A Preliminary Program Evaluation of the Emotional Skills Building Curriculum

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Abstract

This study presents the results of a preliminary program evaluation of a treatment program for court referred offenders: The Emotional Skill Building Curriculum (ESBC). Initial results found low recidivism rates and possible treatment efficacy. Further research applications are discussed.
Keywords: program evaluation, anger management, emotional regulation

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Violent behavior is an inextricable part of the societal fabric of mankind. In the United States over 1.2 million violent crimes occurred in 2015 which is a 3.9% increase from 2014 estimates (Federal Bureau of Investigations [FBI], 2015). These violent crimes included homicide, sex offenses (i.e. rape), and aggravated assaults. Nationally there have been increases in homicides by 10.8% from 2014 to 2015 (FBI, 2015). In 2015, there were an estimated 764,449 aggravated assaults in the nation, a 4.6% increase from 2014 estimates (UCR 2015). While crimes reported provides insight so does the number of arrests. The Unified Crime Report also indicated that over one million arrests took place in 2015 for crimes against a person and crimes against property. The U.S. uses several methods to address ongoing criminal behavior to stem the tide of violence. Some methods involve removal from society, such as incarceration while other methods focus on treatment to prevent further violence. These treatment courts, or specialized courts focus on case management and therapy as a diversionary measure to avoid incarceration and were created to address underlying issues that influence criminal behavior (Strong, Rantala, & Kyckelhahn, 2016). The US Department of Justice identified 1310 specialized courts in 2017 including drug courts, domestic violence courts and mental health courts (DOJ, 2017). The types of mental health treatment vary, however in 2012 49% of problem solving courts offered and participants used some type of anger management treatment (Strong, Rantala, & Kyckelhahn, 2016).

Defining Anger

Anger has been defined as a multidimensional construct with distinguishable characteristics in cognitive, behavioral, and affective, dimensions (Spielberger, Johnson, Russell, Crane, Jacobs, & Worden, 1983). The cognitive dimension of anger is described as the ideas and perceptions that one has related to a stimulus or environment (Cox & Harrison, 2008). The behavioral dimension of anger embodies the emotion and cognitions, also viewed as aggression or the action that occurs as a result of anger (Cox & Harrison, 2008; Besharat & Shahidi, 2010). Anger has been broadly defined as a maladaptive emotion in response to stress provoking stimuli such

as social conditions that involve a threat or frustration (Cox, Stabb, & Bruckner, 1999; Maxwell, Sukhodolsky, Chow, & Chow, 2005; Novaco, 1975). These negative expressions of emotion result in conflict and personal discomfort and are potentially problematic in relation to the intensity, frequency and manner of expression (Maxwell, et al., 2005; Novaco, 2011). While the affective dimension of anger is defined as a negative emotional state or experience (Cox & Harrison, 2008; Maxwell, Sukhodolsky, Chow, & Chow, 2005), there is also research support to view anger as an adaptive method of resolving perceived threats (Lench, 2004). This perception of healthy anger and unhealthy anger is differentiated based on the outcome of the anger response.

While the definition above is broad in terms of describing anger, it is also important to look at anger in the context of theoretical perspectives as well. Novaco (2011) described anger, as it relates to cognitive theory as, potentially problematic in relation to the intensity, frequency and manner of expression. Social constructionists, however, describe anger as a social construct not necessarily intraphysic or solely biological in nature (Averill, 1983). Anger is a construction of the environment and the meaning which we attach to the context of a given anger provoking situation. Emotions including anger are a combination of physiological, expressive, cognitive evaluation, instrumental acts and subjective experience (Averill, 1983).

Violence and Anger

There is an inexorable link between violence and anger (Anderson & Bushman, 2002; Carpenter & Nevin, 2005; Novaco, 2013). Anger can partially be attributed to frustration and the inability to attain or maintain a desired standard, goal or circumstance (Averill, 1983; Beck, 1999). Anger can provide a justification for aggressive behavior due to lowered inhibitions and impaired moral reasoning and judgment (Anderson & Bushman, 2002). Inhibitions are lowered because of the interference with higher level cognitive processes that can take place during periods of anger (Anderson & Bushman, 2002). Respondents in a study by Lievaart, Franken, and Hovens (2016) reported being prone to express their anger toward others and objects with verbal and physical aggression. Anger also aids in a person maintaining aggressive intention over time, while also cueing a hyperfocus on the anger provoking events (Anderson & Bushman, 2002). Ruminating over anger provoking events has been associated with negative affect, suicidal ideation, and increased aggression (Bushman, 2002).

Anger impacts physical health, personal relationships and work performance (Besharat & Shahidi, 2010; Novaco, 1980) and is associated with increased medical visits, greater chronic pain and coronary heart disease ((Besharat & Shahidi, 2010). Of course, anger expression also leads to criminal behavior and resulting court intervention. As stated earlier, the treatment of choice is anger management. Anger management was identified as a need by 38% of juvenile offenders (Vieira, Skilling, & Peterson-Badali, 2009) and Saini (2009) indicated that treating anger is effective in diverse populations including adults with angry parents, violent male prisoners, female and male batterers, incarcerated juveniles, aggressive drivers and others.

Current Treatment

The most common method to treat anger is cognitive behavior therapy (Saini, 2009). Cognitive behavior therapy (CBT) if not used alone is a component of various other treatment methods such as psychoeducation and skills focused treatment. Cognitive behavioral treatment has shown significant improvement in anger management skills across the three anger regulation skill domains; arousal calming, cognitive coping, and behavioral control (Mackintosh, Morland, Frueh, Greene, & Rosen, 2014). Cognitive treatment approaches include changing cognitions and ideas about anger and anger provoking stimuli and environments. In general, cognitive therapies may involve methods of relaxation, reframing of events, coping skills (i.e. imagery and distraction) and interpersonal or social skills training; these techniques are practiced for use later when confronted with an anger provoking stimulus and successful execution is usually followed by contingent reinforcement (Beck & Fernandez, 1998).

Skills based training teaches participants how to handle anger in an assertive manner (Glancy & Saini, 2005). The focus of the sessions is on communication, listening skills, constructive and negative feedback, clarification of options in difficult situations, and assertiveness in initiating reasonable requests and declining unreasonable requests (Glancy & Saini, 2005). Students who completed a social skills focused anger management intervention reported less trait anger, general anger, and expressions of anger (Deffenbacher, Oetting, Lynch, & Morris, 1996).

However, traditional CBT programs have not always been successful in decreasing actual physical aggression (Howells, Day, Williamson, Bubner, Jauncey, Parker & Heseltine, 2005; Lindsay, Allan, Parry, MacLoed, Cottrell, Overend, & Smith, 2004) and CBT treatment by itself is less effective than increased mental health support (Mackintosh, Morland, Kloezeman, Greene, Rosen, Elhai, & Frueh, 2014). In fact, the most successful interventions focus on multiple maladaptive learning environments (Zigler, Taussig, & Black, 1992; Messina, Braithwaite, Calhoun and Kubiak, 2016). Research indicates that numerous treatment modalities may be used to address anger management. Treatment from a developmental model may decrease physical aggression while increasing perspective taking behaviors. (Author, 2010).

Emotional Regulation

According to Ford and Gross (2018) emotion regulation is taking part in feeling control; feelings we have, when we experience them, and how we express them. Bowlby (1982/1969, 1973, 1980) argued that infants are born with a collection of behaviors (attachment behaviors) focused on maintaining proximity to supportive others (attachment figures). From this perspective seeking to be close to attachment figures is an innate process. This primary attachment strategy becomes an affect regulation device, with the intent to provide protection and alleviate distress. Bowlby (1988) posited that successful accomplishment of these affect-regulation functions results in a sense of attachment security. A person views the world as safe and that attachment figures are safe harbors which allow them to explore new environments and engage with others effectively. Gross (2015) proposed that the objective of emotional regulation is to influence the emotional path of oneself (intrinsic) or that of another (extrinsic).

When significant others are unavailable or unresponsive to an individual's needs, then seeking this closeness of proximity does not relieve distress and a sense of attachment security is

not achieved. This lack of security leads to a negative self-concept and distrust of others (Mikulincer, Shaver & Pereg, 2003). Being raised in stressful, conflict laden environments damages the biological and psychological regulatory systems of children which then interferes with the development of coping skills (Evans & Kim, 2010). In fact, poverty in childhood coupled with neglect is a direct predictor of later criminal behavior in adulthood (Nikulina, Widom, & Czaja, 2011). Neurological research verifies that attachment security in infancy directly impacts right brain emotional regulation development and attachment disruptions throughout childhood alter the ability to cope with intense emotions (Schore, 2001). Chronic stress during childhood increases activity in the amygdala during emotion regulation, which may be a contributing factor to the physiological and psychological stress regulation difficulties (Kim et al, 2013). Attachment insecurity is marked by hypersensitivity to perceived threats and rumination (Goodall, Trejnowska, & Darling, 2012). These adults have limited coping skills to handle anger and frustration due to a lack of optimal environmental stimuli in childhood. Attachment insecurity has been linked to aggressive, impulsive behavior, poor social competence and impaired adult relationships (Bowlby, 1980). Viewing anger management through a developmental lens of emotional regulation development provides an added component to traditional treatment.

Purpose of Study

The purpose of this study was to conduct a preliminary summative program evaluation of the Emotional Skills Building Curriculum (EBSC) (Author, 2010) with a population of offenders court referred for anger management treatment. The Emotional Skills Building Curriculum is an alternative form of anger management treatment that focuses on the developmental components of emotional regulation. The treatment plan focuses on building emotional regulation skills rather than focusing on cognitive behavioral techniques of relaxation and thought stopping. The beliefs one holds about the meaning attached to emotion is an abstract metatheory about how the world works (Ford & Gross, 2018). The ESBC was derived from attachment theory and the link between attachment security and emotional regulation; the treatment plan is devised to assist clients in understanding their own physical reactions to emotions, identify emotional reactions based on their attachment to family members or peers and their location i.e. church versus the neighborhood, and then increase self-awareness of how reactions relate to situations. The treatment plan then builds on these skills to develop first perspective taking and then empathy for others and finally finding emotional support. Gross (2015) discussed three important components of emotion regulation, 1) how often does one regulate emotion, 2) belief in ability to regulate emotion (self-efficacy) and, 3) competency in regulating emotion. The ESBC supports this ideology by allowing the participant to learn, practice and gain proficiency in emotion regulation. The program is based on the theoretical underpinnings that insecure attachment styles impede the development of emotional regulation. According to Ford and Gross (2018) individuals who believe their emotions are uncontrollable have fewer coping mechanisms and infrequent incidences of implementation of coping strategies. The ESBC allows individuals to develop new skills and through activities, practice and implementation. Both formative and summative data were collected from participants to determine the efficacy of the ESBC curriculum.

Program evaluations that use a summative program evaluation format to evaluate outcomes are effective measures of program efficacy (Spaulding, 2014). A review of research on anger management programs found these types of program evaluations to be a prevalent model to evaluate the efficacy of anger management programs. Eamon, Munchua, and Reddon (2001) as well as Fetsch, Yang and Pettit (2008) used surveys and assessment tools to perform a summative program evaluation of their respective anger management programs with offender populations. Both designs included pre and posttest data collection along with survey data collected at least three months after the end of treatment.

Method

Participants

The studied population were 292 former clients of an urban, no cost mental health clinic, who had been referred for anger management treatment from 2011 to 2016. Every client referred for anger management in that time period was included in the study. The population was 46% female and 54% male; 87% African American, 5% White, 1% Multiracial and 1% Hispanic; 6% of the population did not indicate a racial identity. Ages ranged from 16-65 with a mean of 33 years of age. Sixty-Seven percent attended group counseling and 33% attended individual counseling. The average number of sessions completed was 8 with a median of 5. Sixty percent of the population either had no health insurance or did not disclose having health insurance. Seventy percent identified their intimate partner status as single, 12% married and 10% as divorced and or separated.

Measures

The principal investigator drafted a post treatment survey and asked fellow professionals in Psychology and Counselor Education to review it for clarity before gathering data. The survey was analyzed and re-written three times to improve language and ensure accurate data collection. The survey included demographic questions (current age, socioeconomic status, intimate partner status, employment status, and health insurance status), questions regarding subsequent police contacts following treatment, and qualitative questions regarding what aspects of the Emotional Skills Building program the participant remembered and/or used. Please see Table I for a list of the data requested through the survey.

Table I

Number of Police contacts since treatment	Number of new criminal charges since treatment
Reason for new charges	Number of new convictions since treatment
Have you been in counseling since treatment?	Reason for counseling since treatment
Please tell us everything you remember about the content covered in the anger management group	What parts of the anger management group did you like best?
What part of the anger management group did you like least?	What parts if any of the anger management group do you use in everyday life?

Procedures

This summative program evaluation involved reviewing the clients electronic and paper client records; and surveying the 292 clients who were referred to a no-cost counseling clinic on the campus of an urban university for anger management treatment due to a misdemeanor or felony conviction from 2011 -2015. The survey collected data between a three month and a four year follow-up. Clients were referred primarily for domestic violence or simple assault. Participant attendance varied based on client motivation and court order, with some clients referred for only one four-hour group session and other clients referred for 26 individual sessions. Each hour of treatment counted as one session. All clients were referred from a district or circuit court probation officer or parole officer. Individuals referred for treatment were informed that the clinic collected data in an anonymous way and they could opt out of research at any time during the treatment. Only client files with consent to research were reviewed and surveyed for this study. Participants who agreed to respond to survey questions agreed to a separate informed consent and the project was reviewed and approved by an institutional review board.

All individuals referred for anger management received treatment using the Emotional Skills Building Curriculum (Author, 2010). The Emotional Skills Building Curriculum (ESBC) is a 12-week treatment program designed to increase self-awareness, emotional regulation, and empathy skills. The program is based on a developmental deficit model and utilizes techniques from attachment theory, social learning theory and solution focused theory (Author, 2010). The treatment program consists of worksheets designed to elicit group process or individual discussion such as feeling charades, where clients act out emotions and others try to guess the emotion as a demonstration of how easily we "misread" other's motivations and feelings, and a race car metaphor (Author, 2010) that uses speed as an analogy for emotional regulation. Counselors received training in the treatment model and used the model for both group and individual modalities for all clients referred for anger management. Training included an online presentation, an online quiz and recorded video demonstrations of each group session. Group counseling occurred on Saturdays for four hours and individual counseling occurred one time per week for 50 minutes.

Past clients were contacted via phone and emailed during 2016. Investigators made three attempts throughout the year at different times and with different methods to reach clients. Clients who were emailed the survey also received two follow up calls. Of the 292 clients who completed treatment and consented to research, we were unable to contact 175 clients due to non-working contact information. One client was deceased, and one was incarcerated. Of the 117 clients with accurate current contact information, 7 clients refused to answer the survey and 30 completed the survey, a response rate of 26%. The investigators also attempted to survey probation and parole officers, but only three responded and although the comments were positive there was not enough data to draw any conclusions.

Both progress notes and survey responses were analyzed using percentages and a text analysis website: https://www.online-utility.org/text/analyzer.jsp. The text analyzer provided a word count of survey responses and progress and similar wording that appeared most frequently was identified for analysis.

Results

Seventy-Three percent of participants completed treatment successfully as defined by completing the court ordered number of sessions. All 292 client reactions based on group and individual progress notes were analyzed for common wording and themes. This analysis found four common themes in the progress notes: participants in group counseling routinely gave advice to each other regarding coping skills; participants often discussed being able to identify triggers to anger, participants preferred group counseling over incarceration, and participants frequently stated that group counseling was different than their expectations.

The 30 former clients (referred to as respondents) who completed the survey were 53% Female and 47% Male, 87% African American, 10% White while 3% of the respondents did not provide information on race, 60% reported currently having health insurance. The average age was 38 and the average income based on 14 data points was $32,000 per year; individuals who did not report income were not included in the calculations. Similarly, only 13 respondents indicated that they currently had employment. Five percent of the respondents did not complete the treatment successfully, meaning they did not complete the court ordered number of sessions. The average number of sessions completed were 8.27 with a standard deviation of 7.25 with a range of one session to 28 sessions.

Only one respondent had a police contact or conviction following treatment. This respondent was a four year follow up. The respondent received a driving while impaired violation. The rest of the surveyed respondents disclosed no subsequent criminal charges, police contacts or convictions since treatment. Seventeen percent of respondents indicated they had sought counseling since ending treatment for matters ranging from substance abuse to marriage counseling.

Responses to the qualitative questions indicated that respondents viewed the treatment as effective. Twenty three percent could identify one or more aspects of the Emotional Skills Building curriculum including “how to control anger”, “walking in someone else’s shoes” and “listening to others” while 7% of respondents could not recollect any aspect of the Emotional Skills Building Program. Feedback about what the respondents liked the best about the treatment were overwhelmingly positive, with only 6% either not answering with a positive statement or providing a negative statement. Common responses included the statements “no judgment”, “realizing I have control over my life”, and “just listening”. Feedback about what they liked least included having to attend the court ordered sessions and one individual identified the counselors as “naïve”. Most respondents indicated “nothing” when asked what they did not like about the treatment. However, 40% of respondents indicated that they do not use any portion of the treatment in their everyday lives. Please see Table II which provides four examples of verbatim responses to the qualitative questions.

Table II

Question	Response
Please tell me everything you remember about the content covered during the anger	Putting your feelings out on the floor and not holding them in.

management group. (for example: emotional charades, the race car, walking in someone else's shoes, acting different in different places with different people)	Taught me how to express myself.. i usually was quite only said one word they taught me to how to express myself more than one word... they let people explain their situation and then we based stuff on that and how you deal ... they had us spell things out and draw the situation, and we also did hangman
	Put yourself in the other person's place and ask what would you do if you were them, think twice and act once do not act on impulse
	Coping skills recognizing triggers deescalating situations
What parts of the anger management group did you like best?	Hearing other people's situations & how you could relate to them.
	Listening to others stories
	Getting classes over with because of probation.
	And the fact that it was free
	All was great
What part of the anger management group did you like the least?	no issues with it
	Wanted to go more than what was offered.
	People would just repeat the same thing every week. I was like "Get over it". I didn't like the part when they sent me to AA
	Nothing. Originally I hated that I had to go but it was good
What part of the anger management group, if any do you use in your everyday life?	Using your words & judgement before acting on
	something that angers you
	Nothing I can recall
	I can only control myself

Discussion

This preliminary program evaluation yielded limited but cautiously optimistic results. The surveyed clients did report a lack of future police involvement and an improved ability to prevent further incarcerations and improved ability to regulate emotion and improve coping skills. Similarly, the results also provide insight into the world view of an individual who is court referred for anger management treatment. The frequency with which members would share stories and offer advice speaks to the importance of validating the client's world view to build healthy cohesion which can often be difficult without beginning with the client's perspective

(Robbins, 2003). Interestingly, the participants' ability to identify triggers to anger during treatment supports that while individuals have insight into the reasons behind their behavior, the insight alone did not prevent angry outbursts, as each participant had been court ordered to anger management treatment. This finding provides further evidence of the need for alternative anger management programs. Finally, the theme that participants had an expectation of treatment that varied greatly from the actual treatment speaks to the stigma associated with mental health treatment. Individuals court ordered to treatment, while preferring treatment over incarceration, expect treatment to be disciplinary in nature rather than supportive or cathartic. When compounded by the stigma associated with race and criminality; offenders referred for treatment are faced with overcoming several barriers prior to engagement (West, Vayshenker, Rotter, & Yanos, 2015). Reframing anger management treatment to be less focused on punishment from the participant's perspective might alleviate one of these barriers.

The importance of rapport and attachment reverberated throughout the survey as well. Surveyed past clients specifically identified issues related to the quality of attachment with the therapist through comments such as "just listening" and "no judgment". Participants could remember aspects of the treatment and verbalize ways that they used the skills in their daily lives. While 40% indicated they did not use the treatment every day, the fact that only one individual had further police contact suggests that the individuals developed improved coping skills. The first few sessions of the ESBC specifically focus on building quality relationships through validation of feelings and attending to the quality of the attachment between group members and therapists. Client feedback that focused on the overall view of the counseling experience support research that the quality of the relationship in counseling is as important as the type of treatment and predicts successful outcome (Kim, Kim & Boren, 2008). Because 73% of the participants completed treatment perhaps the focus on empathy and validity may have spoken to the ability of the program to engage clients in the therapeutic process.

Offenders were referred for anger management treatment for a variety of misdemeanors and felony convictions, including domestic violence, assault and resisting arrest. These individuals are often not given the option of what type of treatment to attend and the cost of such treatment is usually cost prohibitive. Individuals referred to the no-cost clinic attended due to referral from probation or parole based on their lack of health insurance and financial resources. While varied programs may have evidence support, the reality is that not all models fit all clients and that clients benefit when there is compatibility between client and treatment method (Beutler, Moleiro, Malik, & Harwood, 2003). The promising results of this program evaluation support that the ESBC treatment may be a possible option for individuals who are not as successful with CBT focused programs.

Limitations

The inability to reach many of the participants hampered the results of the program evaluation and probably skewed the results toward clients who had access to sufficient resources. The population of individuals who responded mirrored the sample population by gender and race, but not by health insurance or employment, with respondents to the survey reporting more access to health insurance and employment. Participants reached through the survey had working emails and phones, while individuals we could not reach had no working contact

information. This fact speaks to the nature of an indigent population and speaks to the reality of the interactions between poverty, mental health and criminal justice (Nikulina, Widom, & Czaja, 2011). The factors of lack of access to resources and poverty increase stress on an already burdened population and increases the likelihood of physical altercations (McAra, & McVie, 2016). The participants who attended anger management self-selected for either group or individual therapy based on their needs and the availability of clinic hours. Clients may have preferred one modality over the other but were unable to attend due to time or day constraints.

Future Studies

The clinic has instituted a routine screening using the State Trait Anger Expression Inventory (STAXI-2) (Spielberger, 1999) and plans to begin screening for trauma symptoms as well. The treatment plan would also benefit from the inclusion of trauma focused behavioral interventions due to the current neurological research on the link between emotional regulation and Post Traumatic Stress Disorder (McHugh, Forbes, Bates, Hopwood, & Creamer, 2012). An experimental design with pretest and posttest design should be pursued as well.

Conclusion

Clients achieve favorable outcomes when treatment is matched to the specific needs of the client. Therefore, clients should also be afforded treatment options irrelevant of financial resources. The ESBC offers another treatment modality to prevent further police contacts. This study found that even up to four years after treatment clients could identify aspects of the treatment and reported that they had not experienced any further interaction with the criminal justice system. These participants indicated they could utilize empathy and perspective skills to prevent further altercations and were able to report the ability to see someone else's perspective before reacting. While only thirty participants were surveyed, this encouraging result supports that this treatment modality may be effective and provide clients who prefer another type of treatment a choice. Client responses also suggest that they prefer an atmosphere without judgment and the ability to share their experiences. Focusing on building a client's ability to regulate all emotion rather than just focusing on anger provides a wider context to discuss emotional regulation.

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