topic shifted to physical implications of anger. When discussing the impact anger has on a person's physical health, one group member admitted that he has high blood pressure and he can feel it when he gets angry. When discussing other indications the therapist mentioned that when one is feeling tired, this can have an impact on a person's irritability.

The group member mentioned earlier, who appeared to be bored during the sessions, finally spoke up to disagree with the therapist's point of view. When the therapist explained again how being tired can affect how a person feels, this member became irritated himself and, apparently as a way of lessening his frustration, began swearing at the therapist under his breath. This created tension within the group for those that heard him and other members got involved in an effort to calmly explain the concept to him. The rationale for the sudden outburst seemed to come from either the member's boredom with the group or his misunderstanding of the concept being taught. Although

he said that he now understood the logic, the rest of the session remained somewhat tense due to his behaviour.

The therapist and researcher took note of two members in particular who seemed to be competing with each other in their expressions of anger. They seemed to be trying to outdo each other in how many times they got angry and in terms of whose experiences were more violent and offensive. The two men seemed to be proud of their anger 'achievements'. The researcher noticed that the rest of the group displayed an intent interest, a response that appeared to encourage the two men to compete even more. This situation was deemed to be problematical for two reasons. One, these two men did not seem to understand that their actions and arrogant behaviours were not helping the others increase awareness of their own anger and, two, the men did not seem to understand that they were reverting to the behaviours that they were trying to leave behind.

Another observation made by the researcher and therapist related to the horseshoe seating arrangement used during the previous session. They found that the feeling of belonging to the group was not enhanced as the participants sat far apart from each other. For this session, the tables were pulled together so that everyone sat around one big table instead of being spread apart. This arrangement was deemed to be better than being spaced out. It allowed the group members to work closer together, but the therapist and researcher noted that the table was appearing to be used as a barrier for the members to hide behind. Together, they decided to change the seating again for the next session.

A few days after this session, one female group member called the researcher and asked that her phone number be given to another group member who was having trouble finding transportation to the therapy sessions. This member wanted to let the other know

that she would pick her up and drive her to and from the sessions. The researcher said that she would pass along the message. This member then continued to say that she feels that she should not be in this therapy group because her anger seems to differ so much from that of the others. Her anger is directly in response to her husband's infidelity and her going through a divorce. She said that she had a great childhood and felt bad because the other members all seemed to have terrible experiences growing up. The researcher helped her through this dilemma by reminding her that anger is expressed in many ways and can occur for many reasons. The differences in experiences of the group members enhance understanding of other people and the problems that we all can face. The member was able to understand that this therapeutic group is intended to help its members learn how to handle their anger more efficiently. The cause of the anger was not a prerequisite for the group, solely how the anger is managed. The researcher also prompted the member to raise her concerns at a future session if she still has reservations about her attendance.

5.4.3 Session Three

One group member asked to meet with the researcher, one-on-one, before the group session began. This member voiced her worries about a relationship she was having. She felt that her partner was disapproving of her decisions to seek help and was not respecting her as an equal in the relationship. In addition, the participant was concerned about hiding her sexual orientation from the rest of the group members. She felt uncomfortable even talking about her girlfriend as "her partner" due to her fear of losing friendships with the others.

A few hours before this session, the member that was asked to meet with the therapist arrived at his office. The therapist wanted to have a conversation with him concerning his motivation to attend this group and his reason for his outbursts. He told the therapist of his stresses at home, but said that he really needed this help and he could be at the session later that day. He failed to show up once the session started. Six participants showed up for this session. The other missing member called beforehand to tell the researcher that he would not be attending group due to illness.

The atmosphere was noticeably relaxed during this session compared to past sessions. The group members seemed to have benefited from the outburst that happened last week. When the therapist asked the group whether they wanted to talk about the heated discussion that had occurred, the participants stated that there was no need to bring it up since all talk was in a friendly nature. The group participants appeared to be closer this session than ever before.

All members said they enjoyed the relaxation tape. There was one member in particular that thought the technique was rubbish and a waste of time, but after completion he commented that he never realized how tense he really was and that he would appreciate a copy of the tape to use at home. Other members stated that after listening to the muscle relaxation tape, they were ready to have a nap. Another member offered to take the tape home and copy it for the other members. He said that he would have copies for everyone the following session.

At the end of the session, one participant shared his distress related his relationship at home. He was really upset with his wife and was not sure how to handle the situation without getting too angry. The group seemed to empathize with him and

offered different suggestions for dealing with the problem. The therapist and researcher gave praise to the participants when some advice offered was deemed to be well thought through. It was also noted to the members when advice was not viewed as productive. A few members offered assistance by sharing experiences that they each had in their own lives as a means of guidance for the troubled member. When the group dispersed, everyone wished him good luck with his wife and his anger.

5.4.4 Session Four

The researcher altered the seating arrangement by placing all the chairs in a circle without using the table. This way, the members were close together and had no table to use as a barrier behind which they could “hide”. Seven members attended this session. The one missing participant was the same man who met with the therapist individually and had missed the previous session. The session started with the group asking one member about his problem with his wife. It had been discussed the previous week. He explained that he felt he handled the situation better than he would have before, but he still got angry.

There were many anger incidents discussed that happened over the preceding week. They ranged from experiences that were well controlled to those that could have been handled more effectively. The therapist taught the members about cognitive distortions and how they can affect emotions during any situation. Examples were given and the therapist then reviewed incidents that happened to each member and asked them to use their knowledge on cognitive distortions to help explain their actions. The therapist and researcher observed that the group members appeared to have regressed

somewhat due to the incidents they encountered and how each was handled. One member, for example, spoke of how he had followed a car that cut him off in traffic, pulled the driver out of his seat, and pinned him against his car. Another member also had someone cut him off in traffic and when he caught up with the driver, he used a baseball bat to be intimidating. Both of the female members had arguments. One was frustrated with her social worker and hung up on her while talking on the phone. The other female member came home from a weekend away to find that her ex-husband had not washed the dishes or done any laundry. This led to an argument. She explained to the group that she wanted to hit her ex-husband in frustration, but instead she hit herself. She said that she did this because she knew that she shouldn't hit him, but she had to do something to help relieve her anger. Finally, one participant threw a chair across the room at home. He did this in frustration arising from his overloading the washing machine and having it overflow.

When reviewing each of the above situations, the goal of the therapist and researcher was to help the participants find new, more productive methods of gaining control over their anger. One member stated that life would be easier if he did not get angry at all. The therapist explained that everyone gets angry and that a person cannot expect to be anger-free for the rest of life. As the aim of these sessions was to help members learn a new way in coping with anger, it was felt that this new technique should help them manage their anger in ways that were appropriate to the situation. It was also intended that the participants increase their ability in problem solving as to help rectify the problem. Therefore, the therapist and researcher involved the group members by asking them to consider alternative responses for each situation. The group worked

together to decipher the underlying emotions felt, find positive means of expressing their feelings when angry, and discuss how the situation could have been dealt with without losing control. In the group setting, the participants were able to realize that they were helping each other improve behaviours, while at the same time, learning new strategies for themselves that they might not have thought of individually. The group setting allowed the participants to appreciate that they are not alone with their anger and that, in working together, they can both support each other's improvement and empathize with their struggles.

Although there were many issues of angry experiences to talk through during this session, the group members seemed to gain understanding of how cognitive distortions can alter the intended meaning of a comment and have influence on the emotions felt.

5.4.5 Session Five

Before this session began, the researcher called one member that had been absent from the previous two sessions, and, therefore, had missed three sessions in total, to ask him why he had missed the sessions and why he did not call to notify of his absence. He said that he wasn't sure if he would be able to attend future sessions. It was decided to tell him that it would be better for him to wait until the next group of anger management sessions was held so that he would be able to benefit from all the sessions. It was felt that the remaining participants would feel delayed if he returned and it was necessary to review materials that he missed. Upon learning that he was asked to leave the group, he hung up on the researcher.

This session consisted of six participants. Conversations at the beginning of the session revealed to the researcher that the members had attempted to use methods that were taught last week to help cope with any angry situations they encountered. Members stated that the concept of thought awareness had not occurred to them and appeared intrigued with cognitive distortions and how they can affect their patterns of thinking. When the therapist arrived, one member burst into tears due to her frustration with her social worker. She took this time to express many of her concerns and disclosed to the rest of the group that she is a lesbian and that she was afraid of their rejection. One group member responded to her “coming out” by saying that he did not see any problem with her being a lesbian and that it did not change his opinion of her. Another member told her that she was worried over nothing and her sexual orientation was no big deal and had nothing to do with them. The therapist told her that he would talk to her social worker directly the next day. She was so relieved that she was still accepted as part of the group that she continued to cry. At the end of the session, a few participants approached her and gave her a hug.

As noted in Chapter 4, a yarn game was used in this session. As the game started, the entire group seemed to take the compliments seriously and put effort in saying something meaningful to the other members. All of the female members started to cry when they were complimented. For example, the female participant who was in the middle of a divorce was told that she is very pretty. The group members seemed to know that she needed some reinforcement in her capabilities since she was feeling so down.

When the role-playing scenarios began, the group members had trouble applying their new techniques. One participant was not able to control his anger, even though he knew that the experience was in a controlled environment and was not real. His face became red and he started to yell. When it was another member's turn to role-play, she was given a scenario unique to her situation, but she froze when it was her turn to talk. She was unable to process any techniques. The therapist felt that she needed more work in her communication skills on the whole. She tended to get anxious just thinking about her partner being upset with her. Ironically, the male who was not able to control his anger ended up giving this member advice on how to handle her anger and communicate with her partner effectively. The entire group was in awe of his behaviour and jokingly called him "Doctor". The session ended on this light note.

The members reported that they still needed much more practice using the new techniques they had been taught. The therapist and researcher observed that the cohesion of the group itself was helping the members talk openly with one another and express when they thought another member was in the wrong (or right). This, in itself, was deemed helpful for all participants because they were learning from each other's mistakes and able to see how each handles their own anger.

5.4.6 Session Six

Four members were present for this session. One called to say that she was sick and unable to make it. The other two absentees did not contact the researcher to say that they were not coming. When the session began, the members were asked how their past week had been. The participant who was going through a divorce told the group that she

found out that her husband had lied to her again, but she managed the situation well by using the coping skills previously learned and the relaxation techniques that she found helpful. She also stated that she did not accept any blame for his behaviour. Her husband would usually tell her that he lies because of her reaction to his behaviours. She finally understood that she was not to blame for his deeds and the therapist commended her for her breakthrough.

Another group member said that he was cut off in traffic again and his first instinct was to get angry and chase the driver. He said that he quickly was able to talk himself out of it by using the reasoning techniques that the therapist taught.

The therapist asked everyone what thoughts they had of the difference in male and female communication styles. The researcher told the group that by knowing how the genders communicate differently might make us more tolerant and patient with each other. One member said that there was no way he could listen to his wife vent, even when she warned him that she was just venting to get her feelings out and they were not directed at him. Although it appeared that he was trying to be funny, the researcher expressed that she was disappointed and that his behaviour indicated that the last five sessions had been a waste of time. The researcher felt that this participant was continuing to play the role of a “tough guy” so that he could entertain the other group members. The researcher was afraid that his antics would affect the attitudes of the others in the group who were genuinely trying to overcome their own anger. The researcher was trying to tell him that for his benefit, and the benefit of the entire group, issues discussed should be taken seriously as to help resolve the problem, not diminish it.

The therapist believed that this particular member liked to talk this way because he thought that it made the other members laugh. It appeared that the competition felt between him and the other comedic member was still there. Both the therapist and researcher had observed at other times during the session where this member would act more rationally with his wife. This made the researcher believe that his words were solely for show. An example of his more rational behaviour was when he told the group that at work, he was about to yell at his boss, but took time to think about the situation first. He decided to talk calmly with him instead and the problem was settled in favour of the participant. His boss also commended him on his positive attitude (since the boss was expecting him to get angry).

The session ended with a conversation on self-control. One member said that things would be easier if he could control other people. He did not seem to think it was fair that he had to change his ways while other people are not changing their ways. The researcher told him that just because other people are not going to change their ways does not mean that he has to be as stubborn as them. He was told that changing some actions for the better is going to make life easier on him, then why not take some responsibility to make these changes? One cannot change other people, but one can change oneself. The entire group thought about this statement and then made comments on how it is easier to place blame on others than to change one's own perceptions. They seemed to realize that they are in control of their actions and, recognized that although it may be difficult to remain levelheaded, they are responsible for their behaviours.

5.4.7 Session Seven

All seven members were present. There was no apparent tension felt by the members who attended the previous session towards the participants who missed the last week. The session progressed with few questions about the content delivered the previous session. While this session continued with role-playing scenarios and reviewing materials learned over the past sessions, most of this session focused on next week being the final session and the members' possible issues with termination. Most members had the fear of being abandoned once the sessions were over. Although they were given contact information for future reference and told that they would benefit from returning to their referral sources, they still did not feel convinced that they were going to be okay. The vulnerability felt by the members was unmistakable to both the therapist and researcher. The therapist offered comfort and understanding of the anxieties felt by the group members, but he also used this time to express what aims they should have for when the sessions come to an end. The therapist knew that this session was going to be especially difficult with termination issues, so he had a fun activity to break up the intensity of the session. The pig activity gave the group members the opportunity to laugh and enjoy each other's company before the session ended. The group members appeared to find the activity enjoyable and made comments to each other that the possible implications of drawing a big nose on a pig could indicate how nosy that person is.

5.4.8 Session Eight

All members were present for this last session. They were asked to fill out the same questionnaires they completed in the first session and were told that participation in completing the questionnaire was voluntary and all results were held confidential with the researcher. All seven of the group members filled out the questionnaire. The group members had all brought food to celebrate the end of this psychoeducational group therapy. The beginning of the session was used to compliment each other's cooking abilities and chat about the sessions in an informal manner. One member baked a cake in the shape of a pig, to commemorate the pig drawing activity held the previous session.

The researcher asked everyone what they had each liked and disliked about the group process and the materials taught. Most said that they learned a lot from the coping mechanisms and the relaxation techniques used to help calm them down when they started to feel angry. The role-playing techniques were considered to be extremely helpful in allowing the group members to practice what they had learned in a controlled environment so that they could gain confidence for using them at home. The main complaint offered by all the members was that having only eight sessions in the intervention was too short and more were needed to get a better understanding of their anger and how to effectively manage it.

The cohesion that had evolved between the group members was evident as the session came to an end. The members hugged each other, sometimes more than once, and no one was intent on leaving the room right away. They all took their time chatting to one another and talking to the therapist and researcher about their progress and their gratitude for allowing them the opportunity to be a part of these sessions. A few group

members did cry when they were leaving and all wished each other the best of luck with their anger, and their future endeavors.

5.5 Observations from Individual Sessions

Individual sessions were held an hour before the group anger management session began. The researcher met with one member to talk about her difficulties with her partner, communication skills, and the complications of her anger and her alcoholism. She was attending a support group regularly for her substance abuse and was “clean” for over three years, but she was finding it difficult staying in control over the alcohol, the anger, and now issues with her relationship all at once. She attended two individual sessions to discuss these matters.

Another member was asked by the therapist to meet with the researcher on two separate occasions to talk about his marijuana use. This group member was coming to the sessions under the influence of the drug and its effects were impacting the group as a whole. The member was snacking throughout the session and would start conversations with individual members on topics not in relation to anger. This interrupted the other members, even when they told him directly to be quiet. The therapist and the researcher were worried that his behaviour was going to diminish the effectiveness of the psychoeducational sessions if the other members continued to be interrupted by his chatter.

5.6 Observations Made by the Group Members

In the written, open-ended section of the questionnaire, participants were asked to offer any comments they would like to contribute. When the participants were asked to describe the impact these anger management sessions had on their perceived level of anger, all participants stated that the sessions were helpful in teaching them to understand how their anger developed and also, how to take more control over the emotion. In the written, open-ended section of the questionnaire, participants were asked to offer any comments they would like to contribute. The initial questionnaires did not have any commentary under this section, with exception of one. This individual stated that he would not return after this first session individual because he felt no anger at that time. Six of the seven final questionnaires included compliments and complaints about the sessions.

Three remarks deemed to be ‘favorable’ were:

- i) “Good balance between teaching and expressing personal issues.”
- ii) “Learned a lot.”
- iii) “I feel I have accomplished a great deal with my anger. My friends have noticed a difference in my anger and my attitude.”

Two remarks deemed to be ‘constructive criticisms’ were:

- i) “Too short.”
- ii) “Not enough sessions.”

Of the six respondents, five participants wrote favorable comments and four participants were not happy with the number of sessions offered. There were no negative comments related to the psychoeducational content offered.

5.7 Further Discussion of Behaviours Observed

It was observed that as the members of the group became comfortable with each other and began to share more information, they were able to confront other members when they were not paying attention or were going off topic. When one group member began to use humour to lighten the atmosphere of a serious conversation by another member, many in the group told that person to be quiet so that the conversation could be continued. Participants also expressed frustration when a member frequently wanted an update from previous sessions missed.

The researcher noted that as the sessions progressed and more techniques were introduced, the group members were learning new ideas that they had never knew or applied before. After practicing the progressive muscle relaxation technique (see Appendix E), one member stated that he could not believe that he was able to relax while doubtful of its effectiveness beforehand. During the last session he again stated that although he thought that the technique seemed 'stupid' he was still using it whenever he felt himself get angry. Another member asked to borrow the tape used for the Self Help Induction (see Appendix F). When he arrived at the next session, he had copies of the tape for everyone. The members expressed gratitude for this service and the group leaders made note of the enhancement of group cohesion.

During the anger management sessions, participants shared their personal experiences of how their anger affected each of them day to day. One member, for example, vividly described how he followed a car that cut him off in traffic and ended up holding that driver by the throat while threatening his life. Another member described how he went on a rampage and fought with three men in a parking lot, which led to months in jail.

Three of the group members revealed during the screening process that they were suffering from concurrent issues including alcoholism and drug abuse. These difficulties were discussed in individual sessions and these members eventually revealed their concurrent problems to the other group members as the sessions went on.

One group member disclosed being a lesbian during the screening interview. As the sessions progressed, the researcher saw how this secret was inhibiting the participant from advancement and her level of anger did not seem to be decreasing. After revealing her secret to the group they responded by expressing their unconditional feelings towards her and their appreciation for sharing this vital part of herself. This reaction surprised her and she cried with apparent relief for the remainder of the session.

Another member expressed that, at the start of the sessions, he was apprehensive about the positive effects this type of group could offer to him. He was skeptical about the benefits of the exercises used to help the participants learn that they have control over their bodies and how they think. After many new skills and techniques were taught and completed, this member verbally stated that although initially he did not think that this intervention would be worthwhile, he came to feel more relaxed and stated that he was willing to continue the presented techniques at home on a regular basis.

Group members were quick to describe what goals they wished to achieve from this program. There was some conflict in session 2 and 3, as members showed signs of restless as some members were dominating the discussion. One member in particular tended to get off topic quite a bit and the group quickly rebelled against the behaviour. As the sessions continued, some members began to express how their reactions to their anger and other emotions were becoming more apparent and that they were gaining some insight into their behaviours.

The therapist and the researcher reviewed participants' progress through clinical notes taken during and after each session. Thoughts were shared on the frustrations felt by the therapist and researcher during the sessions. Examples include one member coming to the sessions under the influence of marijuana and another member continuously trying to make the members laugh thereby distracting others from the issues being discussed. The therapist monitored improvements in how the group members expressed their anger. This was noted while the participants were role-playing through situations that the researcher designed personally for each of them. As the sessions progressed, many group members adopted the new skills they learned and applied them to situations that they usually found stressful.

Chapter Six – Conclusion & Discussion

6.1. Introduction

This study examined the effectiveness of using a psychoeducational group therapeutic approach to address anger management problems in outpatient participants. Information from this pilot intervention was used to help determine if this type of therapeutic intervention could be appropriately offered through a mental health facility to the general population. The individuals who took part in this intervention were referred by their own physicians, nurses, social workers, psychologists or counsellors. At the time of admission into the group, no member was serving time in a penitentiary or admitted in a hospital.

The data collected is deemed to support the effectiveness of this type of intervention. The findings of this study suggest that the approach has value and is worthy of further study. Its further use as a therapeutic tool appears appropriate.

The insights gained about the usage of the approach, its benefits and limitations, and suggestions for modification and future usage of the technique are discussed below.

6.2 Discussion on the Role of the Therapist

The primary role of the therapist and the researcher was to teach the group participants about the nature of anger and to help them understand why they had expressed their anger in a maladaptive manner. Along with being offered knowledge about their own behaviours, the group members were taught new methods to help them

gain control over their anger. The group members were given the opportunity to practice the newly offered skills and knowledge in a controlled setting, the conference room at the mental health facility. In sessions, they were able to review situations that had made them angry in the past and then rehearse different approaches to handling these situations, thereby determining what worked best for each of them. In addition, the group therapist and researcher offered constructive comments and feedback to help the members improve on their techniques for anger management. In other words, the group members had the opportunity to practice and perfect their behaviours before putting them in action in their own environments.

The purpose of using a psychoeducational intervention was to foster in the group members an understanding of how their dysfunctional methods of thinking affected how they each behaved. This psychoeducational intervention incorporated a cognitive-behavioural design emphasizing that thoughts need to be reasoned so that more adaptive behaviours can be displayed. The leader played a dual role when leading this type of group therapy. Firstly, the leader was seen as the instructor, teaching the group members efficient procedures for coping with their anger. The instruction focused on basic concepts related to anger, such as what it is and how it can be recognized, and then moved to topics such as anger's implications on behaviour and its effects on relationships with others. From there, the leader began instructing the members in methods of coping with their anger in a format that was easy to understand. Secondly, the leader played the role of therapist in helping the group members talk through and understand the background of their anger. With this information, the group members appeared to gain

awareness of the implications their anger had on their own mental health and their current relationships.

The role of the researcher was twofold as well. In addition to helping develop the structure of the intervention and gathering information from the group members and therapist, the researcher also took a therapeutic role, helping educate the participants in anger management, creating activities specifically designed for each person, and offering counseling both during and in between sessions.

Throughout the program, the therapist and researcher worked together to create an environment and strategies that would be most beneficial for the group participants. The progress of the group was monitored through meetings after each session to discuss the roles of the leaders during the session and if any changes should be made. The group leaders worked together to share the responsibility of teaching the group members the information they needed to know, and help them, therapeutically, through applying new skills to their everyday lives.

6.3 Discussion on the Use of Group Therapy

This psychoeducational intervention was delivered using group therapy. Yalom (1995) has explained the stages that group therapy clients usually follow from the beginning to end of the sessions. The initial stage defined by Yalom entails the participant's hesitant participation, dependency, and her or his search for meaning from the group. The first two sessions of the intervention studied appeared to closely follow Yalom's initial stage. All of the group members initially seemed hesitant to speak to the rest of the group and all sat far apart from one another. Although six of the seven

members eventually expressed why each felt help was needed, there was one member who was not as forthcoming and appeared apprehensive in sharing details of his own anger related experiences. This individual chose to take part in these sessions on his own accord, but seemed to have difficulty accepting the benefits of the intervention.

Yalom's second stage involves aspects of conflict, rebellion, and fighting for dominance between the group members. The second and third sessions of this group reflected these patterns of behaviour and also displays of competition between two specific group members. These two men spent time apparently trying to outdo each other with stories about the intensity of their anger and associated violent behaviours. Instead of using offered examples of new methods of behaving, these men competed for popularity within the group. This fight for dominance created conflict with others in the group who quickly tired of their antics. Another situation, which repeated Yalom's stage, involved one group member who felt that the group was not advancing. He stated that he was not getting anything from attending these sessions. This person's outburst, although startling and upsetting to the other participants, helped to promote the integrity of the group as a whole. The development of the group took a step forward when the tension that was being felt was addressed and brought to the foreground of discussion. The members felt relieved and discovered that they were able to voice their own opinions and not just silently take part in the sessions.

Yalom's third stage involves bringing cohesion to the group members that allows the therapeutic process to advance. This improved cohesion was seen in the session that followed the outburst of frustration mentioned earlier. When that session started, the group members were asked if they wanted to discuss what happened during the previous

session. They said that discussion was not necessary. Even though a few participants expressed their frustrations and, at times, negative opinions of the group during the previous session, there was no indication that residual anger was being felt. The group members appeared to be working together to gain information about their anger.

Yalom's third stage of cohesion was felt throughout the third to last sessions. This final stage, involving termination of the group, began in the seventh session. As Yalom's work predicted, the group became worried about their fate after the sessions ended.

Participants worried about their abilities to continue the learning process on their own and about not having the other group members available to offer support and help them in managing their anger.

Yalom's sequence of events was evident throughout the anger management group sessions and the group itself seemed to display the expected group dynamics. It was concluded that the participants appeared to follow normal group growth with reflective interactions among the members and the therapists. The intervention deemed to follow the model proposed by Yalom for desired group procedure.

6.3.1 Use of Psychoeducational Group Therapy

This psychoeducational group sought to educate the members about anger and then to teach methods to help members overcome problematic angry behaviours. This intervention for anger management followed a psychoeducational approach in that the therapists included, in each session, lessons aimed at educating the members about anger and its implications. Sessions also sought to enable members to talk freely about their feelings and own experiences and about how their actions have impacted on their lives.

Each session was designed to emphasize instruction and structured activities. The therapist and researcher planned each session so that specific tasks and topics were presented in an order deemed most likely to foster the members' learning. While the therapist and researcher operated as facilitators and teachers, they also counseled the group members around their specific concerns relating to anger. The therapists felt that they were successful in leading the members through the planned activities and that participants were helped to gain an awareness and understanding of their behaviours.

The group participants appeared to gain insight from the activities used to enhance the content from the sessions. Therefore, in learning how their anger is possibly affecting their behaviours, they were given the opportunity to practice skills before trying them at home. The group members appeared to gain confidence in themselves and their emotional responses.

In addition to the skills and concepts discussed in each session, the group members were given the opportunity to discuss their personal experiences and fears with the other group members, the therapist, and the researcher. The discussions that evolved from the individuals' unpleasant incidents gave the group members the opportunity to learn from the other's experiences and to gain knowledge about how they, themselves, react in similar situations. Therefore, the use of psychoeducational and therapeutic techniques throughout each session allowed the group members to achieve an in-depth understanding of their angry behaviours towards others and on themselves.

6.4 Discussion on the Analysis of the Data

The effectiveness of this pilot intervention was assessed using three sources of data. The first was the quantitative data obtained from the questionnaires used before and after the therapeutic intervention. Comments made by the group members about their learning and about their management of their anger constituted the second source of data. This data included comments made throughout the sessions as well as written comments made in the open-ended section of the questionnaire. The third source used was the clinical observations and notes made by both the therapist and the researcher during and after each session.

The statistical results derived from the questionnaires identified significant differences between the responses on the initial and the final questionnaires. In addition to these findings, the clinical observations by the therapist and the researcher, as well as, comments made by the group members, appeared to demonstrate improvement in members' knowledge of and response to their anger.

6.4.1 Discussion of Statistical Results

The questionnaire scores yielded statistically significant results between the pre and post offerings. Participant 7 appeared to have an increase in the level of depressed feelings after the intervention was completed. Though the increase was small, only the individual would be able to determine why. One explanation for this increase could be that this member was sad about the group coming to an end and, therefore, these feelings were expressed in the responses given. Another possible explanation could be that as the

levels of anger felt by the individual decreased, the perceived level of depressed mood increased as more insight was offered into certain behaviours.

In the analysis of the anger scale, participant 2 was omitted due to the number of items left out in the questionnaire. While missing data was imputed for individuals that left out one or two items, this participant missed too many items to be analyzed. While only the participant knows the reason behind the missing data, perhaps this individual felt that the items did not pertain to him or her. Instead of indicating response option 1, no anger at all, the participant might have left it out completely.

There are a few factors that could have influence over the results. This section will discuss the factors that could have an impact on questionnaire data. There was no opportunity to pilot the questionnaire hence the validity of the questionnaires could have been compromised due to problems or unclearness in the items and statements used. There was no way to identify if the respondents were honest and able to reasonably report their levels of anger, depression, and/or anxiety when marking their responses on the questionnaire. Perhaps, due to the nature of the questions, the group participants may have subjectively inflated or deflated their answers.

The small sample size of this group could possibly have impacted the nature of the results. Validity of statistical measures increases as the sample size of the participants increases (Hopkins, 2000). Nine individuals entered this anger management psychoeducational group therapy program and only seven participants completed all of the sessions. In clinical case studies, small sample sizes are gaining reputability as a dependable research design (Kazdin, 1980). This relatively small number of participants

could make it difficult to generalize the overall impact of this intervention, but the statistical results show significance of the intervention.

Individuals suffering with anger problems can be impeded by a number of comorbid afflictions such as having a mental illness, such as depression or anxiety. Others may be struggling with substance abuse. These factors can influence the degree of improvement perceived by the participants. While the intervention concentrated on teaching about anger, there was therapeutic discussion around other areas of the participants' lives that seemed to have a positive impact on their perspectives of anger. Interest arose, for example, in determining whether a depression enhanced the anger or, alternatively, if the anger brought on a depression. If depression is the primary presenting problem then the anger may subside with treatment of that illness. Although this question may not have relevance towards the need for anger management, it could impact the level of learning and cognitive awareness acquired by an individual.

The setting used for this psychoeducational intervention may have posed problems for some members since the location of the sessions was a conference room in a mental health facility. If the participants felt any embarrassment from possibly being seen at this location and/or had a fear of being stigmatized as having a mental disorder, their progress throughout the anger management sessions may have been affected negatively.

Another scenario that could have attenuated the results on the questionnaires could be a group member's belief about whether she or he suffered from problems with anger. If the member was not convinced that she or he had an anger problem, but was asked to join these sessions by a loved one, then the unwillingness to attend the sessions

may hinder the overall learning process. This situation was noted during a screening session, when one individual told the therapist and researcher that he was attending these sessions because of a request by his wife. His desire to save his marriage and his openness to try seemed to be adequately motivating to make him appropriate to be a part of this group and he showed significant improvements in his perceived behaviours.

6.4.2 Observations and Comments from Participants

When responding to the open-ended question at the end of the questionnaire, each individual wrote that she or he found benefits from taking part in the sessions. All responses indicated increased levels of insight in the participants. When facing a situation where anger was usually the outcome, all members expressed that their styles of coping had changed enough to allow room for cognitive restructuring. By taking some time to think before they acted, participants stated that they had the opportunity to take control of the situation before the situation overwhelmed them.

In the first session, many group members realized that their definitions and perspectives of anger were distorted. By learning that anger is a normal emotion used to aid humans from the time of our existence, the group members seemed relieved to know that they were not abnormal human beings. Participants also reported learning that appropriate expressions of anger positively impacted their own mental and physical health as well as the health of those people around them. Participants also appeared relieved to know that others were afflicted by similar problems and to know they could relate to the frustrations and angst resulting from their inability to control their anger.

During the last two sessions, the group members began discussing their feelings and opinions on this group therapy and the interventions they had learned. The main discussion revolved around participants' reported changes in their thinking and coping with their emotions.

Dealing with cognitive distortions was an integral aspect of the therapy. This focus was deemed to have helped the group members realize that their perceptions of an event may not always be accurate. Recognizing this, the group members reported that they were able to step back from a situation and analyze it before reacting. Group participants reported that they learned that it is okay to get angry at times and how to be angry while staying in control of their emotions.

In addition to learning the nature of cognitive distortions and their impact on how a situation is evaluated, the members commented on the value of a few other skills they were taught throughout the sessions. All of the participants found that the relaxation techniques used helped them become conscious of the tension in their muscles and how this tension affected their emotions. The role-play scenarios used, especially those pertaining to their own personal experiences, were said to be very effective in helping the members deal with their anger proactively.

As noted by Burns et al. (2003), previous research was limited as to the amount of visual material presented in psychoeducational therapy. He also noted that there was limited information on the use of role-playing exercises to increase the clarity of each lesson taught. Role-playing exercises were used frequently in this study to enhance understanding of concepts and to make examples relevant to each participant. In this way, the members had the opportunity to see ways they could handle a situation in the

'real world'. The participants said they benefited from being able to practice using their newly attained skills before using them in their lives. The opportunity to role-play helped make changing their behaviours less threatening since they had the chance to rehearse.

6.4.3 Clinical Observations

Each of the group participants affirmed that the information that they acquired was invaluable. The therapist and researcher observed that the relationships between the group members also served to enhance the learning and therapeutic value of the anger management therapy. The activities used appeared to facilitate the interactions made between the group members and with the therapist and researcher. For example, an activity asking the participants to name someone that they would like to meet, dead or alive, developed into a lively discussion and interaction. The members were able to chat and laugh about their choices, bringing a sense of unity to the group as a whole.

The role-playing activities were important for two reasons. Firstly, as mentioned previously, the activity helped participants to gain confidence using their new techniques. Secondly, other group members also gained insight into their anger and its implications by playing the role of instigator in other people's role-play exercises.

6.5 Use of Outpatient Group Members

Being an outpatient group, the participants knew that taking part was completely their decision. This fact allowed the group members to decide on their own attendance level. While members did attend the sessions regularly, there were a few who missed

one or two sessions. Members of an inpatient group would have little control over their attendance. In addition, these outpatient sessions were offered for no charge. For these reasons, participants may not be as motivated to attend, as might have been the case had they been required or had fee based sessions.

Data from repeated offerings of the program would offer a more in depth perspective on anger levels and on factors that decrease these levels. Similarly, revisiting the group members a few months after completion of this program could add useful data on the long- term effectiveness of this therapeutic approach.

6.6 Limitations of this Study

Additional factors may have limited the effectiveness of this therapy. The first could be the attendance of the group members. The consistency of attending the group sessions may have affected both the individuals themselves and the group as a whole. Even though the participants had the responsibility to show up on time and had committed to attending each session, a number missed at least one session.

Attending individual sessions, offered participants an opportunity to catch up on missed information. This opportunity allowed the group members to learn what they missed so that they were on track in the subsequent session. Although beneficial, this did not give the members the extensive learning experience they would have received by attending the actual session. Absent members did not get to practice using the newly offered material with role-play scenarios and other group activities. Furthermore, they did not get the opportunity to participate in discussion of matters raised by the other group members. In addition to the individual member losing out from missed sessions,

the cohesion of the group itself suffered. Spending time together is needed to maintain the level of trust and comfort necessary for successful group therapy. Absenteeism works against the group, inhibiting the progress of the group members.

Regularly attending group members may have felt some resentment or even anger towards those participants who missed sessions. This smaller group meant less input and that time was spent answering questions from the confused members who missed a particular session and needed to be updated in later sessions. Therefore, the level of attendance may have played a role in acquiring anger management skills, especially since the small number of sessions constrained the amount of time available to learn and practice new skills. Increasing the insistence on better attendance for the intervention could be beneficial for the overall learning process.

Psychoeducational groups typically run from eight to twelve weeks (Burns et al., 2003). This psychoeducational group met for eight sessions over a two-month period. The number of sessions offered could have had some impact on the overall results of anger management skills acquired by the group members. Each group participant stated that more therapy sessions would enhance the usefulness of the lessons learned. Perhaps the addition of more sessions per week or increase the duration of the therapy by two or three more weeks would be beneficial to the attending members. It is important to be aware that group members may have been fearful of termination and loss of the social support rather than having an actual need for more instruction.

While the small sample size did not appear to have a negative effect on the results obtained, it could have affected the dynamics of the group itself, as mentioned earlier.

As stated above, an additional limitation to this study was the lack of longitudinal data gathered to help analyze the data collected. Because the study was on a pilot project for the mental health care facility, the opportunity for further study was not an option at that time.

6.7 Recommendations for future study

This study examined the effects of a group, structured, psychoeducational anger management therapy program and its effectiveness with a voluntary outpatient population. The following recommendations for future research are offered. First, the number of sessions should be extended. Eight weeks did not seem a sufficient amount of time to allow a comprehensive exploration of some of the concepts. Second, a follow up session within two or three months might be beneficial in judging the impact the therapy had on the members and to take note of behavioural changes in the individual. It would be interesting to see how the members would rate the experience six months later. Third, having a larger sample size, by either increasing the number of participants in the group or observing a number of separate groups, would offer a better basis for determining the effectiveness of the intervention. Observing a control group using a different treatment intervention, but following the same study guidelines, may also be beneficial. Fourth, concurrent issues such as alcohol addictions and drug abuse can become problematic for potential gain in anger management skills. Although members were asked to abstain from addictive behaviours throughout the duration of the sessions, more emphasis can be placed on the importance of overcoming these issues that possibly contribute to an individual's anger. Finally, the questionnaire created for this intervention could be

further developed to increase its validity. The structure of the questionnaire can be changed for increased readability. As the opportunity to carry out this study came quickly, there was little opportunity to do further development on it.

6.8 Conclusion

This report reflects the findings from a pilot study of using psychoeducational group therapy to increase anger management. Its benefits for the outpatient population are recorded. Overall, the outcome of these sessions appears to illustrate that outpatients can increase their skills in managing their anger by using this type of intervention. On analysis of the questionnaires, there are statistical improvements noted in the participants' attitude towards their anger, their anger levels, and the depression and anxiety felt. The statements and actions made by the participants are deemed to suggest that there was much insight gained into their anger and their methods of coping with their emotions. The progress made by each member was deemed to be demonstrated through the comments and observations of the therapist and researcher, the progression observed when completing role-play scenarios, and the advice offered by group members on handling their own specific incidents of anger.

The content of the psychoeducational intervention researched suggested this to be an effective means of addressing anger management problems. This intervention appears effective for a voluntary outpatient population, although some aspects of the intervention might be altered to perhaps improve attendance levels. Some changes might include signing a contract for attendance and/ or paying a fee for this service.

The overall satisfaction level experienced by the group participants appeared to be high. Each participant stated that they felt an increase in their anger management skills from attending this intervention. They all commented on the connections made with other members of the group and how the intervention had helped them enhance their abilities cope with their anger. The primary dissatisfaction noted pertained to the number of sessions offered in the intervention. All group members stated that more sessions would be helpful to allow more practice using new techniques and skills taught in the lessons.

It is felt that this study demonstrates that the use of a psychoeducational group therapy intervention is an effective way to increase skills in anger management. The psychoeducational intervention used for these sessions incorporated teaching the group members about their anger and then teaching skills for helping each modify their behaviours towards themselves and others. Offering this intervention on a regular schedule for the outpatient population will increase the general public's awareness of anger issues, allow the public the opportunity to receive support that otherwise may not have been available, decrease the wait time for seeing a professional individually, and increase the amount of time clinicians have to offer to the needs of the society.

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APPENDIX A

Anger Management Scale

Directions: Use this key to indicate how much each symptom has bothered you in the past week. Place a checkmark under the appropriate number.

- 1 = not at all
- 2 = a little
- 3 = some-not much
- 4 = much
- 5 = very much

Anxiety, nervousness, worry or fear					
Feeling things around you are strange or foggy					
Feeling detached from all or part of your body					
Sudden unexpected panic spells					
Apprehension or sense of impending doom					
Feeling tense, stressed, or uptight					
Difficulty concentrating					
Racing thoughts					
Frightening fantasies or daydreams					
Feeling on the verge of losing control					
Fears of cracking up or going crazy					
Fears of fainting or passing out					
Fear of heart attack or dying					
Fears of being alone, isolated or abandoned					
Fears of criticism or disapproval					
Skiping, racing, or pounding heart					
Pain, pressure or tightness in the chest					
Butterflies or discomfort in the stomach					
Restlessness or jumpiness					
Feeling tired, weak, or exhausted					
Your friends or loved ones are saying that you are hurting them.					
People tell you that you need to calm down.					
You are drinking or smoking heavily almost daily to calm down.					
People ask you not to yell or curse so much.					
Have you been feeling sad or down in the dumps?					
Does the future look bleak or hopeless?					
Do you feel inadequate or inferior to others?					

Do you get self-critical or blame yourself?					
Is it hard to make decisions?					
Have you lost interest in your career, family, friends, or hobbies?					
Do you feel overwhelmed and have to push yourself to do things?					
Do you think you are looking old and unattractive?					
Have you lost your appetite or overeat compulsively?					
Is it hard to get a good night's sleep? Are you tired and sleeping a lot?					
Have you lost interest in sex?					
Do you think that like if not worth living or think you are better off dead?					
ANGER INVENTORY					
DIRECTIONS: Using the same key as above, indicate how much each event might bother you. Try to imagine it <i>actually happening to you</i> . How would YOU feel?					
On your way to go somewhere you realize that you lost your keys to the car.					
Going for a haircut and getting more cut off than you wanted.					
Being overcharged by a repairman.					
You are walking along, minding your own business, when someone comes rushing past, knocking you out of his way.					
Being called "a liar"					
You are in an argument, and the other person calls you a "stupid jerk".					
Hearing that a person is being deprived of his legal rights.					
Someone borrows your car, consumes a quarter tank of gas, and doesn't replace it or give you money for it.					
People who think they are always right.					
You are waiting to be served at a restaurant. Fifteen minutes have gone by and you still haven't even gotten a glass of water.					
Struggling to carry four cups of coffee to your table in the cafeteria, someone bumps into you, spilling the coffee.					
Getting your car stuck in the mud or snow.					
You are about to watch a movie in the DVD player and the disc gets stuck in the machine.					
Hitting your finger with a hammer.					

You are driving along at 70 km/h and the guy behind you is right on your bumper.					
You made arrangements to go somewhere with a person who backs off at the last minute, leaving you hanging.					
People asking you personal or private questions just for their own curiosity.					
Being pushed or shoved by someone in an argument.					
You accidentally make the wrong kind of turn in a parking lot. As you get out of your car someone yells at you, "Where did you learn to drive?"					
Someone who pretends to be something he is not.					
Someone makes a mistake and blames it on you.					
You are trying to concentrate and a person next to you is tapping his foot.					
You lend someone something important and they fail to return it.					
When leaving your house, the wind takes the door and slams it shut, cracking the doorframe.					
People who constantly brag about themselves.					
Being thrown into a pool with your clothes on.					
Banging your shins against a piece of furniture.					
Losing a game that you wanted to win.					
You are walking along on a rainy day, and a car drives past, splashing you with water from the street.					
Someone makes a nasty comment about your hair or clothing.					
Someone spits at you.					
You need to get somewhere quickly, but the car in front of you is going 40 km/h in a 70-km/h zone, and won't let you pass.					
Being talked about behind your back.					
Stepping on a gob of chewing gum.					
Hearing that a very wealthy man got season hockey tickets for free.					
Being punished for saying what you really believe.					
You are in a theater ticket line and someone cuts in front of you.					
Being misled or deceived by someone holding political office.					
You are out on a date with someone who subtly or indirectly conveys to you that you just don't measure up to his/her standards.					
While washing your favorite cup, you drop it and it breaks.					
Being falsely accused of cheating.					
Getting punched in the mouth.					

People who are cruel to animals.					
<p>Please use this space for any comments you would like to add about your anger:</p>					

APPENDIX B

APPENDIX C

Anger Management Screening Interview

1. Name
2. Education & Training
3. Work
4. Axis I
5. Axis II
6. Admissions
7. Marital
8. Treatment Received

9. Legal

10. Medication

11. Up Bringing

0-10

11-20

21-Present

12. Attitude toward Anger

13. Reason for his/her attendance

14. Demeanor

15. MSE (mental status examination)

16. Verbal

17. Good for the Group?

APPENDIX D

Activity 1: Getting to Know You

With a partner, take turns asking each other questions so that you can introduce your partner to the rest of the group.

Questions:

1. NAME?
2. WHERE ARE YOU FROM?
3. HOW OLD ARE YOU?
4. SAY SOMETHING UNIQUE ABOUT YOURSELF?
5. WHAT DO YOU LOVE THE MOST?
6. WHAT DO YOU HATE THE MOST?
7. WHO IS YOUR FAVORITE PERSON IN LIFE?
8. WHAT IS YOUR FAVORITE HOBBY?

APPENDIX E

Tuning In To Your Body

When you are preoccupied in your head with daily worries and concerns, you tend to stay out of touch with your feelings. To switch gears and gain access to your feelings, it is necessary to shift your focus from your head to your body. We sometimes do this when we say expressions such as: *heart-broken*, *pain in the neck*, and *gut-level* feeling. Tune in to your body = getting in touch with and identify your feelings.

- i. **Physically Relax:** It is difficult to know what you are feelings when you are tense and your mind is racing. Spend time doing muscle relaxation or some other relaxation technique to slow yourself down.
- ii. **Ask yourself, “What am I Feeling Right Now?”** or, “What is my Main Concern Right Now?”
- iii. **Tune Into That Place In Your Body** where you feel emotional sensations such as anger, fear, or sadness. This is your ‘inner place of feelings’.
- iv. **Wait and Listen** to whatever you can sense or pick up about what you are feeling. **DON’T** try to analyze or judge what’s there.
- v. **If you are unable to tune into your body** because your mind is still racing, go back and repeat steps. Most likely, you need more time to relax.
- vi. **Once you have a general idea of what you are feeling**, it may help you to make it seem more concrete by asking the following questions:
 1. Where in my body is this feeling?
 2. What is the shape of this feeling?
 3. What is the size of this feeling?
 4. If this feeling had a color, what would it be?

APPENDIX F

Muscle Relaxation Technique

1. Get comfortable. Take long, slow deep breaths.
2. Make fists with both your hands and feel the tension. Hold and Release.
3. Bend arms and press both elbows firmly into your sides. Flex arm muscles at the same time. Hold the tension for 5 seconds and then let your arms fall heavy by your sides. Focus on the heavy, relaxed feeling and continue breathing deeply.
4. Flex your feet by trying to touch your toes to your nose. Hold the tension and then relax.
5. Build tension in your upper legs by pressing your knees together and lifting your legs off the chair or bed. Focus on the tension and pulling in your hips. Hold for 5 seconds and then slowly lower your legs back down. Concentrate on the relaxed feeling in your legs and how heavy they feel.
6. Next, pull your stomach in towards your spine. Hold for a few seconds and then voluntarily relax your stomach.
7. Take a very deep breath and hold it until you feel uncomfortable. Slowly let the air out and feel the tension gradually disappear. Notice that you are voluntarily relaxing your body and your breathing.
8. Now imagine that your shoulders are on strings and are being pulled up towards your ears. Feel the tension building in your shoulders, upper back, and neck. Allow your shoulders to droop down as far as they can go. Notice the feelings between tension and relaxation.
9. Pull your chin down and try to touch your chest with it. Now relax and let go of the tension in your neck. Breathe slowly and deeply.
10. Clench your teeth together and focus on the tight sensation in your jaw. After 5 seconds allow your mouth to drop open and relax all the muscles around your face and jaw.
11. Build up tension in your forehead by forcing yourself to frown. Try to pull your eyebrows toward each other and focus on the tension you feel. Now relax. Smooth out all the wrinkles and let your forehead relax.
12. Allow your body to feel relaxed and heavy. Breathe deeply and try to relax every part. Say the word “relax” to yourself with each deep breath you take. Just let go and relax.

APPENDIX G

Self- Help Induction

Let your eyes begin to close...and as they close take a deep breath. A deep breathe starting at the bottom of your ribcage and slowly filling up your lungs. Slowly release this breathe through your mouth and feel every muscle in your body begin to relax. Take another deep breathe and feel yourself relax...relax. Allow your legs to relax...they feel heavier and heavier...heavier and heavier...as they let go of the last bit of muscular tension. Your arms now are becoming more and more heavy...you feel gravity pulling them down...letting go of all tension. You are becoming more relaxed and you can feel your face begin to let go...let go...let go... of tension. Your forehead becomes smooth as silk...smooth as silk...your forehead feels smooth and relaxed, letting go of all tensions of the day. Letting go of every worry and concern. Your cheeks are relaxed, free of tension. Your jaw loosens and relaxes...loose and relaxed. Your jaw lets go of tension as you feel the muscles relax. Let go of any anger...any frustration as you feel your lips begin to part. Release all anger and frustration and become relaxed. Relax your neck and shoulders now...relax...relax. You are drifting deeper and deeper...deeper and deeper into total relaxation. You are feeling peaceful and calm, drifting...drifting...down...down...into total relaxation. And now you see a lovely, peaceful place in front of you. Go to this special place. Look around in your special place and notice all the shapes and colors around you. Notice how your body feels in this special place. Relaxed. Calm. In this special place you feel safe and clam...calm and peaceful. This is a place you feel confident... and you feel your value...you feel

accepting of yourself. You imagine yourself in your special place wearing a confident smile, proud of who you are. You feel positive feelings flowing through every part of your body. And now you see a blackboard in front of you. On the blackboard are old, negative labels you have been given in the past. You see them there. You are a good person...a good person...you are a good person. You are fine.... You are fine the way you are and you have always done the best you can. See those labels on the blackboard and now see an eraser in your hand...you have an eraser and erase those labels from the board...you erase each one...they are gone...they are without meaning to you now. And now you write something on the board...you write down three of your strengths and you feel good writing them. [Pause] .You appreciate these strengths because they are yours, they describe you and you see them on the board. More and more you are feeling good and strong...and now you can let go of your anger. You can let go any need for your anger. Your anger is negative so reject it...reject your anger. The anger has cost you too much...and now you can see what anger has cost you...and you are aware that you no longer need the anger. Let go of the anger...you are letting go of the system that hurts you. You think about the consequences of your acts, you try to understand the consequences of your acts and you are letting go of the old rules that hurt you. And more and more you are kind to yourself...you are a good person...a good person. You are worthwhile because you live and feel...and you feel warm and loving towards yourself...you love yourself because you are a good person. You have legitimate needs and wants...you accept your feelings. And you know now that you are free to make mistakes, it is fine to make mistakes...you do the best you can...you always do the best you can within the limits of your awareness. Today you like yourself more than

yesterday and tomorrow you will like yourself more than today. And tomorrow you will be able to believe more of the positive about yourself...you will remember more and more the positive about yourself. And these positive feelings will stay with you and grow stronger and stronger...the positive feelings will group stronger tomorrow and the day after tomorrow. You feel very relaxed and you know that you will think before you jump to conclusions. You have the upper hand over your anger. You will overcome your anger. You feel very relaxed, very peaceful. And in a few moments you will come back to full conscious awareness feeling stronger and more positive... feeling confident and strong...feeling more accepting of yourself. And in a few moments you will come back up from one to ten. You will come all the way up feeling alert, refreshed and wide awake...you will feel completely alert and awake...you will feel relaxed and renewed when you come all the way up...one ...two...coming up...three...four...feeling more and more alert...five...feeling refreshed...six...coming up to full consciousness...seven...alert and more awake...eight...opening your eyes...nice...ten... fully alert, refreshed, and wide awake.

