

University of Southampton
Doctoral Programme in Educational Psychology

Title: Using Cognitive-Behavioural Approaches to Anger Management
with Young People - An Academic Critique

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Case outline

Dominic is in Year 11 and has been attending a Grammar school since Year 7 (*Please note, names and any other information that could identify the child have been changed throughout this document*). The Special Educational Needs Coordinator (SENCo) raised Dominic for Educational Psychology (EP) involvement, while I was attached to the school as the link Trainee Educational Psychologist. The SENCo described long-standing concerns regarding Dominic's behaviour. Specifically, she described Dominic as having an "explosive temper", reporting he would "storm off" from class and had damaged school property (e.g. punching a hole in the wall). Dominic was known to the Educational Psychology Service; he had been observed by an EP while he was in Year 7 and engaged in individual assessment (exploring his resilience) in Year 9. Previous EP recommendations had been implemented and focused on developing Dominic's sense of belonging and self-esteem.

However, the SENCo reported that Dominic's behaviour had escalated since he had been in Year 11 and he had recently received a fixed term exclusion from school for physical aggression towards a peer. This was the first time Dominic had physically assaulted someone and as a result, he had tried to avoid coming to school in fear that he may hurt someone else. Furthermore, Dominic disclosed that he had engaged in self-harming behaviours and had requested support managing his feelings. Consequently, the SENCo had made a referral to the Child and Adolescent Mental Health Service (CAMHS). However, she was unsure how long Dominic would be on the waiting list before receiving support; thus, enquired as to whether I could become involved.

I raised the case in supervision and my supervisor suggested I contact the local CAMHS provision. Thus, I telephoned the service and discovered it was likely that Dominic would not receive support from CAMHS for approximately 6-12 months. Hence, we agreed it would be appropriate for me to become involved in the meantime. As a result of information

gathering, it was decided that I would engage in a cognitive-behavioural anger management intervention (consisting of 6 weekly sessions, each lasting 1 hour). This was based on material from my initial training in Cognitive Behavioural Therapy (CBT) at University and from the 'Think Good, Feel Good' resource (Stallard, 2003).

Introduction

The current academic critique will explore the use of cognitive-behavioural approaches to anger management (herein referred to as CBAM) with young people. However, first, it will explore the wider debate regarding the use of anger management interventions. Next, it will explore the use of CBAM interventions and the evidence-base for them. Finally, the author will summarise the findings, discuss implications for Educational Psychologists (EPs) and outline the outcome of Dominic's case.

Anger Management Interventions: A wider debate

It is important to acknowledge the wider debate regarding whether we should be using psychotherapeutic anger management interventions with young people. Advocates of anger management argue such interventions are needed considering the short and long-term implications of uncontrolled anger. In the short-term, researchers have identified pupils exhibiting anger problems are at risk of temporary or permanent exclusion from school (Snyder, Kymissis & Kesser, 1999) and engaging in delinquent behaviour (Aseltine, Gore & Gordon, 2000). Furthermore, in the long-term, researchers have found uncontrolled anger is associated with various outcomes, such as, substance abuse, domestic violence, mental health difficulties and health problems (Deffenbacher, Lynch, Oetting & Kemper, 1996). Moreover, researchers have found that when children become aggressive at an early age, the tendency towards violent behaviour tends to remain relatively stable and resistant to intervention

(Whitfield, 1999). Hence, advocates of anger management argue we should be engaging in early intervention to support young people to manage their anger (Humphrey & Brooks, 2006).

In contrast, there are individuals who oppose anger management interventions. For example, Paul (1995) views anger as a “natural, healthy, appropriate, life-enhancing emotion” (p. 2). In addition, Paul (1995) proposed children’s anger is often a response to distress and hence, argued it is a “great communicator” (p. 11). Similarly, Dr. Tana Dineen argues anger can be positive and states:

It used to be thought of as a generally normal and common emotional reaction evoked by something in the external world that the person thinks is wrong. If attention is paid to that, rather than to the internal situation, certainly anger can spur people on to actions that produce positive change (O'Neill, n.d., p. 2).

Therefore, opponents of anger management argue it is a natural emotion; hence, we should try and defend anger from psychological theories and treatments.

What are Cognitive-Behavioural approaches to Anger Management (CBAM)?

Cognitive behaviour therapy (CBT) is a psychotherapeutic intervention, which aims to reduce maladaptive behaviour and psychological distress by altering cognitive processes (Kaplan, Thompson & Searson, 1995). CBT is based on the underlying assumption that affect and behaviour are largely a product of an individual’s cognitions (Kendall, 1991). CBT is used with young people and adults, with a wide range of difficulties (e.g. anxiety, depression, school refusal and pain management) (Stallard, 2003). However, this academic critique will focus on cognitive-behavioural approaches to anger management (CBAM).

According to Durlack, Fuhrman and Lampman (1991) CBAM is an ‘umbrella term’ for a range of interventions that can be offered in various sequences and permutations.

However, CBAM interventions are based on the theoretical assumption that anger is caused by maladaptive thinking patterns (referred to as cognitive distortions or deficits) which mask an individual's core belief about themselves and their surroundings, triggering emotional and behavioural responses (McGinn & Sanderson, 2001). Such cognitive distortions may include biased attributions, where the individual incorrectly interprets social situations (Ho, Carter & Stephenson, 2010); hence, several CBAM interventions with young people take a social-cognitive perspective and also address social skills (Sukhodolosky, Kassinove & Gorman, 2004). However, CBAM interventions with adolescents initially emerged from Meichenbaum's (1977) work on self-talk strategies with adults and Novaco's (1975) work on anger management with adults (Humphrey & Brooks, 2006; Sukhodolosky et al., 2004). Specifically, this work involved stress inoculation training (SIT), where interventions are typically structured into three phases: cognitive preparation; skill acquisition; and application training (Beck & Fernandez, 1998).

Although these approaches have been modified for use with young people, their basic principles still guide the therapeutic process. Thus, CBAM interventions with adolescents typically involve: providing information on the cognitive and behavioural approaches to anger; teaching cognitive and behavioural skills/techniques to manage anger; and facilitating the application of newly acquired skills (Humphrey & Brooks, 2006). This includes several commonly used components: self-instruction; problem-solving; relaxation; affective education; specific coping strategies; and self-evaluation (Ho et al., 2010). Furthermore, this is often supplemented with other techniques, such as, building an anger hierarchy, cognitive restructuring (i.e. teaching alternative thinking and challenging biased expectation) and stress inoculation (graduated exposure to anger triggers to develop individuals' tolerance) (Taylor & Novaco, 2005).

What is the evidence-base for using CBAM interventions with young people?

Since the 1970s, CBT interventions have emerged as the most common approach to anger management (Beck & Fernandez, 1998). However, Humprey and Brooks (2006) argued there is a lack of studies investigating the effectiveness of CBAM interventions with young people, in relation to the scale of the 'problem'. Nonetheless, Beck and Fernandez (1998) conducted a meta-analysis of 50 nomothetic studies investigating the effectiveness of CBAM interventions (with a total of 1640 participants). The researchers found a weighted mean effect size of 0.70, which is suggestive of moderate treatment gains. Hence, it can be inferred that CBT participants were better off than 76% of participants in the control group. This finding was statistically significant and was relatively homogenous across the studies. However, it should be noted that participants were a mix of adults, children and adolescents. Moreover, as the studies were predominantly clinical research (e.g. with prison inmates, young people in juvenile detention centres and adolescents in residential treatment) it is difficult to establish the generalisability of findings to naturalistic settings. According to Snyder et al. (1999) this limitation is a common criticism of CBAM interventions with young people.

Sukhodolosky and colleagues (2004) conducted a more recent meta-analysis specifically investigating the effectiveness of CBAM interventions with children and adolescents. This meta-analysis included 21 published and 19 unpublished studies (with a total of 1953 participants). The researchers found the mean effect size was within the medium range (Cohen's $d = 0.67$), which was comparable with the effects of other meta-analyses of psychotherapy with young people. Hence, concluded CBT interventions were an effective intervention for young people with anger-related difficulties. However, Sukhodolosky and colleagues found the effectiveness of interventions varied according to the target of the intervention and the predominant therapeutic techniques used. Specifically, skills training (d

= 0.79) and eclectic interventions ($d = 0.74$) were significantly more effective in reducing aggressive behaviour than problem-solving ($d = 0.67$) or affective education ($d = 0.36$).

However, it should be noted that the inter-rater reliability of coding into the four treatment types was limited by insufficient description of the intervention and poor treatment integrity in many of the studies. Thus, this should be considered when generalising the findings.

Furthermore, we are unsure about the generalisation of findings from clinical research to naturalistic settings and the long-term implications of findings.

. Thus, despite some methodological limitations, meta-analyses indicate positive effects of CBAM interventions with young people. However, it is fundamental to recognise the multitude of factors which influence their effectiveness. The current academic critique will now explore several of these factors: length of the intervention; ‘treatment readiness’; format; and cultural and community factors. These factors have been chosen as they have received considerable discussion within the literature and are deemed relevant for EPs working with young people in schools.

Length of the intervention

Early research into CBAM interventions identified a trend whereby the longer the intervention, the greater the reduction in anti-social and acting-out behaviours (e.g. Nugent, Champlin & Wiinimaki, 1997). Lochman (1992) argued this was based on the assumption that life scripts are likely to be resistant to ‘quick-fix’ approaches. However, this perspective has been contended by more recent studies. For example, in a meta-analysis, Sukhodolovsky and colleagues (2004) found treatment duration (ranging from 2-30 hours) had no significant influence on the findings. Moreover, several researchers have sought to investigate the effectiveness of brief CBAM interventions with adolescents. This is based on pragmatic

considerations i.e. as CBAM interventions are often implemented when a young person is at risk of exclusion, a longer intervention may not be possible (Humphrey & Brooks, 2006).

In line with this argument, Snyder and colleagues (1999) condensed a ten to twelve session CBAM intervention into four sessions, delivered over two weeks to 50 adolescent psychiatric inpatients in New York. The researchers found participants' anger ratings on self-report questionnaires significantly decreased following the intervention (in comparison to a control group). In addition, behaviour ratings by hospital staff and teachers indicated participants generalised the skills learnt to both hospital and classroom settings at the end of the intervention. However, the researchers were unable to analyse findings at a four to six week follow-up (due to insufficient data); thus, the long-term implications of the intervention are unknown. Similarly, Humphrey and Brooks (2006) conducted an evaluation of a four-week CBAM intervention with twelve UK adolescents (aged 13-14 years) who were at risk of exclusion from school. Analysis of teacher observations (using the Revised Rutter Scale for teachers) revealed a significant improvement in behaviour following the intervention. Furthermore, improvements in 'conduct', 'emotional' and 'pro-social' domains were maintained at a four week follow-up. Thus, Humphrey and Brooks (2006) are 'cautiously optimistic' regarding the effectiveness of brief CBAM interventions. However, it is evident that further research is needed to explore the long-term implications for young people.

'Treatment readiness'

Although it has not received a great deal of attention in the literature, several authors (e.g. Deffenbacher, 1999; Howells & Day, 2003) have identified 'treatment readiness' as an important factor influencing the effectiveness of anger management interventions. Howells and Day (2003) refer to 'low readiness' as, 'characteristics (states or dispositions) within either the client or the therapeutic situation, which are likely to impede engagement in

therapy and which, thereby, are likely to diminish therapeutic change’’ (p. 320). Theoretically, this is based upon the ‘stages of change model’ (Prochaska & DiClemente, 1992). This is a model of motivation, which proposes that individuals move through identifiable stages of change (pre-contemplation, contemplation and action) as they move to resolve a problem.

With regards to anger management, Howells and Day (2003) argued readiness for change can be influenced by a variety of factors, such as, existing beliefs about an anger ‘problem’, being pressured to engage in intervention and lack of understanding of the communicative function of the anger. Although Howells and Day’s discussion focuses on anger management programmes in clinical adult populations, this factor is particularly important when considering CBAM interventions with young people in schools (as young people rarely refer themselves for EP support).

Furthermore, the readiness for change literature raises interesting discussions regarding the therapeutic alliance between the ‘client’ and ‘therapist’. Researchers argue unless individuals are ready to undergo anger management intervention, they are unlikely to be successful as it will prove difficult to establish a therapeutic alliance (Humphrey & Brooks, 2006). This is particularly important as researchers have consistently identified a therapeutic alliance as a significant predictor of intervention outcome across a variety of ‘therapies’ with a range of different client groups (Howells & Day, 2003).

Thus, despite limited research within the anger management literature, readiness for change certainly appears to be an important factor to consider when implementing CBAM interventions with young people.

Format (group vs. individual interventions)

Some researchers have compared the effectiveness of CBAM interventions with young people in different settings. In a meta-analysis, Sukhodolosky and colleagues (2004)

found only six of the 51 studies used an individual format, suggesting group interventions tends to be the method of choice (in the U.S. context). This is likely to be explained by the cost effectiveness of group interventions. In a literature search, there were very few studies investigating this factor. However, early research (e.g. Casey & Berman, 1981) concluded individual and group formats were equally effective for anger-management interventions with young people. Nonetheless, more up to date research, in U.K. school contexts is needed.

Cultural and community factors

In addition to considering contextual factors regarding participants and the nature of the intervention, Akande (2001) argues it is fundamental to recognise wider cultural and community factors that influence individuals' expression of anger. However, Lindsay (2003) argued until recently there has been a tendency within the literature to pathologise emotional and behavioural difficulties in young people. This perspective roots the difficulty as within-child and thus, ignores the influence of environmental factors. Nonetheless, Humphrey and Brooks (2006) found participants reported their triggers of anger were 'deliberate attempts' by teachers to 'infuriate' them. Hence, it is fundamental practitioners consider whole-school change as well as teaching young people specific skills to manage their anger. This approach fits with the multi-element model of behaviour commonly used by EPs, which proposes behaviour management should focus on environmental change, teaching new skills and reinforcement (LaVigna & Willis, 1995).

Summary and Implications for EPs

Overall, meta-analyses suggest positive outcomes of CBAM interventions for young people. However, it is important to acknowledge methodological limitations, such as, the generalisability of findings. Thus, further research is needed to evaluate school-based

CBAM interventions in the U.K. context. Furthermore, it is fundamental to consider that there is a lack of research investigating long-term implications of CBAM interventions. Moreover, when implementing CBAM interventions, EPs need to consider various ethical implications. Firstly, EPs should acknowledge the wider debate regarding whether we should be using anger management interventions with young people; and thus, in line with the health and care professionals council (HCPC) standard of conduct, performance and ethics (HCPC, 2012) EPs need to ensure any intervention is implemented within the best interest of the young person. In addition, researchers indicate EPs need to consider young people's 'readiness for change'; hence, if the young person has been referred for EP involvement by another individual, the EP needs to clearly explain the CBAM intervention to the young person to determine whether this is something they are happy to engage with. Moreover, researchers have emphasised the importance of a 'therapeutic alliance', hence, EPs need to use skills from their training (e.g. active listening) to establish a positive relationship with the young person. Finally, it is fundamental EPs implement the CBAM intervention alongside wider ecological change and use conciliation skills (e.g. positive reframing) to enable school staff and parents to see more interactionist influences on young people's behaviour (i.e. rather than attributing difficulties as a within-child 'problem').

Outcome of the case

The CBAM intervention was deemed appropriate for Dominic given he was explicitly requesting support managing his feelings (thus, was considered 'ready' for change). Impact of the intervention was monitored and evaluated using solution-focused scaling. Firstly, Dominic stated he wanted to learn how to stop himself from bottling up his feelings; secondly, he wanted to learn how stop himself from getting "overly angry". By the final session, Dominic had reduced both scores to a 'good enough' level. In addition, Dominic's father

telephoned school staff to report noticing a positive improvement in Dominic's ability to manage his feelings. This was also reported by Dominic's key worker in school. In order to investigate the generalisation of the skills learnt from the intervention, I reviewed Dominic's progress at an eight week follow-up. School staff reported Dominic had generalised and maintained these skills and there had been no 'outbursts' at school. Unfortunately, it was not possible to meet with Dominic (as he was on study leave) but it was positive to hear that things were going well for him and that he had secured a place at college on his chosen course. Hence, despite the methodological and ethical considerations that must be made before implementing an intervention, it appears that, in this case, the CBAM intervention was positive in helping Dominic to meet his goals.

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