

An In-Depth Look at Anger Solutions™

Introduction

About the Anger Solutions™ Program

The Anger Solutions™ Program was developed out of an expressed need for a comprehensive anger management program that would serve the needs of individuals dealing with a mental illness. Due to contributing factors such as the side effects of medications, varying degrees of cognitive functionality, and in some cases, a decline in mental/emotional stability for the client group, the program needed to be:

1. simple and easy to understand
2. presented in a way that would enable the clients to assimilate their new skills
3. hands-on vs. theoretical in its approach
4. flexible enough to meet the diverse needs of the client group
5. deliverable in a 1-hour format over 10 to 12 weeks

From this initial need, the following philosophy and program format was developed over four years of research and practical application:

1. To keep the program simple, it uses as little technical jargon as possible - keeping it at about the Grade 6/7 level of literacy/understanding (the same as daily newspapers)
2. The program follows the Psycho-Social Rehabilitation Model of Lifeskills acquisition and application in order to ensure the repetition and steady building of new skills
3. The Anger Solutions™ Program uses the WIT Model (Whatever It Takes) to reach its participants - successfully and effectively combining four evidenced-based approaches: Cognitive Behavioural Therapy, Rational Emotive Behaviour Therapy, Reality Therapy (Choice Theory), and Solution Focused Therapy. This not only provides us with various hands-on tools we can apply within the program, but also creates a level of flexibility to work within the individual needs of the client group.
4. The program was designed to be deliverable in one - 1.5 hour modules over a 10-week period. It can be condensed to an 8 week program or extended to 12 weeks.
5. Note that over the initial 4 years of study and use, the program's content evolved in order to meet the needs of a more diverse group (including children, people with Acquired Brain Injury, addictions, corrections, and developmental delay); however, the philosophy and structure has remained the same.
6. The program's wholistic approach addresses pre-cursors to anger development including:
 - poor self-esteem
 - poor communication skills
 - assertiveness training
 - ingrained anger styles, faulty beliefs, personal choice, and misperceptions about anger

Anger Solutions™ Objectives and Expected Outcomes:

1. To educate and empower each participant to make right choices about their anger
2. To encourage the taking of responsibility for one's feelings and actions (vs. laying blame on outside influences)
3. To effect a significant reduction in harmful, inappropriate behaviour on the part of the participant OR to completely eliminate target behaviours identified by the participant
4. Participants will experience an increase in their ability to identify the precursors to their own anger, and will be able to make conscious choices both before anger escalates, and in situations of escalated anger

Typical outcomes that can be expected as a result of successful completion of the program include but are not limited to:

1. Significant increase in self-esteem
2. Decrease or discontinuation of use of drugs or alcohol as self-medication
3. Self-reported improvement in overall quality of life of participants
4. Improvements in quality of mental health
5. Significant decrease in physical ailments and physiological effects of stress
6. Significant reduction or in some cases, complete elimination of target behaviours identified by the participant(s)
7. A marked decrease in participant contact with the law

Comparative Analysis of Anger Solutions™ and Current Programs:

Measuring Success:

One of the great missing pieces of the traditional anger management puzzle is the answer to the question: “How do we know it works?” There are no comprehensive statistics about how many anger management programs are currently in use in Canada or in North America, or the rest of the world! We do not know for sure what therapeutic models are being used for anger management, although the most widely embraced is Cognitive Behavioural Therapy. Other methods include Jungian storytelling, and traditional psychotherapy. It is hard to say how successful anger management programs truly are, as there have been no comprehensive studies in this respect either. We could assume that anger management has experienced some success over the years, due to the fact that they continue to run and to receive referrals; however, how successful are they exactly, and how can we know for sure?

Most programs use some form of assessment at intake and exit - again, these assessments are not standardized - some create their own, others will use validated assessments but again, there is a great deal of variance across the board, so it is hard to say what anger management does for participants.

- ❑ Does anger management help with the reduction of aggressive and/or violent behaviour?
- ❑ Does anger management result in a more positive self-esteem for participants?
- ❑ Do people who participate in anger management become more aware of their emotions and the precursors to their angry responses?
- ❑ Do people going through the correctional system experience a reduction in recidivism as a result of anger management?
- ❑ Do people with addictions experience a reduction or an elimination of their drug/alcohol dependency as a result of anger management?

We could ask many more questions like this, and have to search all over for the answers. Through the Anger Solutions™ network of facilitators and certified trainers, the search becomes easier. Participating agencies and private practitioners use the same standardized, validated assessment tools at intake and at exit, and relay the results of each group back to BRC. Over time, this will provide a great body of research to show the success of Anger Solutions™ in a variety of settings - mainly, mental health, addictions, and corrections.

Currently we use two standardized assessments:

The Clinical Anger Scale - to measure the level of clinical anger at intake and exit

The Rosenberg Self-Esteem Scale - to measure the client's self-reported perception of his/her self-esteem at intake and at exit.

The third assessment is one that I created: The Anger Solutions™ Intake and Exit Surveys - to assess the participant's level of self-awareness of their emotions and precursors to their behaviours. It also measures the frequency of inappropriate expressions of anger at intake as compared to exit.

A Multi-Pronged Approach:

The most commonly used approach anger management program is the Cognitive Behavioural approach. This model employs a single approach (Cognitive Behavioural Theory) to the issues of anger and aggressive behaviour. It examines the link between thought and behaviour, and applies a fairly intellectual approach to thought changes and behavioural choices.

Anger Solutions™ applies a variety of methodologies with the understanding that there are different thinking styles and that people communicate differently. For example some individuals learn better by listening to others speak (storytelling, seminars, lectures, audio books) because they are auditory processors. Others who are more kinesthetic, respond to triggers that evoke feeling; they prefer hands-on learning activities rather than “book learning”; and they may express themselves more openly and use more feeling words. Visual learners respond to pictures or word-pictures, they “see” things as they are being explained, and if they cannot visualize what they are learning, it will not make as much sense. In recognition of the different learning styles and behavioural styles, Anger Solutions™ utilizes a diversity of approaches in order to reach each type of individual. The program can easily be adapted to meet the needs of a particular style in the case of individual counseling, but is also flexible enough that it will engage each member of a group despite his/her particular learning or behaviour style.

Andrews and Gavreau (1990; 1992) found that the three factors contributing to positive outcomes across both institutional and non-institutional programs were; interpersonal skills training, individual counselling and behavioural programs. Andrews also found that cognitive-behavioural oriented interventions and increasing sophistication regarding style and type of intervention characterized the most promising programs. Anger Solutions™ effectively combines interpersonal skills training and behavioural programming with individual or group counseling/coaching. In addition, the Anger Solutions™ program could be defined more clearly as “Cognitive Behavioural Reality Therapy” - as it combines the best of both approaches within a psychosocial rehabilitation/solution-focused model of delivery. Other therapeutic approaches are intertwined into the program to support the learning styles of different participants, presenting a new twist on existing methodologies.

Whereas the main focus of CBT-based programming is Interpersonal Problem Solving, the main focus of the Anger Solutions™ program is to challenge beliefs, thereby modifying behaviour. Similar to the CBT approach, Anger Solutions™ sees belief (not just thought) as the basis of action. Therefore the goal of the Anger Solutions™ program is to help participants to recognize their beliefs, to eliminate or alter the faulty ones that lead to risky behaviours or aggression, and to make informed decisions that help them to replace unwanted behaviours with positive alternatives.

In addition to addressing anger reducers, personal approach styles, communication skills, and interpersonal problem solving, the Anger Solutions™ addresses some of the pre-cursors to anger and aggression such as self-esteem, grief and coping with loss, and developing an awareness of one's own feelings. The process of Self-evaluation, a notion conceptualized by Dr. William Glasser (Choice Theory/Reality Therapy) is an integral part of the Anger Solutions™ process, as it teaches participants how to evaluate their thoughts, responses, and possible outcomes for their choices *before* acting.

One of the other key concepts in the Anger Solutions™ program is that of personal responsibility. Participants come to learn that they alone are responsible for their choices, and that if they desire better outcomes, they must choose better responses to the frustration signals in their lives. By engaging participants in the process of evaluating and choosing their responses to various stimuli, they learn to take responsibility for each choice they make; and, with improvements in self-esteem and the resolution of other underlying factors (such as grief/loss, forgiveness), participants are better able to make wiser and safer choices.

Finally, a key component of the Anger Solutions™ program is the section that deals with releasing residual anger. Participants are taught that anger is not only an emotion, but it carries with it a certain amount of energy. This energy often is displayed through behaviour (verbal or physical aggression, abuse, crying, yelling, etc.); however, these behaviours could potentially be harmful to oneself or to others. Participants are shown a variety of safe, appropriate, practical, and inexpensive ways to release residual anger so that they can truly resolve their anger on both an emotional and a behavioural level; however, these options are not taught to participants until they have acquired and begun to apply the skills of anger resolution to their lifestyle. The goal is to encourage participants to make right choices concerning their anger, with a view to resolving it - and then using the release techniques only as a way to bring their bodies' physiology back to baseline. Resources are also provided so that issues that fall outside the scope of Anger Solutions™ can be addressed at that time (e.g. addictions, eating disorders, childhood sexual abuse, etc.).

Success Rate:

A meta-analysis of CBT in the application of anger management (Beck and Fernandez) produced the following findings: based on 50 studies incorporating 1,640 subjects, it was found that CBT produced a grand mean weighted effect size of .70, indicating that the average CBT recipient was better off than 76% of untreated subjects in terms of anger reduction. Based on data compiled from participating Anger Solutions™ providers, Anger Solutions™ can boast a consistent success rate of 80% or higher.

Retention Rate:

Wilfey (1986) found that anger management programs for incarcerated women using a treatment approach based on the research of Raymond Novaco netted a retention rate of only 50%. Rucker (1991) also noted that attendance to anger management programs - again for incarcerated women - showed dwindling numbers as the weeks went by. Anger Solutions™ by comparison, maintains a fairly high retention rate - typically in a group of 10, it can be expected that two will drop out. Reports from our Anger Solutions Facilitators indicate that the majority of participants would like the program to be longer - that they enjoy the sessions, and appreciate the format of the program as well as the notion that they can choose their outcomes. Over a little more than 10 years, our retention rate continues to hover at about the 80% mark.

Case Studies

Domestic Violence turns Around

Client, age 24, male, married with one child, was estranged from his wife, facing criminal charges for domestic abuse, and going through the detoxification process for alcohol consumption. He engaged in the Anger Solutions™ Coaching program (15 weeks) on his own accord, and notified his probation officer that he had secured counseling. At intake, client was couch surfing, unemployed,

and seeking employment. Target behaviours that he identified included: verbal aggression, verbal abuse, physical aggression (swinging at people), clenching of teeth and fists, and speaking through clenched teeth (identified by others as frightening or intimidating behaviours). He secured employment soon after beginning the program, and subsequently moved into his own apartment.

At intake, his wife was denying him access to his child. Over the course of the first six weeks, his behaviour and choices had changed such that his estranged wife allowed him to begin visits with his child, first through his parents, and then with her present. He learned to evaluate his responses and to identify his feelings so that he could share them assertively with her rather than resorting to aggressive behaviours. He made the conscious choice to walk away from her when she attempted to bait him into responding aggressively, and learned to remain calm when she attempted to escalate any confrontation. He also learned to transform his automatic response of clenching his teeth and fists into the first stage of a relaxation process - first clenching, then making a conscious effort to breathe deeply, and to slowly unclench his fists and teeth; he was able to re-focus his attention to relaxing his physiology and working towards an ideal outcome, rather than “getting his way” in the short term. By learning to release his residual anger in constructive ways, he no longer felt the need to lash out at his wife. At exit, the client was gainfully employed, on the road to reconciling with his wife, and had open access to his daughter.

Four years after completing the program, the client reports that he is happily married, now with two children. He and his wife have successfully come through some challenges in their relationship, and have begun to achieve the goals they have set for themselves, including purchasing their first home, and saving for a vacation. The client reports that he has not had any contact with the law since he completed the Anger Solutions Program - in fact, he states that this is the first time in his life that he has not been in jail, on bail, or on probation since the age of 14. The client has also managed to stay drug free (with the exception of a 3 week relapse) for a solid four years. ***This case was presented at the 2008 International Conference on Family Aggression in Preston, UK, and at the 2008 ICAM Conference (International Conference on Alternative Medicine and Mental Health) in Toronto, Ontario.***

Working with Resistant Participants

The Anger Solutions™ program proves to be equally effective whether applied to group or individual counseling sessions. In a group setting with 8 participants, one of the participants (retired police officer with mental health issues) who had asked to come “just to observe”, attended each session faithfully, but refused to contribute to the group. He maintained that he “never gets angry”, but was just interested in what the group was doing. The program is designed so that each module builds on the one that precedes it. We covered the first three modules of feelings, anger styles, and how anger develops. In each session, the participant was asked to contribute to the exercises and discussions, but he always refused. However, in the fourth session, (personal approach styles - aggressive, passive, and assertive behaviour), he chose to enter into the discussion, and from that point forward, was an active participant in the group. The key for him was two-fold; first, he needed to feel accepted and un-judged by his peers; second, his *beliefs* about what anger is were faulty - he believed that anger was intense negative behaviour (murder, rape, extreme violence), which is why he maintained that he “never got angry”. Once he altered his beliefs about anger, he was able to both participate freely in the group, as well as to make conscious choices about how to change his current responses to anger. Our approach with resistant participants is that they can attend as long as they do not disrupt the group. We have found over the years that even the most resistant clients will eventually make a change as they listen and learn, and eventually come to the understanding that by changing their beliefs, they can change their behaviour. This finding has been supported by the reports of Anger Solutions™ Facilitators across the province.

An Alternative Approach for Persons with ABI (Acquired Brain Injury)

The client in question was a female, 32 years of age, who had acquired a traumatic brain injury at the age of 3. At intake, she was living independently in her own apartment with assistance from family, a Supported Independent Living program (S.I.L.), the Ontario March of Dimes for employment, her neuropsychologist, and a social worker.

The client's target behaviours included verbal aggression, kicking, name-calling, throwing things, and threatening physical behaviours.

The goals of the program were as follows: to increase client awareness of physiological and behavioural cues; to increase her awareness of her own feelings; to decrease the frequency and intensity of target behaviours; to increase her assertiveness skills, and to increase her ability to discontinue target behaviours independently.

Program Goals Achieved (after approximately 15 weeks)

- awareness of cues increased
- awareness of feelings increased
- target behaviours decreased (verbal aggression, name-calling, and threatening physical behaviours decreased; kicking, and throwing things were eliminated by end of program)
- assertiveness skills increased
- ability to cues self to discontinue target behaviours increased significantly

The Anger Solutions™ program was implemented in 1997 with this client, at which time; she was receiving service from residential housing support, case management, an interdisciplinary team including family physician, neuro-psychologist, and employment counselors from the Ontario March of Dimes. The Ontario March of Dimes employment counselor assisted with implementation of the program for the sake of enabling the client to transfer her newly acquired skills to both social and employment situations.

The program was tailored somewhat to meet the client's particular learning needs (stemming from her acquired brain injury). This client was unable to secure employment because of anger issues, and often displayed target behaviours in public, making her an unpredictable (therefore unsuitable) candidate for employment. The client is the youngest in a large family with a long history of dysfunction, and a tendency to all react with inappropriate behaviours when experiencing anger. They did not buy in to the benefits of the program at first, and could not understand why the client needed assistance; after all, she behaved exactly like they did. Once they began to see the behavioural changes, they became strong supporters of the programming, and assisted wherever possible to deliver messages to the client that were consistent with the program goals.

The client's family observed a significant decrease in the occurrence of target behaviours when interacting with the client. Case managers and relief workers also noted improvements in the areas described under "Program Goals". The client herself indicated that she was able to cope with irritants much better, and had a higher frustration tolerance. She could also identify the inappropriate behaviours that came from family members, and acknowledged making conscious choices not to reciprocate their behaviours.

The last reports I received from the current case management team (2004) stated that the client is gainfully employed on a part time basis at a local McDonalds, continues to live on her own (with limited S.I.L. support), and is experiencing continued success in her emotional control as well as in interpersonal relationships with family and her interdisciplinary team. ***This case was first presented at the 1998 Inter-urban Conference on Brain Injury in Ottawa, Ontario.***

Authorized Anger Solutions™ Providers

The Anger Solutions™ Program has been received in training by over 100 agencies/private practitioners in more than 15 cities across Ontario. Since introducing the Train the Trainer (T3) program in 2005, we have trained and certified 42 trainers in Cornwall, Ottawa, Kingston, Peterborough, London, Napanee, Haliburton, and Niagara. We also have Certified Trainers in Newfoundland, Nova Scotia, and in the islands of Trinidad & Tobago.

Some of the agencies currently using the Anger Solutions™ program as part of their core services include:

- ❑ Eastern Health - St. John's, Newfoundland
- ❑ Division of Education, Youth Affairs & Sport - Trinidad & Tobago
- ❑ John Howard Society - Peterborough
- ❑ John Howard Society - Ottawa
- ❑ Montfort Hospital - Ottawa
- ❑ Youth Services Bureau - Ottawa-Carleton
- ❑ Amethyst Womens Addiction Treatment Centre - Ottawa
- ❑ Mohawk Council of Akwesasne - Cornwall
- ❑ Canadian Mental Health Association - Cornwall
- ❑ Canadian Mental Health Association - Oxford County
- ❑ Canadian Mental Health Association - Sault Ste. Marie
- ❑ Mission Services of London - London, Ontario
- ❑ Point in Time - Haliburton, Ontario
- ❑ Mental Health Services - Belleville and area
- ❑ Lennox & Addington Community Mental Health Services - Napanee
- ❑ Child and Youth Wellness Centre - Brockville

The program is also in use by various counsellors in private practice, and has been facilitated in a one-day basic training format to students of the Addictions Counselling Program at CDI Colleges in Hamilton, Ottawa, and Windsor, Ontario, and the Ontario Association of Social Workers Niagara Branch. Since 2007 Anger Solutions™ has been a part of the online curriculum at TAPE Educational Services, based in Toronto. Anger Solutions™ is recognized by the Centre for Excellence in Children's Mental Health as evidence-based.

Respectfully submitted by,

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