Evaluating the Effectiveness of an Anger and Aggression Awareness Counselling Program to Increase Coping Skills for At-Risk Youth

by

Sarah Lacombe

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DEDICATION

I would like to dedicate this work to my parents for their unconditional love and support throughout this journey.
ABSTRACT
Anger is a complex emotional construct, which is comprised of cognitive, behavioural, and physiological components; it can be expressed both physically and verbally. Managing anger appropriately continues to be a growing concern for children and adolescents because of the negative consequences associated with aggressive behaviour. Without intervention, angry and aggressive youth are put at an increased risk of delinquency, academic failure, substance abuse, and disruptive behaviour disorders. It is, therefore, crucial to ensure that they are receiving appropriate interventions. This study evaluated whether an individual counselling program targeting anger and aggression awareness for at-risk youth in an alternative community school setting would increase the youths’ abilities and skills to deal with their anger and aggression in a pro-social way, which would further decrease levels of aggressive behaviours. The cognitive-behavioural focused anger and aggression awareness individual counselling program (primarily focusing on identification of physical indicators of anger, relaxation strategies, and cognitive restructuring) was designed based on an unevaluated manual (Nash, 2008) previously created for the alternative school program. The counselling sessions were delivered over an eight-week span with one-hour sessions per week. To evaluate the effectiveness of the counselling program for the participants, four pre-treatment and post-treatment assessments were administered. The findings of the study did not support the hypothesis; various explanations and discussion of possible reasons as to why the findings were not supportive were outlined. Recommendations for future research included implementing the program consecutively for 8 weeks without combining or omitting sessions, providing contingencies for completion of homework and anger logs, and lastly, incorporating more observable methods of data collection so that there could be more objective evidence of effectiveness than just self-report measures.
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Chapter I: Introduction

Overview
This study was administered at an alternative school program in the community that provides academic and nonacademic support for adolescents who have been suspended or expelled from regular school. The program was for both female and male students between the ages of 10 and 17. The students were suspended or expelled from the schools for a variety of reasons such as, drug use, truancy, uttering threats, and most often, some form of physical violence.

A manual was created specifically for the program to promote anger and aggression awareness amongst the youth. Unfortunately, this manual never had the chance to be implemented in the classroom or evaluated for its effectiveness. Thus, the agency/program had an interest in implementing and evaluating the effectiveness of the manual.

Rationale
Anger is a complex emotional construct, which is comprised of cognitive, behavioural, and physiological components; it can be expressed both physically and verbally. School-aged children and adolescents who show a tendency to display aggressive behaviour have a greater likelihood of being disciplined at school in ways such as detention, suspension, or expulsion (Stanley, Canham, & Cureton, 2006).

For the purpose of this study, at-risk youth refers to children and adolescents with problem behaviours who have been suspended or expelled from school. Alternative school programs help the youth stay on track with academic work, as well as build cognitive skills that can help to integrate the youth back into mainstream schools. According to Kellner, Bry, and Salvador (2008), at-risk youth who do not receive help regarding their aggressive behaviours are more likely to engage in risky behaviours. Furthermore, Blake and Hamrin (2007) stated that children who display aggression might be more likely to be headed towards a path of delinquency, academic failure, antisocial behaviour, and conduct problems. In late adolescence, youth who display aggression are at a higher risk for early substance abuse and overt delinquency. Thus, there is a need to provide these at-risk youth with interventions that provide them with appropriate skills to regulate their anger. Fossum, Handegård, Martinussen, and Mørch (2008) stated that there is still a need for further research in effective outpatient interventions for at-risk children and especially adolescents.

It was hypothesized that the implementation of a counselling program on anger and aggression awareness for at-risk youth in an alternative community school setting would increase their ability and skills to deal with their anger and aggression in a pro-social way, which would further decrease levels of aggressive behaviours.

Synopsis
This thesis includes a thorough review of the literature regarding the issues surrounding anger and aggression in at-risk youth. It reviews best practices that are used in individual counselling programs for anger and aggression. The implementation and assessment are
discussed in the methodology section of the report. The setting, participant, and materials are also described in this section. The findings of the study are described in the results section, while strengths and limitations are presented in the discussion section of the report.
Chapter II: Literature Review

Anger and Aggression in At-Risk Youth

According to Stanley, Canham, and Cureton (2006), emotional and behavioural needs of youth are becoming a growing concern for professionals and school boards. With the increase of these problems, schools are seeing an increase of disruptive behaviours such as aggression. These issues generally result in the suspension or expulsion of the students who may be referred to alternative schooling. Often times these students only face punishment and do not receive treatment for the issues. When anger and aggression problems are left untreated in youth, they are at an increased risk of delinquency, academic failure, and drug use (Stanley et al., 2006). They also may lead to or increase family and social instability (Hains, 1989). Adolescent anger and aggression may be precursor to severe disruptive behaviour disorders such as Oppositional Defiant Disorder (ODD) and Conduct Disorder (CD). ODD describes youth who engage in age-inappropriate characteristics of stubbornness, hostility, and defiant behaviours. CD describes youth who repeatedly and persistently show a pattern of severe aggressiveness and antisocial acts such as inflicting pain on others, physical and/or verbal aggression, and stealing (Mash & Wolfe, 2005).

Managing anger appropriately continues to be a growing concern for children and adolescents because of the negative consequences associated with the aggressive behaviour. It is, then, crucial to ensure that they are receiving appropriate interventions. In a meta-analysis study conducted by Wilson, Lipsey, and Derzon (2003), anger-based programs in schools were shown to be most effective when programs incorporated behavioural approaches and counselling, whereas multimodal and peer mediation interventions showed a lesser effect. Furthermore, Blake, and Hamrin (2007) stated that cognitive behavioural therapy-based groups reduced the frequency and severity of behavioural problems among children with disruptive behaviour disorders, such as oppositional conduct disorder.

Cognitive-Behavioural Approach

Cognitive and behaviour therapies (CBT) use techniques that are based on scientific evidence to understand and treat a variety psychological symptoms and disorders. According to Blake and Hamrin (2007), cognitive-behavioural techniques are the most widely studied and empirically validated treatments for anger and aggression in youth. Some of the techniques most often used include cognitive restructuring, relaxation strategies, social skills training, and arousal management. Anger programs based on CBT use these techniques to encourage their participants to alter their thinking patterns and replace aggressive behaviour with prosocial behaviour.

Beck and Fernandez (1998) conducted a meta-analysis of 50 cognitive-behavioural programs for the treatment of anger. They used a computer search of PSYCINFO and Dissertation Abstracts International from 1970 to 1995. Keywords such as anger control, anger treatment, and anger management were use to find articles as well as cross-references. Only cognitive-behavioural treatments were selected, where as studies using only a cognitive approach, a behavioural approach, or a relaxation approach were excluded from the meta-analysis. The authors included published and unpublished studies in their meta-analysis. The studies generally included some combination of cognitive restructuring, problem-solving, anger control, relaxation, and role-plays. After the search was conducted, a total of 50 relevant studies
were included in the meta-analysis, 40 used control groups, and 10 used a single-group, repeated-measures design. From the 50 studies, there were 1640 subjects who were predominately clinical – prison inmates, abusive spouses and parents, college students with anger problems, mentally handicapped clients, juvenile delinquents, adolescents in residential settings, and children with aggressive classroom behaviour. The studies generally used self-report measures or behavioural ratings to evaluate the dependent measures.

To calculate effect size Beck and Fernandez (1998) calculated the Glass’s $d$ where means and standard deviations were available for treatment and control groups. For single-subject, repeated-measures design studies or those without standard deviations and means, the effect size was calculated from $t$- and $f$-values. Furthermore, all 50 studies were weighted by sample size and averaged to produce a grand weighted mean $d$.

With only one exception, all effect sizes were positive in value. The grand weighted mean $d$ effect size was 0.70, which means that the average subject in the CBT treatment condition fared better than 76% of those not receiving CBT. Subjects receiving CBT experienced a 67% treatment success rate where as control subjects had only a 33% success rate. Thus, the meta-analysis conducted by Beck and Fernandez (1998) revealed that the use of CBT for the treatment of anger is justified by its effectiveness in achieving desired treatment goals. Furthermore, since the populations investigated in this meta-analysis included a broad range of individuals experiencing anger and aggression issues, it was demonstrated that CBT has a general utility in the treatment of anger.

To further support the effectiveness of implementing CBT to individuals with aggression issues, Sukholdosky, Kassinove, and Gorman (2004) also conducted a meta-analysis looking at the use of CBT for anger and aggression programs and its effects on the participants. The techniques looked at in this analysis included affective education (emotion identification and relaxation training), behaviour modification (social skills training and anger control training), and cognitive skills training (cognitive restructuring). Sukholdosky et al. found an effect size ($d=0.67$) in the medium range, suggesting that it is an effective treatment for anger and youth.

**Individual Format**

Studies have shown that there are both advantages and disadvantages to individual therapy and group therapy. The initial use of CBT was on a very individual basis between therapist and client; however, in recent times, there has been a shift to using CBT in group format (Bieling, McCabe, & Anthony, 2006). There has been a shift from individual therapy to group therapy because a CBT group format can offer some benefits to the organization, therapists, and clientele. As noted by Bieling et al., a group format can offer a sense of universality for the clients because they become aware that others are facing similar difficulties. Using a group format is financially beneficial because one or two counsellors can treat more clients at the same time. Groups also allow for the use of role-plays between participants to practice skills and techniques learnt in therapy.

In contrast, according to Farmer and Chapman (2008), individual therapy has some important benefits that group therapy cannot offer. In one-on-one counselling, the counsellor is able to focus all of his/her attention on the client to establish specific goals and target behaviours. The counsellor can also provide more support in regards to homework review and concerns or
difficulties the client is experiencing. Furthermore, a therapeutic rapport between the counsellor and the client is likely to develop more quickly than in a group format. Clients may be more apt to participate and disclose in the sessions as opposed to in group due to feelings of intimidation and insecurities (Huston, 2008). Individual therapies can go at the pace needed for the client. In individual therapy, the counsellor does not need to be concerned with the challenges that come with group therapies. According to Beiling et al. (2006) the three factors that can be a challenge in group format are: patient factors, structure, and leadership. It is possible that a certain mix of patient characteristics in a group will cause issues with group cohesion making it difficult for the group to continue. In addition, the size of the group may cause challenges; for example, if the group is too big it may cause a lack of involvement for members or material may be covered too quickly. Lastly, leaders may negatively impact the group if their style is too rigid or perhaps too lax.

**Cognitive-Behavioural Techniques in Anger Management Programs**

There are many cognitive-behavioural techniques that can be used alone or in combination with one other in anger programs that can help reduce anger and aggression in the individual, as well as increase knowledge and appropriate use of social and coping skills. These techniques include cognitive restructuring techniques (self-talk, thought stopping, and cognitive distortions), behavioural techniques (relaxation training, anger logs, homework, and identifying physical indicators), and psychoeducation (information about anger and aggression).

Cognitive therapies are implemented when a person’s thoughts, interpretations, and self-statements about environmental events cause a strong effect on emotional and behavioural functioning. During treatment for anger and aggression, clients are helped to identify their irrational and distorted thoughts and are taught how to construct a more rational thought pattern (Knorth, Klomp, Van den Bergh, & Noom, 2007). Altering the internal processes help the youth to manage their experience with anger, to re-think their options, and choose a pro-social behavioural response (Feindler & Starr, 2003). Self-talk is the development of new, more effective self-statements or self-instructions; the new self-statements can change old thinking and behaviour patterns and direct new responses to problemmatic situations (Knorth et al., 2007). The aim of verbal self-instruction is to delay the aggressive reaction. Examples of self-talk include “stay calm,” “don’t take it personally,” and “what’s the problem?”. Similarly, Hains (1989) referred to self-instructions as reminders that can be used to keep the youth under control in a triggering situation or in the problem-solving process. The results of Hains study indicated that for three of the four participants, their self-instruction statements used to cope with anger at least doubled after the initiation of the anger-control intervention. Another cognitive technique focuses on cognitive distortions which are ways of thinking that can cause problems. Some examples of cognitive distortions include all-or-nothing thinking, overgeneralization, and jumping to conclusions. During anger interventions, these cognitive distortions are identified and replaced by more effective cognitive styles (Knorth et al., 2007).

Behavioural techniques and physiological training are implemented when the individual reacts to anger provoking situations in an inappropriate manner such as physical or verbal aggression. Clients are helped to recognize physical indicators and environmental situations that trigger anger and aggression. In addition, clients are taught techniques such as relaxation training to reduce these physiological effects. According to Gaines and Barry (2008), introducing the monitoring of physical indicators of anger, such as increased heart rate or sweating, allows the
youth the opportunity to recognize these physical symptoms of anger and engage in appropriate behaviours rather than resorting to aggression. Gaines and Barry state that it is important to be able to reduce a physical response when an individual is working towards the prevention of an aggressive response. In order to reduce the physiological symptoms, the youth must first be able to identify which physical indicators they experience and for which triggers.

Triggers are antecedents of behaviour, often precursors to aggressive behaviour. They can be external triggers, which are events that happen in the environment, or they can be internal which are thoughts, feelings, and physical sensations. According to Feindler and Starr (2003), the use of self-monitoring through logs or ABC charts (a worksheet that has the client look at the antecedents of the behaviour, the behaviour itself, and the consequences that result due to the behaviour) is an effective way for youth to identify triggers and physical responses. Often physical indicators begin to occur after a trigger, which leads up to the unwanted behaviour. The authors mention that it is important that the youth know that these physical responses to triggers are normal and frequently occurring for humans but they do have control over these responses. Methods that have shown to be effective in reducing physiological responses include various relaxation techniques (Feindler & Starr, 2003).

Gaines and Barry (2008) further mention that one of the most effective coping skills to reduce the physical symptoms of anger is relaxation strategies. More specifically, strategies that their study showed to be most beneficial are deep breathing and progressive muscle relaxation. Relaxation training is often used in combination with cognitive-behavioural therapy to help reduce tension and physiological symptoms caused by an anger-provoking situation, which allows the youth to shift attention to internal processes rather than the provoking situation (Knorth et al., 2007). Gaines and Barry state that when youth use relaxation techniques to reduce physical responses to anger they were able to avoid becoming angry in the first place, calm down, and to better think through and appropriately cope with the anger.

Hazaleus and Deffenbacher (1986) conducted a study that compared cognitive and relaxation coping skills interventions for anger reduction with a non-treatment control group. Results of this study suggest that both relaxation and cognitive intervention could effectively reduce anger. Also, after a four-week follow-up, participants in cognitive and relaxation groups demonstrated significantly less general anger, physical symptoms of anger and a tendency to cope with provoking situations than did the control groups. Similarly, the results of a study conducted by Deffenbacher and Stark (1992) suggest that relaxation can be an effective anger reduction intervention when delivered in a consistent training format with emphasis on careful skills development and rehearsal. More specifically, Nickel, Lahmann, Tritt, Leow, Rother, and Nickel (2005), studied the effects of progressive muscle relaxation for anger in male adolescents. They conducted the State-Trait Anger Expression Inventory (STAXI) on 252 subjects to determine which of them scored more than a 16.0 on the Anger Out. Of those 252 subjects 81 had a score greater than 16.0; of those 81 subjects, 40 were randomly selected to participate in the 8-week treatment of progressive muscle relaxation, while the remaining 41 participants formed the control group. The STAXI assessment was administered pre- and post- treatment for both groups; the adolescents in the treatment group scored lower on the assessment after treatment. Progressive muscle relaxation appeared to be effective in the treatment of anger in male adolescents.
Cognitive-behavioural therapy programs often incorporate certain tools that will help increase the effectiveness of the treatment for the clients. The tools most frequently used are behavioural role-plays, behaviour logs, goal setting, and homework. Role plays are an efficient tool for exploring aggressive behaviours and practicing alternative techniques learnt throughout the anger program such as self-talk and relaxation techniques, which increase the likelihood that these techniques will be transferred to real life situations (Blacker, Watson, & Beech, 2008). According to Beiling et al. (2006), behavioural role-plays are useful when clients are learning a new skill or technique and are not comfortable practicing/using it in real life situations. Role-plays in anger programs generally use a scenario of a triggering event that would cause the client to notice physical indicators and then the individual must use techniques learned in the group to increase the chances of using an appropriate behaviour rather than an aggressive behaviour.

Self-monitoring is used in cognitive-behavioural programs to help clients become more aware of their emotions, behaviours, triggers, and consequences. Self-monitoring is a procedure where the client collects information on behaviours in their natural environments (Farmer & Chapman, 2008). Information revealed from self-monitoring can be useful for clients and professionals. In anger programs, self-monitoring generally takes the form of journals and daily anger logs. Kellner, Bry, and Salvador (2008) state that anger logs can serve as a teaching tool, provide information on patterns regarding a specific behaviour, and can also be used as a data collection method.

Goal setting is a technique used in cognitive-behavioural therapies; this is a collaborative process between the professional and the client (McWirther & Page, 1999). Specific behavioural goals are made collaboratively between the professional and the client to obtain a sense of where the client expects to be and what the client hopes to achieve by the time the program is finished. These goals can be short term or long-term. The use of goal setting requires the youth to stay motivated to accomplish the goals.

According to Gonzalez, Schmitz, and DeLaune (2006), homework is a crucial part of CBT and is one of the reasons why it can be accomplished in such a short timeframe. They say that, by having the client complete homework, he/she is given the opportunity to practice and learn the skills, as well as discuss and challenge any difficulties the client may experience with the counsellor. This allows the client to have confidence in his/her ability to use the technique or tool upon discharge.

One example of an anger control program is that of Kellner and Bry (1999) who implemented an anger management program weekly for ten weeks with each session lasting about 30 minutes. Participants included one female and six males between the ages of 14 – 18. All participants had mild to severe anger control difficulties. Their initial sessions discussed the psychoeducational components, including the physiology of anger, physical indicators, and identifying triggers. In the following few sessions, techniques were introduced on how to reduce the physiological effects and triggers. These techniques included relaxation training and cognitive restructuring. They incorporated role-plays to help youth practice the techniques. They evaluated the effectiveness of the anger management program by having parents and teachers rate the youths’ behaviour on the Conduct subscale of the Conners’ Rating Scale one week before programming started and one month after the programming ended. In addition, the
number of incidents of physical aggression were recorded six months before and after programming. Results indicate that there were improvements on all three measures. For the teacher Conduct subscale, the students mean score was 92.57 before the program and 80.28 after the program, which was statistically significant. The parents’ Conduct subscale yielded a mean of 81.00 before the program and 65.00 after the program, which also was statistically significant. For the number of physical incidents, the youth averaged 1.28 physically aggressive incidents during the first 6 months, and .28 during the last six months, which did not yield statistical significance but was in the right direction. It may have not reached statistical significance because of only a small amount of participants were studied.

Summary

Youth who are referred to alternative school programs have been suspended or expelled from their regular schools. Many of the situations that lead up to the suspension or expulsion generally include some form of anger or aggression issues, whether it is verbal or physical. Without anger management intervention, these youth are put at an increased risk of delinquency, academic failure, substance abuse, and disruptive behaviour disorders (Stanley et al., 2006). Overall, the research has shown that an anger program based on a cognitive-behavioural approach is empirically validated. Anger programs based on CBT encourage their participants to alter their thinking patterns and replace aggressive behaviour with prosocial behaviour. Some effective techniques used in these programs include cognitive restructuring, self-talk, identifying physical indicators, and relaxation training. An important part of CBT anger programs is the use of behavioural role-plays, self-monitoring, and homework (Kellner & Bry, 1999).

The current anger and aggression awareness program utilized the techniques found in anger programs based on a CBT approach, including cognitive restructuring, relaxation techniques, role-plays, self-monitoring, and homework (Blake & Hamrin, 2007). This program took an individualized approach that provided more immediate support for the participants in regards to treatment goals and difficulties experienced (Farmer & Chapman, 2008). The current study evaluated the effectiveness of the manual specifically created for a particular agency and clientele. It was hypothesized that the implementation of an individual counselling program on anger and aggression awareness for at-risk youth in an alternative community school setting would increase the youths’ ability and skills to deal with their anger and aggression in a pro-social way, which would further decrease levels of aggressive behaviours.
Chapter III: Method

Participants

The study had two participants for the individual anger and aggression awareness counselling program. To be included in the study, the participants must have been suspended or expelled from regular school and attending an alternative school program. As well, the youth must have been between the ages of 10 and 17 years of age and displayed issues surrounding anger and aggression both in the past and present. Participant 1 was a 17-year-old male adolescent who was attending an alternative school program for students who have been suspended or expelled from their community schools. The participant had been diagnosed with Oppositional Defiant Disorder and ADHD. He was referred to the alternative school program after a physical assault of a peer. Participant 2 was a 16-year-old male also attending the alternative school program. He was diagnosed with ADHD at the age of eight and had multiple suspensions throughout primary and secondary school. He was referred to the alternative school program for uttering threats to another student, for which he was also charged by police. Both participants were further referred to the anger and aggression counselling program by the coordinator and staff at the alternative school program, due to the participants’ history of anger and aggressive behaviour both in school and in the community. Written consent was obtained from both participants and their parents/guardians before the initial session (Appendix A). The researcher explained the purpose of the study, the benefits, and the risks associated with participating in the study, and information regarding confidentiality. This was explained to the participants in a meeting at the alternative school program; a phone call was made to the parents informing them of these details and that a consent form would be sent home with the youth. Additionally, it is to be noted that the St. Lawrence Research Ethics Board approved this research study.

Design

The independent variable was the individual cognitive-behavioural focused anger and aggression awareness counselling program which was designed based on an unevaluated manual (Nash, 2009) previously created for the alternative school’s program to decrease the participants’ anger and aggression, as well as increase the participants’ skills and abilities to appropriately deal with anger and aggression. The program used was a pilot; thus, some of the results can yield some valuable, although limited, information about its use with such a population. To evaluate the effectiveness of the counselling program for the participants, four pre- and post-assessments were administered prior to the intervention and during the last session (see measures section below). The dependent variable of the intervention was the participants’ self-reported anger and aggression coping skills and behaviour, measured by the questionnaires. The counselor who implemented the intervention was a fourth year student in the B.A.A of Behavioural Psychology at St. Lawrence College under the supervision of the coordinator of the alternative schools program as well as a faculty member of St. Lawrence College. Data were analyzed through descriptive statistics. The information collected was presented in a bar graph, which gave a visual
representation of the pre- and post-assessment scores. Findings are presented in the results section.

**Setting and Apparatus**

Sessions took place within an office in the alternative school’s building to provide a private and comfortable environment for the researcher to deliver the program and for the participant to express emotions and thoughts. To ensure safety, the researcher and alternative school staff had a walkie-talkie system available throughout all sessions. The researcher set up the room and materials and photocopied necessary sheets prior to the beginning of the session. Materials needed included pens, paper, the manual, and a student handbook (including activity sheets, logs, and homework).

**Measures**

**Pre-treatment and post-treatment assessments.**

Four pre- and post-assessments were used to evaluate the effectiveness of the anger and aggression counselling program to decrease the participant’s anger and aggression, as well as increase the participant’s skills and abilities to appropriately deal with anger and aggression. The Anger & Aggression Awareness Test (Nash, 2009; Appendix B) was a 10 question test that was developed by the creator of the Anger and Aggression Awareness Manual specifically for the manual. Questions were formed based on different sections of the manual, and the assessment was also supplemented with a few questions from an existing anger management assessment from Fitzell (2007). There was no measure of reliability or validity for this assessment, as it had not yet been implemented. Permission to reproduce this measure was received from Nash.

Beliefs Supporting Aggression Assessment (Bandura, 1973) was a six-question, four point Likert-scaled assessment, which was targeted for 12-16 year olds. Response choices were: Strongly Agree, Agree, Disagree, and Strongly Disagree, which were scored as 4, 3, 2, and 1 respectively. There was a total possible score of 24; such a score indicated a strong favorable attitude towards using violence. The BSAA had an acceptable level of reliability and validity, with an internal consistency of .66. This assessment measured normative beliefs regarding aggression.

The Modified Aggression Scale (Bosworth & Espelage, 1995) was made up of 22 Likert-scaled questions. The response choices were: No Opportunity, Never, 1 or 2 Times, 3 or 4 Times, and 5 or more Times, which were scored as 1, 1, 2, 3, and 4 respectively. Question 5 was a reverse scored item. The MAS had four subscales: fighting, bullying, anger, and cooperative/caring behaviour. The fighting and anger subscales had a possible score of 20; a high score indicated more fighting and aggressive behaviour. The bullying subscale had a possible score of 16, and a high score indicated more bullying behaviour. Lastly, the cooperative/caring subscale had a possible score of 32, and a high score indicated more cooperative and caring
behaviour. The MAS was shown to be reliable and valid, with internal consistency ranging from .60 to .83.

The Social Desirability Scale (Crowne & Marlowe, 1960) was an assessment made up of 33 True/False questions that could be answered in a socially desirable way. Responses were scored as 1 for true and 0 for false. This scale was used to measure the importance of being socially accepted and therefore indicating the likelihood of answering assessment questions openly and honestly. It had a possible maximum score of 33, with a high score indicating that being seen in a socially desirable way was important.

**Ongoing assessments.**

The study had several ongoing assessments which included the Client Engagement Scale that was used to monitor and measure the client’s interest and participation in the discussions and activities being worked on in that session. The researcher rated the participants’ body language, eye contact, participation, and openness on four separate Likert scales after each session was completed. Homework completion and anger log completion were two other ongoing assessments used in the study; they were used to gauge the participant’s level of commitment, motivation, and understanding of the treatment plan. The anger logs were also used as a form of self-monitoring for the frequency of anger and aggressive behaviours.

**Procedure**

Before the intervention was started, the alternative school coordinator and the researcher selected the participants based on the inclusionary criteria previously mentioned. The participants agreed to participate, and informed consent was obtained from the participants and their parents/guardians. The researcher was the primary facilitator of the anger and aggression awareness counselling program, under the supervision of the coordinator of the alternative school program. Once consent was obtained, the researcher conducted a behavioural interview and administered the pre-assessments during an initial meeting, and then sessions were started.

The anger and aggression awareness counselling program was based on the Anger and Aggression Awareness manual (Nash, 2009). Permission was obtained from Nash to use the manual, and the consent form authorizing this use is filed at St. Lawrence College. The anger and aggression awareness counselling program took place at the alternative school program over an eight-week span with one-hour sessions per week. The anger and aggression awareness counselling program was based on a cognitive behavioural approach, primarily focusing on physical indicators of anger, relaxation strategies, and cognitive restructuring. The initial session included an introduction to anger and aggression, as well as goal setting. The second session went into depth to define what anger and aggression are so that the participant had a clear understanding of what these terms mean. Next, the focus of the workshop was on identifying physical indicators of anger and aggression, as it was crucial for the participant to recognize signs when he was becoming angry or aggressive. The fourth session focused on relaxation.
techniques, such as deep breathing and progressive muscle relaxation, which were used as prosocial coping skills when he became angry. The fifth session included information on cognitions and how to change them. Tools like self-talk and thought stopping were used to help the participant cope with negative or distorted thoughts. During the sixth session, the effects of substance use and abuse on emotions were discussed. The next session focused on decision-making and the choices and consequences that followed a decision. Finally, the eighth session was an overview of topics discussed and skills learnt throughout the entire counselling program. Post-test assessments were administered during the last session. Throughout the course of the sessions, various activities such as role-plays and worksheets were used. There was also homework assigned to the participant after each session to be completed before the next session, as well as self-recording with an anger log. For a more detailed outline of the sessions, see Appendix C.
Chapter IV: Results

The principal hypothesis of this study was that the implementation of a counselling program on anger and aggression awareness for at-risk youth in an alternative community school setting would increase their abilities and skills to deal with their anger and aggression in a pro-social way, which will further decrease levels of aggressive behaviours. To evaluate the effectiveness of the counselling program the researcher administered pre-treatment and post-treatment assessments and used ongoing assessments such as the Client Engagement Scale.

Pre-/Post-Treatment Assessments

Anger and Aggression Awareness Test.

Pre- and post-treatment scores for the anger and aggression numerically scaled item for the Anger and Aggression Awareness Test are presented in Figure 1. Results indicated that at pre-treatment Participant 1 perceived his ability to deal with anger and aggression on the higher level of the scale indicating that he was confident in his abilities to effectively deal with anger and aggression; his score remained stable, only increasing by 1.5 units at post-treatment.

Participant 2 perceived his ability to deal with anger and aggression in the mid-range of the scale at both pre- and post-treatment, suggesting that he felt he could effectively deal with anger and aggression some of the time or in some situations. In addition to the numerically scaled item, this test had true/false and short answer questions. There was no change in Participant 1’s or Participant 2’s pre- and post-treatment answers for the true/false question section of the test. In regards to the short answer questions, most post-treatment answers were more indepth and recognized specific techniques, where as pre-treatment answer were vague and at times questions were left blank, for example “What are 5 physical cues to anger?” and “What can you do when you notice a physical cue to anger?”. Question 5 was omitted from the short-answer section of the test due to lack of time to cover that session; this question was based on the substance abuse material.
Figure 1. Anger and Aggression Awareness Numerical Item Scaled Scores

Beliefs Supporting Aggression Assessment.
The Beliefs Supporting Aggression Assessment (BSAA) pre-treatment and post-treatment results are illustrated in Figure 2, and raw scores are presented in Appendix D. Results for both Participant 1 and Participant 2 indicated that their beliefs are in the midrange of supporting aggression at both pre- and post-treatment. A score in this range indicated that both participants have beliefs and attitudes towards and against using violence to resolve disagreements or conflicts.
Modified Aggression Scale.

Pre- and post-treatment results for the Modified Aggression Scale (MAS) for Participant 1 are shown in Figure 3, and raw scores are presented in Appendix E. His scores for the fighting subscale indicated that he fell into the lower-midrange at both pre- and post-treatment, suggesting that he engaged in some fighting behaviour. Participant 1 obtained a low score on the bullying subscale at pre-treatment indicating little bullying behaviour; this score remained stable at post-treatment. On the anger subscale, his pre-treatment score indicated that he was in the lower mid-range, suggesting that he occasionally engaged in aggressive behaviour, while his post-treatment score showed a slight increase, indicating more aggressive behaviour. Lastly, he obtained a higher score on the caring/cooperative subscale at pre-treatment suggesting more caring/cooperative behaviour; this score increased even further at post-treatment.
Participant 2’s results for the MAS are shown in Figure 4, and raw scores are presented in Appendix E. Participant 2’s scores fell into midrange for the fighting and anger subscales at pre-treatment, indicating that he sometimes demonstrated these behaviours. At post-treatment, results demonstrated that there was a slight increase on the fighting subscale indicating more fighting, and the anger subscale remained stable. In regards to the bullying subscale, Participant 2 obtained low scores at both pre- and post-treatment, indicating little bullying behaviour. Participant 2 obtained a high score for the caring/cooperative subscale indicating that he demonstrated these behaviours quite frequently. There was a slight decrease on the caring/cooperative subscale suggesting less of this behaviour than at pre-treatment.
Social Desirability Scale.

The pre- and post-treatment Social Desirability Scale results are presented in Figure 5, and raw data can be found in Appendix F. Pre- and post-treatment results for Participant 1 both fell into the high scoring range suggesting that being seen in a socially acceptable way was of high importance to him. There was a negligible increase from pre- to post-treatment scores. Pre-treatment score for Participant 2 on the Social Desirability Scale showed that he was a high scorer, indicating that he tended to present himself in a socially desirable light. There was a significant decrease in his score at post-treatment, placing him in the average range, suggesting that he was less concerned about answering in a socially desirable way at that point.
Ongoing Assessments

Client Engagement Scale.

The researcher completed the Client Engagement Scale (raw data found in Appendix G) at the end of every session for each participant indicating the level of engagement. Table 1 illustrated the level of client engagement for six sessions for Participant 1 by rating body language, eye contact, participation, and openness. Scores of the Client Engagement Scale for Participant 1 indicated that he was actively engaging during most sessions by showing he was relaxed and open, and using appropriate eye contact, and participation for the majority of sessions. However, there were some occasions where Participant 1 had a lower engagement on the body language, participation, and openness subscales.
Table 2 illustrated the level of client engagement for seven sessions for Participant 2 by rating body language, eye contact, participation, and openness. Scores of the Client Engagement Scale for Participant 2 indicated that he was actively engaging during most sessions by demonstrating that he was relaxed, and that he used an appropriate amount of eye contact and participation. It also illustrated that he was open to most or all ideas and concepts throughout many sessions. The data also demonstrated that Participant 2 occasionally had lower levels of engagement on the body language, eye contact, and participation subscales during some of the sessions.

<table>
<thead>
<tr>
<th>Subscale</th>
<th>Items</th>
</tr>
</thead>
<tbody>
<tr>
<td>Body Language</td>
<td>Client was mostly fidgety and inattentive</td>
</tr>
<tr>
<td></td>
<td>0</td>
</tr>
<tr>
<td>Eye Contact</td>
<td>Client engaged in no eye contact</td>
</tr>
<tr>
<td></td>
<td>0</td>
</tr>
<tr>
<td>Participation</td>
<td>Client did not participate in discussions and activities</td>
</tr>
<tr>
<td></td>
<td>0</td>
</tr>
<tr>
<td>Openness</td>
<td>Client rejected ideas and concepts</td>
</tr>
<tr>
<td></td>
<td>0</td>
</tr>
</tbody>
</table>
Homework completion.

Participant 1 completed 37.5\% of the assigned homework and did not complete 37.5\% of the homework. Participant 2 completed 25\% of the homework and did not complete 50\% of homework that was assigned. The remaining 25\% of homework completion was not required for either participant.

Anger log completion.

Participant 1 completed the anger logs 28.5\% of the time, did not complete them 57\% of the time, and was not required to complete them 14\% of the time. Participant 2 never completed an anger log; thus, he did not complete them 87.5\% of the time, and they were not required 12.5\% of the time.
Chapter V: Discussion

This study examined the effectiveness of an anger and aggression awareness-counselling program for at-risk youth in an alternative school program with two male participants. These individuals had been having difficulties in school and with the law due to issues surrounding anger control. It was hypothesized that the implementation of the counselling program would increase the participants’ abilities and skills to deal with their anger and aggression in a pro-social way, which would further decrease levels of aggressive behaviours.

Interpreting Results

The scores on the numerically scaled item on the Anger and Aggression Awareness Test slightly increased for Participant 1 and remained stable for Participant 2. Both participants’ answers improved on the short answer questions and remained stable on the true/false questions. This indicates that both participants initially indicated that they knew the appropriate responses when faced with anger or aggression provoking circumstances. They did show a bit more detailed knowledge about how to respond at post-test although their self-ratings on confidence on dealing with anger showed negligible change. The BSAA results indicated that the results remained stable for both participants, demonstrating that there was little to no change in their beliefs or attitudes towards using aggression for resolving disagreements and conflicts. Results for the MAS remained fairly stable with slight increases or decreases on various subscales for both participants. This indicates that their behaviour in regards to fighting, bullying, aggression, and cooperativeness/caring did not have any significant changes from pre- to post-treatment. The results for the Social Desirability Scale showed at negligible increase for participant 1 indicating that the importance of being perceived as socially desirable had become slightly more important. A significant decrease in the results for Participant 2 suggested that being seen as socially desirable was not as important to him at post-treatment.

Overall, the changes in scores from the pre-treatment and post-treatment assessments generally remained stable or slightly increased/decreased, therefore indicating that the hypothesis was not supported. This was in contrast to what was found by Beck and Fernandez (1998) and Sukholdosky, Kassinove, and Gorman (2004) in demonstrating that the use of CBT anger programs are effective in increasing coping skills. There are several possibilities that may explain why the hypothesis was not supported; these will be explored below.

First off, the initial intention of this research was to look at the effectiveness of the manual in a group format. Unfortunately, there were not enough youth at the organization to create a group, thus the switch to an individual counselling format was made. As mentioned in the literature review there are advantages to working one-on-one with a client such as stronger therapeutic rapport, more support, and encouragement, as well as a more individualized treatment plan (Farmer & Chapman, 2008); however, some of the key components of the manual were not utilized to its full potential. The use of role-plays were planned to be used in many of
the sessions on various topics, but in the individual counselling sessions it was difficult to make full use of the role-plays. Often times there were too many roles for just two people, and it would have been a good time for the youth to be creative in acting out role-plays with one another. Role-plays are essential for allowing clients to practice the newly acquired techniques and have also been shown to help transfer these skills into real life situations, as noted by Beiling et al. (2006) in the literature review. Since the use of role-plays were cut down and not used to their full potential, it may have been a factor in the outcome of the study.

Another essential part of the program was homework and the use of an anger log as a form of self-monitoring. As previously mentioned in the literature review by Gonzalez, Schmitz, and DeLaune (2006) and Kellner, Bry, and Salvador (2008), homework and self-monitoring (anger logs) are extremely important parts of CBT programs. Homework is an important component of the program because it allows the participants the opportunity to practice and improve upon the skills learnt in session. The literature also indicated that the use of logs is an important way of motivating participants to use the skills and also a way of monitoring the participants’ progress. Results from the homework completion and anger log completion demonstrated that the participants only completed the homework or anger logs some of the time, if at all. The participants’ not completing the homework or anger logs may explain why there were no significant changes between pre-treatment and post-treatment scores since they missed out on a good portion of the material, activities, and techniques.

The program also incorporated the client engagement scale as an on-going assessment. Overall, both participants were relaxed and actively engaged in discussions. However, at times, they did have lower levels of body language, eye contact, openness, and participation. This suggested that they may not have been interested in what was being presented or perhaps there were external events occurring that were affecting them in session sometimes.

Some structural issues could have played into how effectively the program was delivered. It was recommended and set up that the program had 8 sessions that ran for eight consecutive weeks, each lasting approximately an hour. Due to events such as absences, professional development days, setbacks in receiving consent forms, and limited timeframe, the program had to be reshuffled in order to implement the material within the timeframe. Session 6 on substance abuse was omitted for both participants to make up for time restraints. Participant 1 had six meetings where sessions one and two were combined and seven and eight were combined. These sessions were combined together because they were each covering related material and were shorter sessions; thus, combining them would make covering other material possible. Participant 2 had 7 sessions with no combined sessions; however, sessions were delivered twice a week. These changes could have affected the effectiveness of the study because too much material may have been presented too quickly, not giving the participants enough time take it in. It may have even affected the homework completion.
Interestingly, results from the social desirability scale for participant 2 demonstrated a significant decrease from his pre-treatment score, suggesting that he was less concerned about answering in a social desirable way. Participant 2 would have begun to answer more openly and honestly, on the other assessments in a similar fashion to the way he did on the Social Desirability Scale. This could have explained why there were no significant changes between pre- and post-treatment scores on the assessments, or perhaps why his score on the caring/compassion subscale on the Modified Aggression Scale may have actually worsened at post-treatment. Throughout the treatment, it appeared that there was an increase in the therapeutic rapport; it would be interesting to see if there was a connection between that increase and the decrease in the Social Desirability Scale by Participant 2.

Indeed, the study had several factors that may have contributed to the nonsignificant results, but it did demonstrate some areas of success. Results from the Anger and Aggression Awareness Test suggested that both participants increased their understanding on some of the major components delivered because they were able to provide more elaborate and thoughtful answers for the short-answer questions. Some of these components included: ability to identify triggers and physical cues of anger and aggression, knowledge of how to cope with feeling of anger and aggression and how de-escalate situations involving conflict. This assessment also indicated that Participant 1’s own perception of being able to deal with anger and aggression increased, further demonstrating the understanding of the program and potential of using techniques in real life situations. Both participants took part extremely well in the session on relaxation techniques including deep breathing and progressive muscle relaxation. This researcher had the opportunity to witness Participant 1 engage in deep breathing and keep himself under control when he was clearly experiencing anger. Participant 2 verbally stated that he practiced progressive muscle relaxation at home and found it to be helpful in keeping in calm.

**Strengths and Limitations**

A major strength of the study was that the manual used for the counselling program was created for at-risk youth specifically at this agency, and it incorporated suggestions and feedback from the agency staff who worked directly with the youth. Another strength was that this program incorporated a variety of evidence based cognitive behavioural techniques that were appropriate for the age levels in the agency. Furthermore, this study used a variety of assessments that evaluated different aspects of anger and aggression.

Limitations of the study included limited direct observation of the participants outside scheduled session times, which made it difficult to know if the behaviour had improved or not in the participants’ natural environment. As stated above, time constraint was another limitation of this study. Some of the material was omitted all together, while others were rushed through therefore having an impact on the effectiveness of the study. Client motivation to complete homework and anger logs outside of session was poor; this could have affected the outcome of the study by the lack of the self-monitoring component.
Having a small sample size was a limitation because the participants' characteristics may not be representative of that general population; perhaps the program may have worked better for other people. Having a small sample size also limits the analysis of results to descriptive statistics where a larger sample size could have the ability to use statistical analysis such as the related-samples Wilcoxon test. It would also give a better representation of the effectiveness on the population by having means and standard deviations.

A further limitation on the study was the assessments used. Most of the assessments used were pre- and post-treatment self-report type assessments. The issue with these assessments is that the participants may have a biased or unrealistic view of themselves or may be trying to please by giving the “right answer.” It would have been beneficial to use the self-report measures in conjunction with direct observation and parent/staff measures such as interviews, questionnaires, or observations. Another limitation encountered in regards to the assessments was that the Anger and Aggression Awareness Test was developed by the creator of the manual and had not been tested for reliability or validity. Therefore, this assessment may not have measured what it was created to measure.

**Multi-level Challenges to Service Implementation**

There were some challenges that were faced in regards to the client, program, organization, and society when working in an alternative school for at-risk youth who were suspended or expelled from regular school due to issues with anger.

**Client level challenges.**

It was challenging to work with youth who were not motivated or interested to fully participate in the study. Even though it was voluntary, the youth participated in it because they were under the pressure of family, school, and sometimes the law, rather than for their own benefit. When youth were not committed to working towards the goals set in treatment they often did not put their full effort into it, thus missing sessions, not completing homework and self-monitoring, and not taking sessions seriously. This lead to the youth not fully comprehending and using the material and techniques learnt in session in their daily lives. However when this occurred it was important to encourage the youth to take the most out of the program that he or she can and that they could have all the support they need.

**Program level challenges.**

One of the major challenges encountered at the program level was working around time restrictions. Since there was a specific period in which the program needed to be implemented, there was some shuffling around of the counselling program to meet this demand. By doing so, certain material needed to be omitted from the counselling program outline, some sessions needed to be combined, while sessions were being held twice a week rather than once. This affected the way that information and techniques were being delivered to the participants, which further affected the final outcome of the study.
Organizational level challenges.
When providing services to participants for an agency that shares a building with other agencies that all have different programs running and services being offered it was quite challenging to have a room available to conduct the counselling sessions. This meant that at times sessions needed to be conducted in a noisy environment or a cluttered room affecting the atmosphere for the program delivery. It may have caused the participants to feel uncomfortable and unimportant. It also had issues surrounding confidentiality.

Societal level challenges.
Society often fails to give youth who have had difficulties with anger problems, which have often resulted in school suspensions or expulsion or difficulties with the law a second chance. This is challenging because after providing services to these youth they are not given the opportunity from society (schools, community, authorities, and parents) to work towards and maintain the techniques learnt in counselling.

Contributions to the Behavioural Psychology Field
Given the nature of the non-significant results, it was demonstrated that, even with the volume of empirical evidence supporting cognitive behavioural techniques for anger management, it is still crucial to evaluate newly created programs to ensure their effectiveness. This study also emphasized the importance of using self-monitoring, homework, and role-plays that has been shown in the literature.

Recommendations for Future Research
With the results of this study not supporting the hypothesis, it would be important to evaluate the effectiveness of this anger and aggression awareness manual with a larger sample size, either as individual or group format. It would be beneficial to implement this program in group format so that all of the techniques could be used to their full potential, such as role-playing. Delivering the material in a visual manner such as power points and chart boards may help in keeping the participants’ interest. It would be additionally important to implement the program consecutively for 8 weeks without combining or omitting sessions. It would also provide a more accurate representation of the effectiveness for this population, and better statistical analysis could be completed.

It is further recommended to incorporate more observable methods of data collection so that the effectiveness can have objective evidence than just self-report measures. It would be beneficial to have more parental and staff involvement during functional interviews and throughout the assessment procedures rather than just relying on the self-reports of the participants. To ensure that homework and anger logs are being completed throughout the entire program there could be some form of reinforcement built in. Another recommendation would be to make sure that the goal setting is very specific and attainable and has objectives that can be measured throughout various points in the program. Further research in regards to building a
comfortable and trusting environment for the participants before presenting program would be interesting to see if it had any influence on the effectiveness of the program itself.
References


Appendices

Appendix A: Consent Forms

Consent Form - Youth

TITLE: Evaluating the Effectiveness of an Anger and Aggression Awareness Workshop to Increase Appropriate Anger Related Coping Skills for At-Risk Youth.

STUDENT: SARAH LACOMBE

COLLEGE SUPERVISOR: DR. SUSAN MEYERS

PHONE: 613-329-1046, EMAIL: smeyers@kos.net

Invitation

I am a student in my 4th year in the Behavioural Psychology at St. Lawrence College and I am currently on placement at Youth Diversions – School and Non-Academic Program. As a part of this placement, I am completing a special project called an applied thesis and am asking for your assistance to complete this project. The information in this form is intended to help you understand my project so that you can decide whether or not you want to participate. Please read the information below carefully and ask all the questions you might have before deciding whether or not to participate.

WHAT IS THE PURPOSE OF THE STUDY?

The purpose of this study is to evaluate the effectiveness of an anger and aggression awareness workshop for at-risk youth. Youth who display aggression are at a higher risk for early substance abuse, delinquent behaviour, and school dropout. Thus, there is a need to provide these at-risk youth with interventions that provide them with coping skills to regulate their anger. It has been noted, that there is still a need for further research in effective outpatient interventions for at-risk children and especially adolescents. This study proposes that the implementation of an anger and aggression awareness workshop for at-risk youth in an alternative community school setting will help increase the use of appropriate coping skills, as well as increase their knowledge and understanding of anger and aggression, which will further decrease levels of aggressive behaviours.

WHAT WILL YOU NEED TO DO IF YOU TAKE PART?

If you agree to take part in the study, there will be eight weekly workshop sessions on anger and aggression that run for about an hour each that you would be expected to attend. During these sessions, there will be activities or discussions that you could participate in such as recognizing physical symptoms due to anger, learning relaxation techniques and proper ways to
manage anger. There will be three questionnaires that you will take prior to the first session and at the final session. The questionnaires will be the Anger & Awareness Test, the Beliefs Supporting Aggression Assessment, and the Modified Aggression Scale. It should take about 30 minutes to complete all questionnaires each time. There will also be an Anger Log for you to keep track of any verbal or physical aggression that may occur. Occasional homework assignments related to the session will be assigned to be completed for the following session.

**WHAT ARE THE POTENTIAL BENEFITS TO ME OF TAKING PART?**

The potential benefits of participating in the study are that you might learn about how anger and aggression affects you. You might also learn new appropriate coping skills to help stay calm during situations that would normally cause you to act out aggressively – both physically and verbally.

**WHAT ARE THE POTENTIAL BENEFITS TO OTHERS OF TAKING PART? (IF APPLICABLE)**

Information from this study may help future youth at this agency who experience aggressive behaviours.

**WHAT ARE THE POSSIBLE DISADVANTAGES AND RISKS OF TAKING PART?**

The risks of participating in this project are minimal but may include becoming tired or bored from answering questions or sometimes becoming upset during discussions.

**WHAT HAPPENS IF SOMETHING GOES WRONG?**

If something does happen to go wrong you can talk to me your workshop leader, or the program coordinator of SNAP. If needed, you could take time-out from the workshop to go for a short walk and talk to a SNAP staff.

**WILL MY TAKING PART IN THIS PROJECT BE KEPT PRIVATE?**

We will make every attempt to keep any information that identifies you strictly confidential unless required by law. All documents will be identified only by code number and kept in a locked filing cabinet at SNAP in a locked classroom for seven years. Information on computer will be password protected. You will not be identified by name in any reports, publications, or presentations resulting from this project.

**DO YOU HAVE TO TAKE PART?**

It is up to you to decide whether or not to take part. If you do decide to take part, you will be asked to sign this consent form. If you do decide to take part, you are still free to withdraw at any time, without giving any reason, and without having any penalty.
CONTACT FOR FURTHER INFORMATION.

The Research Ethics Board at St. Lawrence College has approved this project. The project will be developed under the supervision of Susan Meyers, my supervisor from St. Lawrence College. I really appreciate your cooperation. If you have any additional questions or concerns, feel free to ask me, Sarah Lacombe at slacombe21@student.sl.on.ca, or you can contact my College Supervisor, Susan Meyers by phone (613) 329-1046 or by email at smeyers@kos.net. You may also contact the Research Ethics Board at appliedresearch@sl.on.ca.

CONSENT

If you agree to participate in the project, please complete the following form and return it to me as soon as possible. A copy of this signed document will be given to you for your own records. An additional copy of your consent will be retained at the agency and in a secure location with the Research Ethics Board at St. Lawrence College.
CONSENT

By signing this form, I agree that:

• The research project has been explained to me.
• All my questions have been answered.
• Possible harm and discomforts and possible benefits (if any) of this project have been explained to me.
• I understand that I have the right not to participate and the right to stop at any time.
• I am free now, and in the future, to ask any questions about the research project.
• I have been told that my personal information will be kept confidential.
• I understand that the results of this project may be published or presented in a professional conference.
• I understand that no information that would identify me will be released or printed without asking me first.
• I understand that I will receive a signed copy of this consent form.

I hereby consent to participate.

Participant Printed Name: ____________________________

Age of Participant (If Under 18):______________

Signature: _________________________________ Date: ________

SLC Student Signature: ________________________ Date: ________

Printed Name: ________________________________

Witness: ________________________________ Date: ________

Printed Name: ________________________________
CONSENT FORM – PARENT/GUARDIAN

TITLE: Evaluating the Effectiveness of an Anger and Aggression Awareness Workshop to Increase Appropriate Anger Related Coping Skills for At-Risk Youth.

STUDENT: SARAH LACOMBE

COLLEGE SUPERVISOR: DR. SUSAN MEYERS

PHONE: 613-329-1046, EMAIL: smeyers@kos.net

Invitation

I am a student in my 4th year in the Behavioural Psychology at St. Lawrence College and I am currently on placement at Youth Diversions – School and Non-Academic Program. As a part of this placement, I am completing a special project called an applied thesis and am asking for your assistance to complete this project. The information in this form is intended to help you understand my project so that you can decide whether or not you want your youth wants to participate. Please read the information below carefully and ask all the questions you might have before deciding whether or not you want them to participate.

WHAT IS THE PURPOSE OF THE STUDY?

The purpose of this study is to evaluate the effectiveness of an anger and aggression awareness workshop for at-risk youth. Youth who display aggression are at a higher risk for early substance abuse, overt delinquency, and school dropout. Thus, there is a need to provide these at-risk youth with interventions that provide them with coping skills to regulate their anger. It has been noted that there is still a need for further research in effective outpatient interventions for at-risk children and especially adolescents. This study proposes that the implementation of an anger and aggression awareness workshop for at-risk youth in an alternative community school setting will help increase the use of appropriate coping skills, as well as increase their knowledge and understanding of anger and aggression, which will further decrease levels of aggressive behaviours.

WHAT WILL YOU NEED TO DO IF YOU TAKE PART?

If you agree for your youth to take part in the study, there will be eight weekly workshop sessions on anger and aggression that run for about an hour each that your youth would be expected to attend. During these sessions, there will be activities or discussions that your youth could participate in such as recognizing physical symptoms due to anger, learning relaxation techniques and proper ways to manage anger. There will be three questionnaires that your youth will take prior to the first session and at the final session. The questionnaires will be Anger & Awareness Test, the Beliefs Supporting Aggression Assessment, and the Modified Aggression Scale. It should take about 30 minutes to complete all questionnaires. There will also be an Anger Log for you to keep track of any verbal or physical aggression that may occur.
Occasional homework assignments related to the session will be assigned to be completed for the following session.

**WHAT ARE THE POTENTIAL BENEFITS TO ME OF TAKING PART?**

The potential benefits of participating in the study are that your youth might learn about how anger and aggression affects him/her. Your youth might also learn new appropriate coping skills to help stay calm during situations that would normally cause him/her to act out aggressively – both physically and verbally.

**WHAT ARE THE POTENTIAL BENEFITS TO OTHERS OF TAKING PART? (IF APPLICABLE)**

Information from this study may help future youth at this agency who experience aggressive behaviours.

**WHAT ARE THE POSSIBLE DISADVANTAGES AND RISKS OF TAKING PART?**

The risks of participating in this project are minimal but may include your youth becoming tired or bored from answering questions or sometimes becoming upset during discussions.

**WHAT HAPPENS IF SOMETHING GOES WRONG?**

If something does happen to go wrong your youth can talk to me the workshop leader, or the program coordinator of SNAP. If needed, your youth could take time-out from the workshop to go for a short walk and talk to a SNAP staff.

**WILL MY TAKING PART IN THIS PROJECT BE KEPT PRIVATE?**

We will make every attempt to keep any information that identifies your youth strictly confidential unless required by law. All documents will be identified only by code number and kept in a locked filing cabinet at the agency in a locked classroom for seven years. Information on computer will be password protected. You will not be identified by name in any reports, publications, or presentations resulting from this project. Only SNAP staff, Youth Diversion’s executive director and parents will have access to the file.

**DO YOU HAVE TO TAKE PART?**

It is up to you and your youth to decide whether or not he/she should take part. If you do decide your youth would like to take part, you will be asked to sign this consent form. If you do decide for your youth to take part, your youth is still free to withdraw at any time, without giving any reason, and without incurring any penalty.
CONTACT FOR FURTHER INFORMATION.

The Research Ethics Board at St. Lawrence College has approved this project. The project will be developed under the supervision of Susan Meyers, my supervisor from St. Lawrence College. I really appreciate your cooperation. If you have any additional questions or concerns, feel free to ask me, Sarah Lacombe at slacombe21@student.sl.on.ca, or you can contact my College Supervisor, Susan Meyers by phone (613) 329-1046 or by email at smeyers@kos.net. You may also contact the Research Ethics Board at appliedresearch@sl.on.ca.

CONSENT

If you agree for your youth to participate in the project, please complete the following form and return it to me as soon as possible. A copy of this signed document will be given to you for your own records. An additional copy of your consent will be retained at the agency and in a secure location with the Research Ethics Board at St. Lawrence College.
CONSENT

By signing this form, I agree that:

- The research project has been explained to me.
- All my questions have been answered.
- Possible harm and discomforts and possible benefits (if any) of this project have been explained to me.
- I understand that I have the right for my youth not to participate and the right to stop at any time.
- I am free now, and in the future, to ask any questions about the research project.
- I have been told that my youth’s personal information will be kept confidential.
- I understand that the results of this project may be published or presented in a professional conference.
- I understand that no information that would identify my youth will be released or printed without asking me first.
- I understand that I will receive a signed copy of this consent form.

I hereby consent for my youth to participate.

Parent/Guardian Printed Name: ____________________________

Name and Age of Participant (If Under 18):____________________

Signature: ____________________________ Date: ________

SLC Student Signature: ____________________________ Date: ________

Printed Name: ____________________________

Witness: ____________________________ Date: ________

Printed Name: ____________________________
Appendix B: Anger and Aggression Awareness Test

Participant 1 – Pre-Treatment Assessment

Anger & Aggression Awareness Pre-Test

Name: Subject 1  Date: Oct. 27, 2010

True or False – circle either T for True or F for False

1. I can explain the way I feel without using the word angry. T/F
2. If I get angry because of what someone else did, it is his or her fault. T/F
3. I do not notice when I start to get mad. T/F
4. I know the steps that lead up to me getting angry or starting a conflict. T/F

Short Answer – provide a short answer below for each question

1. What is a SMART goal? To focus on getting my \( \text{[response]} \)
2. What are 5 physical cues to anger?
   - heavy breathing
   - clenched fists
   - hot skin
   - frowning
   - [other physical cues]
3. What can you do when you notice a physical cue to anger?
   - take a second to think, take a deep breath, think about the consequence before you get angry
4. What are two ways to de-escalate conflict?
   - talk it out or \( \text{[response]} \)
5. How can drug/substance use affect anger and aggression?
   - \( \text{[response]} \)
6. On a scale of 1-10, with 1 meaning not at all and 10 meaning completely, rate your ability to effectively deal with anger and aggression?
   - \( \text{[response]} \)
Participant 1 – Post-Treatment Assessment

Anger & Aggression Awareness Pre-Test

Name: __________________________ Date: ______________

True or False – circle either T for True or F for False

1.) I can explain the way I feel without using the word angry. [T/F]  
2.) If I get angry because of what someone else did, it is his or her fault. [T/F]  
3.) I do not notice when I start to get mad. [T/F]  
4.) I know the steps that lead up to me getting angry or starting a conflict. [T/F]

Short Answer – provide a short answer below for each question

1.) What is a SMART goal? __________________________

   *logical, benefits in good way*

2.) What are 5 physical cues to anger? __________________________

   *hotness, red face, tensed muscles, sweating, clenching fists, heart race increase*

3.) What can you do when you notice a physical cue to anger? __________________________

   - break down situation in head
   - deep breaths
   - decide which choice benefit in the end

4.) What are two ways to de-escalate conflict? __________________________

   - calm tone
   - express own feelings

5.) How can drug/substance use affect anger and aggression? __________________________

6.) On a scale of 1-10, with 1 meaning not at all and 10 meaning completely, rate your ability to effectively deal with anger and aggression?

   1 2 3 4 5 6 7 8 9 10

Participant 2 – Pre-Treatment Assessment

Anger & Aggression Awareness Pre-Test

Name: ____________________________  Dates: ____________________________

True or False – circle either T for True or F for False

1.) I can explain the way I feel without using the word angry. T/F

2.) If I get angry because of what someone else did, it is his or her fault. T/F

3.) I do not notice when I start to get mad. T/F

4.) I know the steps that lead up to me getting angry or starting a conflict. T/F

Short Answer – provide a short answer below for each question

1.) What is a SMART goal?
   
   to walk away from conflict.

2.) What are 5 physical cues to anger?

   ________________________________

3.) What can you do when you notice a physical cue to anger?

   ________________________________

4.) What are two ways to de-escalate conflict?

   Walk away
   Apologize for whatever had happened

5.) How can drug/substance use affect anger and aggression?

   It all depends on the drug/substance
   i.e.: Marijuana calms the body where cocaine does the

6.) On a scale of 1-10, with 1 meaning not at all and 10 meaning completely, rate opposite your ability to effectively deal with anger and aggression?

   1  2  3  4  5  6  7  8  9  10

Participant 2 – Post-Treatment Assessment

Anger & Aggression Awareness Pre-Test

Name: __________________________ Date: ____________

True or False – circle either T for True or F for False

1.) I can explain the way I feel without using the word angry. T/F

2.) If I get angry because of what someone else did, it is his or her fault. T/F

3.) I do not notice when I start to get mad. T/F

4.) I know the steps that lead up to me getting angry or starting a conflict. T/F

Short Answer – provide a short answer below for each question

1.) What is a SMART goal?

2.) What are 5 physical cues to anger? (Changes in body, speech, thoughts, intensity)

3.) What can you do when you notice a physical cue to anger? (Deep breaths, think positively, self-talk, talk to someone)

4.) What are two ways to de-escalate conflict? (Talk it out, how I feel about situation)

5.) How can drug/substance use affect anger and aggression?

6.) On a scale of 1-10, with 1 meaning not at all and 10 meaning completely, rate your ability to effectively deal with anger and aggression?

1 2 3 4 5 6 7 8 9 10

# Appendix C: Session Outline

<table>
<thead>
<tr>
<th>Session #</th>
<th>Session Plan</th>
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| Pre-Session – Functional analysis and pre-assessments | a) Administered behavioural interview and pre-assessments  
- Anger and Aggression Awareness Test  
- Beliefs Supporting Aggression Assessment  
- Modified Aggression Scale |
| Session #1 – Introduction to Anger and Aggression and Goal Setting | a) Introduction to anger and aggression awareness  
b) Goal Setting – short-term, long-term and SMART goals  
c) Homework: Anger Logs |
| Session #2 – Defining anger and aggression | a) Define Anger and Aggression  
- anger web  
b) ABC’s of Anger  
c) Your Anger Pattern  
d) Homework: Aggressive Behaviour in Hollywood & Anger Logs |
| Session #3 – Physical Anger Cues | a) Review homework  
b) Physical Anger Cues  
c) COPING with Anger  
d) Homework: COPING with anger habit checks |
| Session #4 - Techniques to manage anger and aggression including relaxation techniques | a) Initial activity – quote  
b) Role Play – COPING strategy  
c) Progressive Muscle Relaxation  
d) Word Search  
e) Homework: Practice Progressive Muscle |
| Session #5 - Cognitions surrounding anger and aggression | a) Self-Talk  
b) Cognitive Distortions  
c) Thought Stopping  
d) "I" Statements  
e) Homework: Review previous weeks homework  
   Emotions, Self-Talk and Perception work sheet |
|-------------------------------------------------------|--------------------------------------------------|
| Session #6 - Substance abuse and emotions              | a) Review Homework  
b) Discussion on substance abuse and emotions  
c) Neurons, Synapse, and Receptors  
d) Homework: weekly substance use log |
| Session #7 - Decision making                           | a) Review Homework  
b) You be the Judge activity  
c) Choice Wheel  
d) The Cold Within story |
| Session #8 – Conclusion                                | a) Review homework  
b) Closing discussion/statements  
c) Tips to build resilience  
d) Post-Assessments |
### Appendix D: Beliefs Supporting Aggression Assessment (BSAA) Raw Data Table

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Appendix E: Modified Aggression Scale (MAS) Raw Data Table

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Appendix F: Social Desirability Scale Raw Data Table

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Appendix G: Client Engagement Scale

Participant 1

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<td>Client participated in some discussions and activities</td>
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## Participant 2

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<thead>
<tr>
<th>Sessions</th>
<th>Body Language</th>
<th>Eye Contact</th>
<th>Participation</th>
<th>Openness</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Client was relaxed for most of the session</td>
<td>Client engaged in moderate eye contact</td>
<td>Client participated in some discussions and activities</td>
<td>Client agreed with most ideas and concepts</td>
</tr>
<tr>
<td>2</td>
<td>Client was relaxed for most of the session</td>
<td>Client engaged in appropriate eye contact</td>
<td>Client participated in discussion and activities throughout the entire session</td>
<td>Client agreed with most ideas and concepts</td>
</tr>
<tr>
<td>3</td>
<td>Client was relaxed for most of the session</td>
<td>Client engaged in moderate eye contact</td>
<td>Client participated for most discussions and activities</td>
<td>Client agreed with most ideas and concepts</td>
</tr>
<tr>
<td>4</td>
<td>Client was relaxed for the entire session</td>
<td>Client engaged in appropriate eye contact</td>
<td>Client participated in discussion and activities throughout the entire session</td>
<td>Client agreed with all ideas and concepts</td>
</tr>
<tr>
<td>7</td>
<td>Client was relaxed for the entire session</td>
<td>Client engaged in appropriate eye contact</td>
<td>Client participated in discussion and activities throughout the entire session</td>
<td>Client agreed with most ideas and concepts</td>
</tr>
<tr>
<td>5</td>
<td>Client became fidgety and inattentive as session progressed, eye contact</td>
<td>Client engaged in little eye contact</td>
<td>Client participated in some discussions and activities</td>
<td>Client agreed with most ideas and concepts</td>
</tr>
</tbody>
</table>